Cannon Dermatology LLC

SERVICES AGREEMENT

This Agreement is between Cannon Dermatology LLC ("Practice"), whose principal place of business is 2012 S. Tollgate Road, Suite 206, Bel Air, MD 21015 (the "Office"), and patient

_____("Patient"), who resides at

_____.

I. Introduction

This patient contract is intended to establish the service and compensation arrangement between Cannon Dermatology LLC and Patients in the following four payment categories:

1. Medicare-eligible patients, i.e. those who are eligible beneficiaries of the federal Medicare program;

2. Medicaid patients, i.e. those patients covered by the Maryland Medicaid program administered by the Maryland Department of Human Services;

3. Commercial insurance patients, i.e. patients covered by commercial third-party insurance programs such as Aetna, HighMark, Cigna, etc.; and

4. Self-pay patients, i.e. patients who have no coverage of any third-party insurance program.

II. Fee Agreement

1. Physician agrees to provide the following medical or cosmetic services to Patient (the "Services"):

    a. Medical, surgical and cosmetic dermatology (care of skin--mucosa, hair and/or nails).

2. Patient agrees to pay Physician pursuant to the then-current fee schedule, which is posted on Cannon Dermatology LLC website and available at the Office upon request. The fee schedule is subject to change at any time without prior notice.

3. Payments for Services shall be made at the time the Services are rendered, unless otherwise agreed upon by Patient and Practice.

III. Medicare Patients

1. Although Patient may be an eligible Medicare beneficiary, Practice has informed Patient that Dr. Cannon ("Physician") has opted out of the Medicare program effective September 24, 2018 for a period of at least two years. Physician has voluntarily opted out of Medicare participation and has not been excluded in any way.

2. Patient understands that, because Physician has opted out of the Medicare program, Medicare will not pay Practice or reimburse Patient for any service provided hereunder; these services will not be covered services under the federal Medicare program. Furthermore, Medicare will not directly reimburse Patient for any such services, and Patient agrees not to submit a claim to Medicare for reimbursement.

3. Patient has been advised and acknowledges that no Medicare fee limitations or any other restrictions or regulations apply to the charges for the services hereunder.

4. Patient has accepted and agreed to the terms set forth in the Medicare Opt Out Agreement, executed contemporaneously with this Agreement, and the terms of such Medicare Opt Out Agreement are incorporated herein.

IV. Medicaid Patients

1. Physician is not a participant in the Maryland Medicaid program.

2. Patient understands that, because Physician has opted out of the Medicaid program, Medicaid will not pay Practice or reimburse Patient for any service provided hereunder; these services will not be covered services under the federal Medicaid program. Furthermore, Medicaid will not directly reimburse Patient for any such services, and Patient agrees not to submit a claim to Medicaid for reimbursement.

3. Patient has been advised and acknowledges that no Medicaid fee limitations or any other restrictions or regulations apply to the charges for the services hereunder.

V. Commercial Insurance

1. Physician does not participate in or accept payment from any third party commercial insurance program, and will not submit any claim to such programs or payment on behalf of Patient.

2. Physician makes no representation regarding whether Patient may or may not submit any claim for reimbursement to any third-party insurance program, and if a claim is submitted, whether any of the fees charged by Physician will be reimbursed to Patient. Such coverage depends entirely upon the contractual arrangements between Patient and the third-party insurance program, and Physician is unaware and will not inquire about or submit claims for such coverage.

VI. Self-Pay Patients

1. Patient acknowledges that Physician does not participate in and Patient is not covered by any third-party insurance program of any kind and Patient is personally responsible for all Physician charges.

VII. General Provisions

1. Patient understands that Patient has a right, as a Medicare, Medicaid or private insurance beneficiary, to obtain covered items and services from physicians and practitioners who participate with such insurance programs and who have not opted out of Medicare. Patient also acknowledges that Patient is not compelled to enter into a private contract with Physician, but Patient agrees to be responsible to make payment in full for the services at the time services are rendered.

2. Patient acknowledges that a copy of this contract has been made available to Patient.

3. Patient is not currently in an emergency or urgent health care situation and Patient's ability to enter into this Private Contract is not compromised in any way.

SERVICES AGREEMENT

Executed on _____ by:
Date

_____ _____
Patient Name Patient Signature

AND

Cannon Dermatology LLC_____ By: _____
Sarah Cannon, M.D.
Physician Signature

(410) 216-0202 [p]
(408) 915-6337 [f]
2012 S. Tollgate Rd, Suite 206
Bel Air, MD 21015
info@cannondermatology.com
www.cannondermatology.com

Cannon Dermatology LLC

Privacy Notice – REVIEW CAREFULLY

Although Cannon Dermatology LLC is not subject to the Health Insurance Portability and Accountably Act ("HIPAA"), we nevertheless choose to provide privacy rights similar to those you expect from your other medical providers and we remain subject to all applicable Maryland laws as well. We prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

You have the following rights with respect to your protected health information ("PHI"):
• The right to revoke previous authorizations in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.
• The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a requested restriction in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
• The right to inspect, copy and amend your PHI.
• The right to receive an accounting of disclosures of your PHI.
• The right to obtain a paper copy of this notice from us upon request.
• The right to be advised if your protected PHI is intentionally or unintentionally disclosed.

We may use and disclose your medical records only for each of the following purposes:
• Treatment- providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor or a specialist doctor communicating with your primary care doctor.
• Payment including such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review.
• Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service.
• The Practice may also be required or permitted to disclose your PHI for law enforcement purposes, public health reporting, abuse and neglect, regulatory agencies, judicial and administrative proceedings, coroners, medical examiners, funeral directors, threats to health and safety, military/veterans, workers' compensation, marketing/fundraising, appointment reminders, information about treatment alternatives or health-related benefits and services, other uses and disclosures permitted by the Privacy Regulations. • We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
• With notification or a proper authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. We require all Business Associates to protect the confidentiality of your health information.

The following uses and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:
• Most uses and disclosure of psychotherapy notes;
• Uses and disclosures of your PHI for marketing purposes, other than if such communication is conducted face-to-face or concerns products or services of nominal value
• Disclosures that constitute a sale of PHI under HIPAA; and

• Other uses and disclosures not described in this notice. We are required by Maryland law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI. This notice is effective as of December 10, 2018 and it is our intention to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practices from our office. You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the Maryland Board of Medicine. We will not retaliate against you for filing a complaint.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AND THAT I MUST PROVIDE WRITTEN AUTHORIZATION FOR RELEASE OF MY PHI AS SET FORTH WITHIN THIS NOTICE. ADDITIONALLY, I UNDERSTAND AND ACKNOWLEDGE THAT AUTHORIZED PERSONS OR ENTITIES THAT RECEIVE PHI INFORMATION MAY NOT BE A HEALTH CARE PROVIDER, HEALTH PLAN, OR OTHER ENTITY COVERED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT THE INFORMATION DESCRIBED ABOVE MAY BE RE-DISCLOSED AND NO LONGER PROTECTED BY THESE REGULATIONS

_____ _____

Signature of Patient or Representative Date

_____ _____

Patient's Name Date of Birth

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

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A copy of the completed and signed Authorization form has been provided to the patient or representative:

_____ Yes

_____ No

_____ _____

Signature of Authorized Practice Representative Date

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