FILL OUT ONLY IF YOU HAVE MEDICARE:

Medicare Patient Private Physician Contract

This agreement, entered into the date below, is between **Scott Wolfe, MD,** whose business address is 523 East 72nd Street, NY, NY 10021 and patient named:

Patient Printed Name: ____ DOB: ________________

Address: ____and is a Medicare Part B beneficiary or eligible, seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician decided to opt-out of the Medicare program effective January 26, 2017 and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act. Physician agrees to provide the following medical services to Patient ("Services"): general medical care including but not limited to physicals, chronic and acute disease management, delivery attendance and minor skin surgery or wound care. In exchange for Services, the Patient agrees to make payment directly to Physician.

Patient also agrees, understands and expressly acknowledges the following:

Patient agrees not to submit a claim (or to request Physician to submit a claim) to the Medicare program with respect to the Services for payment, even if covered by Medicare Part B. Initials ______

Patient is not currently in an emergency or urgent health care situation. Initials ______

Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services. Initials ______

Patient acknowledges that secondary or supplemental plans may not provide payment or reimbursement for the Services because payment is not made under the Medicare program. Initials ______

Patient acknowledges that patient has a right, as a Medicare beneficiary, to obtain Medicare covered items/services from physicians and practitioners who have not opted-out of Medicare, and that patient is 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. Initials ______

Patient agrees to be responsible to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided. Initials ______

Patient understands that Medicare payment will not be made for any items or services furnished by the Physician that may have otherwise been covered by Medicare if there were no private contract. Initials ______

Patient acknowledges that a copy of this contract has been made available. Initials ______

Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his/her beneficiaries. Initials ______

Executed by Patient or if Patient’s Representative

Patient Signature: ____ Date: ________________

New Patient Evaluation Form
Scott Wolfe, MD

Today's Date: ________________

Name: ____ Date of Birth: ____________________

History of Current Complaint:

1. Which side is affected? ☐ Right ☐ Left ☐ Both
2. Which hand do you write with? ☐ Right ☐ Left ☐ Both
3. Reason for today's visit? ____
4. For how long? ____

Past Medical History:

☐ High blood pressure
☐ High Cholesterol/Lipids
☐ Coronary artery disease (CAD)
☐ History of heart attack (MI)
☐ Congestive Heart Failure (CHF)
☐ Atrial Fibrillation
☐ Diabetes mellitus (type I or II)
☐ Hyper/hypothyroidism
☐ Hyperparathyroidism
☐ Asthma
☐ COPD / Emphysema
☐ Kidney Disease
☐ Sleep Apnea
☐ Rheumatoid Arthritis
☐ Psoriatic Arthritis
☐ Psoriasis
☐ SLE / Lupus
☐ Peptic Ulcer Disease
☐ GERD / Reflux
☐ IBD: Crohn's or UC
☐ Hepatitis
☐ History of Stroke or TIA
☐ Seizure Disorder
☐ Parkinson's disease
☐ Anemia
☐ Cataracts/Glaucoma
☐ Cancer, Type: ________________
☐ History of Substance Abuse
☐ Weight loss/Weight gain
☐ Fever/Sweats/Chills
☐ Osteoporosis/Osteopenia
☐ Other: ______________________
☐ Metal implants in body?

Medications:

Medication	Dosage	Medication	Dosage
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Surgeries:

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

Allergies:

Allergy	Reaction	Allergy	Reaction
1.		3.	
2.		4.	

Social History:

Occupation: ____ Alcohol Intake: _______________ Drinks/week

Smoking: ☐ Prior Smoker, Quit: ___________ ☐ Current Smoker, # of Packs per day: ________ x ________ years

Vital Signs: (for official use only)

Height: __________ Weight: __________ BP: _____________ Pulse: _________ Temp: _________