IVF PHOENIX

INSURANCE STATEMENT/MEDICARE or AHCCCS DISCLAIMER:

To my patients and prospective patients: Please read and sign this statement to ensure there is no confusion amongst anyone as to whether my office accepts Medicare patients or AHCCCS. We have never enrolled to participate and do not intend to participate with Medicare nor AHCCCS. Because of the current Medicare and AHCCCS situation, it is necessary to inform you of this and have you sign and date this declaration.

I, ____, understand that Dr. John L. Couvaras, and/or his office have informed me that he does not accept patients with Medicare or Medicaid nor AHCCCS, either as primary or secondary insurance.

I, ____, declare that I will not attempt to bill Medicare, Medicaid, nor AHCCCS for services rendered in his office.

I, ____, am making these declarations under penalty of perjury.

In signing this statement, I fully understand that I have represented to them that I am not covered by Medicare or by Medicaid or by AHCCCS, nor do I intend to seek such coverage.

I realize that it is my responsibility to notify this office of any change in my insurance status, especially regarding Medicare.

I realize that failure to notify this office of Medicare or AHCCCS eligibility prior to services rendered constitutes fraud.

By signing this statement, I admit that the above is true and I will notify the doctor and the office staff prior to any change in my insurance status, especially Medicare or AHCCCS status. I have been counseled of this situation and will be expected to pay in full on the day of service, unless I have other insurance with which Dr. Couvaras is a participant.

____________________________________ ______________________

Patient signature Date

____________________________________ ______________________

Doctor/Staff signature Date