Howard County Direct Primary Care

ATTACHMENT C: PHYSICIAN-PATIENT AGREEMENT

I, the undersigned, wish to receive my primary care medical services from Howard County Direct Primary Care, LLC (the "Practice") and its providers, Orsolya Polgar, MD, PhD ("Dr. Polgar") and Benita Walton-Moss, R.N., C.R.N.P. ("Ms. Walton-Moss"). I understand that these medical services are offered subject to the following terms and conditions:

1. **Effective Date**. This Provider-Patient Agreement (the "Agreement") shall be in effect for a period of one (1) year beginning on the date I sign this agreement, as indicated beneath my signature below. (If I am a minor, the effective date of this Agreement will be the date my parent or legal guardian signs this Agreement.) This Agreement will automatically renew each year thereafter for an additional one-year renewal period, provided that I pay the Annual Fee (or first monthly installment, if applicable) prior to the renewal date. If I do not make such payment by the renewal date, this Agreement will automatically terminate.

2. **Covered Services**. I understand that the Practice will provide (a) certain standard primary care medical services as requested by me or as deemed necessary in accordance with the established standard of care; and (b) certain enhanced services in connection with or as a supplement to these standard primary care medical services. Dr. Polgar will be the primary provider of covered services; however, Ms. Walton-Moss may provide certain ancillary services or coverage for Dr. Polgar when she is unavailable. All of these standard and enhanced services are listed in Attachment A and are covered by the Annual Fee, except as expressly stated otherwise in Attachment A. Additional services beyond those covered by the Annual Fee will be billed to me at the Practice's standard rates (pricing for these services is available upon request and on the Practice's website).

3. **Non-Participation in Medicare and Insurance Plans**. I understand that the Practice, Dr. Polgar, and Ms. Walton-Moss do NOT participate or contract with any insurance plans, including, but not limited to, Health Maintenance Organizations (HMOs), Points of Service Plans (POSs), Preferred Provider Organizations (PPOs) or Preferred Provider Networks (PPNs), and that Dr. Polgar and Ms. Walton-Moss have opted out of the Medicare program. I therefore acknowledge that (a) the Practice will bill me, and not Medicare or my insurance plan, directly for the Annual Fee and any applicable additional charges; (b) payment of any additional charges is due at the time the services are rendered; and (c) I, instead of Medicare or my insurance plan, will be fully and personally responsible for paying the Annual Fee and any applicable additional charges. I agree not to submit the Annual Fee or any applicable additional charges to Medicare or my insurance plan (except as noted in 5. below) for reimbursement, and the Practice will not do so either. I understand that I may, at any point, elect to obtain medical care from a health care provider who has not opted out of the Medicare program or who participates with my insurance plan, rather than receiving medical care from the Practice.

4. **Medicare Part B Beneficiaries**. If I am a Medicare Part B beneficiary, or if I will become a Medicare Part B beneficiary at any time within two (2) years after the date of this Agreement, I also agree to the terms listed in Attachments D and E, and will sign Attachments D and E in addition to this Agreement to confirm my acceptance of those terms. I understand that Dr. Polgar and Ms. Walton-Moss are each required to enter into a new private contract with me for each two-year period that Dr. Polgar and Ms. Walton-Moss have opted out of the Medicare program.

5. **Submission of Charges to Insurance Plans**. Certain insurance plans permit patients of the Practice to submit claims for services provided by the Practice. If my insurance plan is one of those, upon request the Practice will provide me with a statement that I can submit to my insurance plan in accordance with the plan's rules. Medicare, TRICARE, and HMOs do NOT permit me to submit claims for any services provided by the Practice, and I agree not to submit a claim for any such services to Medicare, TRICARE, or any HMO.

6. **Termination of this Agreement**. I understand that I may choose not to renew this Agreement by not paying the Annual Fee (or first monthly installment, if applicable) by the renewal date, after which this

Agreement is considered terminated and I will no longer be considered a patient of the Practice. I may also cancel this Agreement at any time by sending the Practice written notice (a) stating that I wish to cease using the Practice for my medical services and (b) requesting that a copy of my medical record be sent to either another physician or directly to me. The Practice may also terminate this Agreement, Dr. Polgar's physician-patient relationship with me, and Ms. Walton-Moss's nursing relationship with me at any time upon ninety (90) days' written notice; in such case, the Practice will assist me in finding another primary care physician to take over my care at the end of the 90-day notice period. If this Agreement is terminated by either the Practice or me before the expiration date of this Agreement, a pro-rata portion of the Annual Fee (based on whole months remaining in the Agreement) will be refunded to me within ninety (90) days after the effective date of the termination. If I have already received my Annual Physical Examination for the year, then $300 will be deducted from any pro-rata refund owed to me.

Patient

_____
Patient Signature

_____
Patient Name (*please print*)

Date: _____

Howard County Direct Primary Care

By: _____
Orsolya Polgar, M.D., Ph.D.

Date: _____

If the Patient is a minor, the Patient's parent or legal guardian must sign below indicating the parent or guardian's acceptance of the above terms and agreement to pay the Annual Fee on behalf of the Patient:

Name of Parent or Legal Guardian (*please print*): _____

Signature of Parent or Legal Guardian: _____

Date: _____

Howard County Direct Primary Care

ATTACHMENT D: MEDICARE ADDENDUM

I agree, understand and expressly acknowledge the following:

- Dr. Orsolya Polgar has opted out of the Medicare program effective July 1, 2017 for a period of at least two years, through at least June 30, 2019.
- Neither the Practice nor Dr. Polgar is excluded from participating in Medicare Part B under Sections 1128, 1156 or 1892 or any other section of the Social Security Act.
- I accept fully responsibility for payment of the Practice's charges for all primary care medical and other related items and services ("Services") furnished to me by the Practice or Dr. Polgar.
- Medicare fee limitations do not apply to what the Practice and Dr. Polgar may charge for the Services they provide to me.
- I will not submit a claim (or request that the Practice or Dr. Polgar submit a claim) to the Medicare program for payment for any Services provided to me by the Practice or Dr. Polgar, even if the Services are covered by Medicare Part B.
- Medicare payment will not be made for any Services provided to me by the Practice or Dr. Polgar even if those Services would have otherwise been covered by Medicare if I had not signed this Physician-Patient Agreement and this Attachment D (Medicare Addendum), and a proper Medicare claim had been submitted.
- I enter into this Physician-Patient Agreement with the knowledge that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare and that I am 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 of Medicare.
- Medigap plans do not provide payment or reimbursement for items and services (such as any Services provided to me by the Practice or Dr. Polgar) not paid for by Medicare and other supplemental plans may likewise deny payment or reimbursement for such services.
- I am not currently in an emergency or urgent health care situation and do not currently require emergency care or urgent health care services.
- A copy of the Physician-Patient Agreement (Attachment C) with this Medicare Addendum (Attachment D and E) has been provided to me.

_____	_____
Patient's Name *(please print)*	Patient's Legal Representative
_____	_____
Patient's Signature	Legal Representative's Signature
_____	_____
Date	Date