Innovative PAIN & PROCEDURAL CENTER

Patrick Retterath, M.D.

Pain Management

Acknowledgment of Medicare/Conditions of Coverage

I hereby, on this day, dated _____ 20_____ , acknowledge that prior notice has been given to me, about;

Patient Rights and Responsibilities,

Name, address and telephone number of representative in the state's governing authority with whom I can register complaints or concerns,

Website address for the office of Medicare Beneficiary Ombudsman.

I have also been advised of the physician performing the procedure, Dr. Patrick Retterath, has ownership interest in this facility. I have chosen to be treated at this facility, Innovative Pain & Procedural Center.

_____ _____

Patient/Guarantor Signature Date

_____ _____

Witness Signature Date

5/09