Warren Klausner, D.O.

129 Jewell Street, Santa Cruz, California 95060

Informed Consent For:

Treatment Not Covered By Medicare

And

To Not Bill Medicare Or Any Secondary Insurance Plan

I, _____ _____ ,
print patient name patient date of birth

have been informed by Dr. Klausner the following in-office treatment

_____

is not covered by current Medicare guidelines. I have been informed and understand Medicare cannot and will not be billed for this service. I agree to pay the full cost to Dr. Klausner at the time I receive this treatment. I understand no secondary or medi-gap insurance can be billed for this service as well. I agree to never submit any claim on my own to Medicare or secondary insurance for reimbursement of this treatment. I understand I will not receive a super bill or any insurance coded receipt for this service from Dr. Klausner or his staff and associates.

_____ _____
patient signature date

_____ _____
print patient name social security number