OUR MEDICARE POLICY

This bulleted list is a summary of our policies toward Medicare. More information is described in an article available on our web site.

- All patients pay for their medical care at time of service. We do not accept assignment from any insurance company, not even Medicare.
- Dr. Woliner is classified as a non-par provider with Medicare. This means that Dr. Woliner's staff will submit to Medicare on your behalf. Medicare would then forward your claim to your secondary insurance. After Medicare processes this claim, you will receive a reimbursement check directly from Medicare. This reimbursement check will be based on the level of coverage of your secondary insurance, whether you met your deductible or not, and the type of service.
- Some services (see below), are not covered by Medicare at all. In such cases, you will not receive any reimbursement for those services and you will be solely responsible for their cost. Non-covered services include:
  - All non face-to-face time such as:
    - Telephone Consultations
    - Filling out disability forms
    - Filling out other forms you ask us to fill out
    - Writing consult notes to other physicians
    - Calling and having extended conversations with other physicians, family members, and other persons you wish us to speak with.
  - Counseling time
    - Counseling time is needed for the doctor to explain your medical condition, abnormal laboratory test results, and details of the intricate treatment plans that are created specifically for you.
  - Body Composition Analysis to measure percent body fat and lean body mass
  - Intravenous Vitamin Infusions
  - Nutritional Supplements
  - Educational Supplies

Even if Medicare sends you a notice stating you are due a refund if you paid for this service, this is not the case. When Medicare never pays for a certain service, no specific Advanced Beneficiary Notice (ABN) needs to be signed by you for HFM to be allowed to bill you for these services.

I understand that Medicare may not pay for certain services provided at Holistic Family Medicine, LLC. I am entitled to know how much these services cost before I receive them. I acknowledge that I am solely responsible for the cost of services provided.

Patient name _________________________Signature ________________________ Date ___________