



**MEDICARE OUT-OF-NETWORK ACKNOWLEDGEMENT**

Our providers are **not enrolled with or participating in Medicare**. As a result:

- Our office does **not submit claims to Medicare**.
- Payment for services is due at the time of service.
- Upon request, we will provide a detailed receipt (walkout statement) for you to submit your own claim.
- Any reimbursement is determined solely by Medicare and is not guaranteed.

By signing below, I acknowledge that this office will not bill Medicare on my behalf and that I am financially responsible for all charges incurred.

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**Patient Name (Print):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If signed by Legal Representative:**

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Office Representative/Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_