VITAE
INTEGRATIVE MEDICAL CENTER

Agreement of Exempt Insurance or Self-Pay

This agreement is between Vitae Integrative Medical Center, whose principal place of business is 2925 Debarr Rd. Suite. 150, Anchorage, AK 99508 and...

Patient Name: _____ Date-of-Birth: _____

Please select the exempt billing option that applies to you:

- ❏ Self-Pay or Out-of-Network Insurance
- ❏ Medicare / Medicaid
- ❏ Tricare / Veterans Affairs (VA)
- ❏ Health Share / Cost Share

Patients with Medicare Part B seeking services covered under Medicare Part B pursuant to section 4507 of the Balanced Budget Act of 1997: the medical provider has informed the patient and/or the legal representative that the physician has opted out of the Medicare program effective September 2007.

Please acknowledge the following statements. The patient or legal representative acknowledges, agrees and understands the following:

_____ (initial) I accept full responsibility for the payment of all physician charges for all services furnished by the medical provider.

_____ (initial) I agree there are no limits that apply to what the physician may charge for items or services provided by the medical provider.

_____ (initial) I agree that I cannot submit a claim to Medicare or Medicaid and I cannot ask the medical provider to submit a claim to Medicare or Medicaid.

_____ (initial) I agree that it is my responsibility to submit claims to TriCare, VA, UMR, and any Health Shares / Cost Shares for reimbursement and that Vitae Integrative Medical Center cannot guarantee coverage and/or reimbursement.

VITAE
INTEGRATIVE MEDICAL CENTER

_____ (initial) I agree that payment will not be accepted from any insurance company or entity if there was no private contract and/or a proper claim had been submitted.

_____ (initial) I acknowledge that I have the right to obtain Medicare covered services by physicians and practitioners who have not opted out of Medicare.

_____ (initial) I understand that Medi-Gap plans, supplemental plans, and/or healthshares may elect not to make payments for items and services not paid for by Medicare.

_____ (initial) I agree that I am not currently in an emergency or an urgent health care situation.

_____ (initial) I acknowledge that a copy of this contract is available upon request.

_____ _____

Signature of Patient, Guardian, or Legal Representative **Date Signed**

_____

Printed Name

Telephone: (907) 929 - 2222
Fax: (907) 929 - 2225

2925 Debarr Rd. Suite 150
Anchorage, AK 99508

www.vitaeheal.com