INFORMED CONSENT FOR: TREATMENT NOT COVERED BY MEDICARE

(And to not bill Medicare or any secondary insurance plan)

I, _____ _____

Print patient name Patient date of birth

have been informed by Dr. Klausner the following in-office treatment is not covered by current Medicare guidelines. I have been informed and understand Medicare cannot and will not be billed for this service. I agreeto pay the full cost to Dr. Klausner at the time I receive this treatment. I understand no secondary or medi-gap insurance can be billed for this service as well. I agree to never submit any claim on my own to Medicare or secondary insurance for reimbursement of this treatment. I understand I will not receive a super bill or any insurance coded receipt for this service from Dr. Klausner or his staff and associates.

Patient signature Date

_____ _____

Print patient name Social Security Number

_____ _____