

KENNETH R. COHEN, M.D.

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PRIVATE CONTRACT FOR PATIENTS INSURED BY MEDICARE

DATE:

PATIENT:

I ACKNOWLEDGE THAT DR. KENNETH COHEN IS EXCLUDED FROM MEDICARE.

I ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF DR. COHEN'S CHARGE FOR ITEMS OR SERVICES FURNISHED BY HIM.

I AGREE NOT TO SUBMIT A CLAIM TO MEDICARE OR TO ASK DR. COHEN TO SUBMIT A CLAIM TO MEDICARE.

I UNDERSTAND THAT MEDICARE PAYMENT WILL NOT BE MADE FOR ANY ITEMS OR SERVICES FURNISHED BY DR. COHEN THAT WOULD HAVE OTHERWISE BEEN COVERED BY MEDICARE IF THERE WERE NO PRIVATE CONTRACT AND A PROPER MEDICARE CLAIM HAD BEEN SUBMITTED.

I UNDERSTAND THAT I HAVE THE RIGHT TO OBTAIN MEDICARE-COVERED ITEMS AND SERVICES FROM OTHER PHYSICIANS AND PRACTITIONERS WHO HAVE NOT OPTED OUT OF MEDICARE, AND THAT I AM NOT COMPELLED TO ENTER INTO PRIVATE CONTRACTS THAT APPLY TO OTHER MEDICARE COVERED SERVICES FURNISHED BY OTHER PHYSICIANS OR PRACTITIONERS WHO HAVE NOT OPTED OUT.

I UNDERSTAND THAT MEDIGAP PLANS DO NOT, AND THE OTHER SUPPLEMENTAL PLANS MAY ELECT NOT TO, MAKE PAYMENTS FOR ITEMS AND SERVICES NOT PAID FOR BY MEDICARE.

X _____

SIGNATURE OF PATIENT

X _____

KENNETH R. COHEN, M.D.