Howard County Direct Primary Care

ATTACHMENT A: SUMMARY OF SERVICES INCLUDED IN THE MEMBERSHIP FEE

Comprehensive Package (see Attachment B for payment options and discounts)	**Adults age 50+** **$1,950/year, paid by check or cash** **Adults age 50-** **$1,850/year, paid by check or cash**
Annual physical & comprehensive preventive health assessment	Included
Office visits	Up to 10/year
Annual flu shot	Included
EKG	Included
Pulmonary function testing	Included
Rapid testing (flu, strep, urine, pregnancy)	Included
Blood draw & urine collection	Included
Hemoglobin A1C testing	Included
Direct access by online patient portal, cell phone, & e-mail	Included
Prescription refills	Included
Fax/e-mail	Included
Prior authorization of medications	Included
Review of tests & consults from other providers	Included
Coordination of hospital care	Included
House calls (if deemed medically necessary)	Included (counts towards the annual visit limit)
Preop evaluation	Included (counts towards the annual visit limit)
Telehealth visit (phone or Zoom)	Included (counts towards the annual visit limit)

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ATTACHMENT B: MEMBERSHIP OPTION ELECTION FORM

Office use only
Monthly fee: _______
or Yearly fee: _______
Anniversary: ________

Patient's name: **Date:** __________

Membership Options (please check all that apply):

☐ **Option A**: *Comprehensive package*, paid in 12 *monthly installments* as a recurring credit card payment or ACH draft. Due by the 5th of each month.

☐ **Age 50-** $ 158.50 /month
☐ **Age 50+** $ 167/month

☐ **Option B**: *Comprehensive package,* paid in full by *check, or cash*. Payment due at the time of signing the Agreement and on the yearly anniversary afterwards.

☐ **Age 50-** $ 1,850/year
☐ **Age 50+** $ 1,950/year

☐ **Option C**: *Comprehensive package,* paid in full by *credit card*. Payment due at the time of signing the Agreement and on the yearly anniversary afterwards.

☐ **Age 50-** $ 1,900/year
☐ **Age 50+** $ 2,000/year

☐ **Family Discount**: *$75.00 off* each membership, per family members enrolled (can be combined with the advance payment discount above). Number of family members enrolled: _______

This Agreement will automatically renew each year for an additional one-year period, provided that I pay the Membership Fee shown by the due date. If I do not make such payment by the applicable due date, this Agreement will automatically terminate, unless other arrangements have been made. Prior to the beginning of the first contract year, I will sign and return a Membership Option Election Form. I may change the payment options for any subsequent contract year by returning a new signed Membership Option Election Form prior to the beginning of the new contract year; otherwise, my prior Membership Election Form will remain in effect.

New patients, please be sure to enclose all of the following:

☐ Attachment B: Membership Option Election Form

☐ Attachment C: Physician-Patient Agreement

☐ Attachment D (if applicable): Medicare Addendum

☐ Check (if applicable) made payable to **Howard County Direct Primary Care, LLC**

(Late fee of $30 for payments made after the due date and for returned checks.)

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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 Orsolya Polgar, MD, PhD ("Dr. Polgar"). I understand that these medical services are offered subject to the following terms and conditions:

1. **Effective Date:** This Physician-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 by Dr. Polgar in accordance with the established standard of care for internal medicine physicians; and (b) certain enhanced services in connection with or as a supplement to these standard primary care medical services. All of these standard and enhanced services are listed in Attachment A and all of these services 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 and Dr. Polgar 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 has 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 Attachment D, and will sign Attachment D in addition to this Agreement to confirm my acceptance of those terms.

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 listed, the Practice will provide me with a statement that I can submit to my insurance plan in accordance with the plan's rules. Medicare 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 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 and Dr. Polgar's physician-patient 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's Signature

____
Patient's 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: __________________________________

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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, 2019 for a period of at least two years, through at least June 30, 2021.
- 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) has been provided to me.

____
Patient's Name (*please print*)

____
Patient's Signature

____
Date