

Powerful Health and Wellness

2106 Seminole Dr. NW

Huntsville, AL 35805

Non-Participation Agreement for Medicare and Medicaid Policy

Patient Acknowledgment and Agreement

This agreement (the “Agreement”) is entered into between Powerful Health and Wellness, LLC (the “Practice”) and the undersigned patient (the “Patient”), with respect to the provision of healthcare services by the Practice.

1. Non-Participation in Medicare and Medicaid

The Practice does not participate in Medicare or Medicaid and is not a Medicare or Medicaid provider. The Practice does not submit claims for reimbursement to Medicare or Medicaid for any healthcare services provided to the Patient. By signing this Agreement, the Patient acknowledges that the Practice does not bill Medicare or Medicaid for services, and as such, the Patient agrees to pay the Practice directly for all healthcare services rendered.

2. Patient’s Responsibility for Payment

The Patient understands and agrees that they are personally responsible for the payment of all healthcare services provided by the Practice, regardless of whether those services would be covered by Medicare or Medicaid if the Practice were a participating provider. The Patient agrees to pay the Practice’s fees directly for all services provided.

3. No Medicare or Medicaid Reimbursement

The Patient acknowledges that because the Practice does not participate in Medicare or Medicaid, the Patient will not be eligible to receive reimbursement from Medicare or Medicaid for any services provided by the Practice. The Patient further acknowledges that they cannot submit claims to Medicare or Medicaid for services rendered by the Practice.

4. Informed Consent for Services

By signing this Agreement, the Patient affirms that they have been informed that the Practice does not participate in Medicare or Medicaid, and that they have the option to seek care from a Medicare or Medicaid participating provider. The Patient understands that this Agreement is necessary before any healthcare services are provided.

5. Acknowledgment of Non-Coverage

The Patient acknowledges that they are not entitled to reimbursement from Medicare or Medicaid for services received from the Practice. The Patient affirms that they have not been pressured or coerced into entering into this Agreement, and they freely choose to receive services from the Practice on a direct payment basis.

6. Patient’s Statement Regarding Medicare/Medicaid Enrollment

The Patient affirms that they do not currently have Medicare or Medicaid coverage. The Patient further affirms that they do not wish to have any services provided by the Practice

billed to Medicare or Medicaid and understand that no such billing will occur. If the Patient becomes eligible for Medicare or Medicaid in the future, they understand that this Agreement may need to be updated or revised accordingly.

7. Duration of Agreement

This Agreement is valid for the duration of the Patient's care with the Practice unless the Patient chooses to terminate their relationship with the Practice or until the Patient elects to enroll in Medicare or Medicaid or another insurance program that the Practice does not accept.

8. Right to Review and Seek Advice

The Patient has the right to seek advice from an attorney, financial advisor, or other healthcare professional before signing this Agreement. The Patient has had the opportunity to review and ask questions regarding the contents of this Agreement.

Patient Acknowledgment

By signing below, the Patient acknowledges and agrees to the terms of this Agreement. The Patient certifies that they have read and understood the contents of this Agreement and voluntarily agree to the provisions outlined above. If purchasing online by clicking the acknowledgement checkbox, patient agrees and acknowledges this policy.

Patient Name (Printed): _____

Patient Date of Birth: _____

Patient Signature: _____

Date: _____

Practice Representative Name (Printed): _____

Practice Representative Signature: _____

Date: _____