Alexander C. Simotas, M.D.
Assistant Professor of Rehabilitation Medicine
The Hospital for Special Surgery
429 East 75th Street, 4th Floor
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FOR MEDICARE INSURED PATIENTS ONLY

Date: _____/_____/_____

Patient Name: _____

Date of Birth: _____/_____/_____

Medicare ID Number: _____

I have been informed and hereby understand that Dr. Simotas is a non-participating provider with "Medicare-National Government Services". I have been informed that I will be billed the Medicare limiting fee amount at the time medical service are rendered. The office will then file the paid claim to Medicare-National Government Services for my reimbursement. The Medicare limiting fee amount is 15% greater than the Medicare approved fee amount for non-participating providers. I understand that Medicare will reimburse me 80% of allowable charges, minus any deductible not yet met for the calendar year.

I authorize the release of any medical or other information necessary to process this claim. I also request payment pf government benefits either to me or to Dr. Simotas should he decide to accept assignment.

Effective Date: These statements shall be effective from the date of the signature below until December 31st of the current year, unless you notify Dr. Simotas's office otherwise in writing at the address written above.

A photocopy of this agreement/authorization shall be considered as effective and valid as the original.

_____ _____/_____/_____
Signature of policyholder or authorized person — Date

_____ _____/_____/_____
Witness — Date