PATIENT-PHYSICIAN MEDICARE CONTRACT AGREEMENT

THIS PATIENT-PHYSICIAN AGREEMENT (this "Agreement") is made this day of _____ (the "Effective Date"), by and between Your Private MD, LLC ("YPMD"), and _____ ("Patient, or Medicare beneficiary").

BACKGROUND INFORMATION

Dr. Love-Walker has elected to opt out of Medicare, under §1128, 1156 or 1892 of the Act. As a result she will not submit to Medicare for reimbursement of medical fees while providing care to a Medicare patient. In addition, the physician and patient understand and agree to the following:

1. The Medicare beneficiary or the beneficiary's legal representative accepts full responsibility for payment of the physician's or practitioner's charge for all services furnished by the physician/practitioner;

2. The Medicare beneficiary or the beneficiary's legal representative understands that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner;

3. The Medicare beneficiary or the beneficiary's legal representative agrees not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare;

4. The Medicare beneficiary or the beneficiary's legal representative understands that Medicare payment will not be made for any items or services furnished by Dr. Love-Walker that would have otherwise been covered by Medicare if there were no private contract, and the proper Medicare claim had been submitted;

5. The Medicare beneficiary or the beneficiary's legal representative enters into the contract with the knowledge that the beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary 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;

6. The Medicare beneficiary or the beneficiary's legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;

IN WITNESS WHEREOF, the parties have signed this Agreement effective the date first written above.

_____	_____	_____
(Patient Signature)	(Type Patient Name)	(Date)

Mailing Address:
Gina Love-Walker, MD
Your Private MD, LLC
170 Taylor Station Road, Suite 210
Columbus, Ohio 43213