BRIAN K. SMITH, D.D.S., M.D., INC.
14601 Detroit Avenue, Suite 630
Lakewood, OH 44107
(216) 228-4232 Fax: (216) 228-9136

By signing this contract, I understand and agree that I will not submit (or request that my oral and maxillofacial surgeon submit) a claim to Medicare or its agents for services provided by **Brian K. Smith, D.D.S., M.D., Inc.**, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by **Brian K. Smith, D.D.S., M.D., Inc.**, and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral and maxillofacial surgeon for services provided.

I understand that Medigap plans do not, and other health and medical insurance plans may elect not to make payment for such services.

I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that **Brian K. Smith, D.D.S., M.D., Inc.** is not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective on _____ and will expire on _____.

Patient Name: _____

Patient's Signature: _____

Oral and Maxillofacial Surgeon's Signature: _____