# Barry F. Gritz, M.D.

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**Board Certified**
**Diplomat of the American Board**
**Of Psychiatry and Neurology**

**230 Westcott Suite 210**
**Houston, TX 77007**
**713-869-7400 OFFICE**
**713-869-7404 FAX**

**Tax ID # 126549629**
**NPI # 1487635892 BG**
**NPI# 1821157363 CW**
**NPI#1831561901 AW**

Patient Name: ______________________________

Provider :__________________________________

## MEDICARE / MEDICAID PROGRAM OPT-OUT CONTRACT

1. I understand that my provider has opted out of the Medicare/ Medicaid program.
2. I further understand that I am entering into a private contract with my provider.
3. According to Medicare/ Medicaid regulations, a claim cannot be filed for my visits, either by my provider
4. or by me. Medicare/ Medicaid will impose fines for violation.
5. I also understand that all prescriptions written by an opt-out provider will not be covered under Medicaid and will have to be self-pay.

By signing below, I understand that payment in full is due at time of service in the amounts of:

| | | |
|---|---|---|
| 90792: | $ 350.00 | (New Evaluation) |
| 99213: | $ 100.00 | (Medication Management) up to 15 min. |
| 99214: | $ 200.00 | (Extended Medication Management) up to 30 min. |
| 99215: | $ 250.00 | (Medication Management) up to 45 min. |

________________________________________ ____________________
Signature Date

(If you have secondary insurance to Medicare, please ask the receptionist for a receipt. You may then file that receipt to Medicare requesting a denial, so that your secondary insurance may be billed directly from Medicare.)

Please note that Medicaid will not pay for medications written by this office, due to our opt-out status. Medicaid will only cover medications written by an in network provider.