R O Y   M .   S T E F A N I K ,   D O

P S Y C H I A T R Y

P O B O X 8 6 1 5 7 6
V I N T H I L L F A R M S , V A 2 0 1 8 7 - 1 5 7 6
P H O N E (7 0 3) 8 3 0 - 1 5 0 0

F A X (7 0 3) 8 3 0 - 0 0 0 1
A D M I N @ F A I R F A X M E N T A L H E A L T H . C O M
W W W . F A I R F A X M E N T A L H E A L T H . C O M

MEDICARE OPT-OUT CONTRACT

______________ Date   ____ Patient Name   _______________________ DOB

Please complete this document if you are a Medicare patient; otherwise, please check "Not Applicable" and initial.

❑ Not Applicable ________________
initial

Please be informed that this agreement indicates, and as signed by both this writer and my patient referenced above, that my patient is a Medicare beneficiary and this writer, Roy Michael Stefanik, DO is a physician excluded from participation in the Medicare program.

My patient agrees that by signing this contract, he/she will not submit a claim or request that the aforementioned practitioner submit the claim to Medicare. My patient also acknowledges that Medigap plans do not reimburse and that other supplemental insurance plans, such as FEP, may elect not to make payments for services furnished by a physician or practitioner under the opt-out portion of the contract. The patient also agrees to be responsible for payment and acknowledges that this practitioner is not limited to the amount that he or she may be charged for services rendered. The conditions listed on this letter are to go into effective immediately. If requested or needed by my patient, I will provide him/her a copy of the appropriate documentation indicating my exclusion from participation.

____ Roy Michael Stefanik, DO   ____ Patient Signature

❑ The patient was provided a copy of this signed agreement.