KEVIN E CARLSON MD, PA
ATTACHMENT A: SUMMARY OF SERVICES

Services	
annual professional fee	$2,100
co-pay	none
annual physical & comprehensive preventative health assessment	yes
additional visits included	12/yr
HCGH in-patient visits included	7/yr
fee per add'l visit over allotment	up to $200[1]
annual flu shot	yes
EKG, pulmonary function, routine office procedures (as needed) [2]	yes
direct access by cell phone & email	yes
blood draws & urine collections	12/yr
telephone medicine consultation	yes
prescription refills	yes
fax/email all test results	yes
pre-authorization forms[3]	yes
prior authorization of medications[3]	yes
review of tests & consults from other providers	yes
coordination & supervision of Emergency Room care	yes
travel medicine advice & admin of necessary vaccines[4]	yes

[1] depending on level of service & charged at Practice's standard rates
[2] routine skin procedures, ear lavage.
[3] except when in-plan physician referral is required by your insurance company
[4] cost of vaccines charged separately

ANNIV: #_____-_____ **Name:** _____, _____

_____

KEVIN E CARLSON MD, PA
ATTACHMENT B

R- **$** _____ **#** _____

Paid: _____

Annual Retainer Fee
$2,100 per patient.

Family discount $100 per patient for family members enrolled.

This Agreement will automatically renew each year thereafter for an additional one-year renewal period, provided that I pay the Annual 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.

Returning patients need only submit this page with payment.

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

☐ Attachment B:

☐ Attachment C: Physician/Patient Agreement **H&P (_____) -**

☐ Attachment D (if applicable): Medicare Addendum

☐ Check made payable to: **Kevin E Carlson MD, PA** **Email:** _____
Late fee of $50 for payments made after renewal date.

Mail or bring to:
Kevin E Carlson MD, PA
10700 Charter Drive, Suite 200
Columbia, MD 21044

Questions:
Brenda Katz
410-910-7444

Email: Brenda@KevinCarlsonMD.com

Website: www.KevinCarlsonMD.com

KEVIN E CARLSON MD, PA
ATTACHMENT C: PHYSICIAN/PATIENT AGREEMENT

I, the undersigned, wish to receive my primary care medical services from Kevin E Carlson MD, PA (the "Practice") and Kevin Carlson MD. 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 year beginning on the date I sign this agreement, as indicated beneath my signature below. This Agreement will automatically renew each year thereafter for an additional one-year renewal period, provided that I pay the Annual Fee shown in Attachment B 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.

2. **Services and Fees**: I understand that the Practice will provide certain primary care medical services as requested by me or as deemed necessary by Dr. Carlson in accordance with the established standard of care for primary care medical services. The Practice provides several different service options and fee structures. The specific services available to me and the applicable fees based on the service option I have chosen are listed in Attachments A and B. Prior to the beginning of the first contract year, I will sign and return a Service Option Election Form indicating my choice of service option. I may change service options at the beginning of any subsequent contract year by returning a new signed Service Option Election Form prior to the beginning of the new contract year, otherwise, my prior Service Option Election Form and service option choice will remain in effect. Any medical services provided to me by the Practice which are not covered by the Annual Professional Fee will be billed to me at the Practice's standard rates.

3. **Non-Participation in Medicare and Insurance Plans**: I understand that the Practice and Dr. Carlson do NOT participate or contract with any insurance plans, including, but not limited to, Health Maintenance Organizations (HMOs), Point of Service Plans (POSs), Preferred Provider Organizations (PPOs) or Preferred Provider Networks (PPNs), and that Dr. Carlson 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 such 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 for reimbursement except as specifically noted in #5 below, 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, and that if I obtain medical services from such other health care provider, more favorable reimbursement may be available to me.

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 during the initial one-year term of the 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. If I become a Medicare Part B Beneficiary during any renewal term of this Agreement, I agree to sign Attachment D and submit it to the Practice.

5. **Submission of Charges to Insurance Plans**:
   a. **Medical Services Covered by the Annual Fee**: Certain insurance plans permit patients of the Practice to submit claims for medical services covered by the Annual Professional Fee. If requested, the Practice will provide me with a statement that I can submit to my insurance plan in accordance with the plan's rules.
   b. **Medical Services Not Covered by the Annual Fee**: Unless I belong to an HMO or am a Medicare Part B beneficiary, I understand that I may submit to my insurance plan claims for medical services covered by my insurance plan and not covered by the Annual Fee. Because I will pay the Practice directly for such services, any reimbursement by my insurance plan will be sent directly to me. If the Practice is mistakenly reimbursed by my insurance plan or Medicare, then the Practice will return the check to my insurance company or Medicare. I understand that my insurance plan may not pay at all for some services provided by the Practice, and may only make a partial payment for other services provided by the Practice. I further understand that the Practice makes no representations or promises regarding the amount of payment to be received for any claim(s) I may submit to my insurance plan.
   c. **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 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. Carlson'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 end of the contract year, a pro-rata portion of the Annual Fee (based on whole months remaining in the contract year) will be refunded to me within ninety (90) days after the effective date of the termination. The value of any services received during the contract year will be deducted from any pro-rata refund owed to me.

Patient Name (printed): _____ KEVIN E CARLSON MD, PA .

Patient Signature: _____ By: _____
Kevin E Carlson, M.D., President

Date: _____ 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 (printed): _____

Signature of Parent or Legal Guardian: _____

Date: _____

KEVIN E CARLSON MD, PA
ATTACHMENT D: MEDICARE ADDENDUM

I agree, understand and expressly acknowledge the following:

- Dr. Kevin Carlson has opted out of the Medicare program.
- Neither the Practice nor Dr. Carlson is involuntarily excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.
- I accept full 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.
- Medicare fee limitations do not apply to what the Practice and Dr. Carlson may charge for the Services they provide to me.
- I will not submit a claim (or request that the Practice or Dr. Carlson submit a claim) to the Medicare program for payment for any Services provided to me by the Practice or Dr. Carlson, even if the Services are covered by Medicare Part B.
- Neither the Practice nor Dr. Carlson will submit a Medicare claim for Services they furnish to me and no Medicare reimbursement will be provided for such Services.
- Medicare payment will not be made for any Services provided to me by the Practice or Dr. Carlson even if those Services would have otherwise been covered by Medicare if I had not signed this Physician/Patient Agreement and Attachment C (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. Carlson) 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) is available upon request.

Patient Name (printed) _____

Patient Signature _____

Date _____