Patient Services Agreement

PURPOSE OF THIS AGREEMENT

This agreement is being formed between Dr. Benjamin Capper M.D. (referred to as "I," "my," and "me") under the umbrella of his California Professional Medical Corporation legally named Capper Medical Corp, and the undersigned (referred to as "you" and "your") for the provision of professional medical evaluation and treatment services. The purpose of this agreement is for the undersigned to grant informed consent for medical treatment, clarify our respective roles and responsibilities, and ensure we have a common understanding of how we will work together. It describes the medical services that may be provided, those services that are not provided, and how those services may be paid for.

Medical Board of California - Notice to Patients

Dr. Benjamin Capper is a licensed medical doctor (M.D.) in the state of California. He is board certified in internal medicine by the American Board of Internal Medicine. Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to

[1] www.mbc.ca.gov;

[2] email: licensecheck@mbc.ca.gov; or

[3] call 800-633-2322

OPEN PAYMENTS

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

PHYSICIAN RESPONSIBILITIES:

I, Dr. Benjamin Capper, agree to:

[1] Provide medical services consistent with generally accepted standards of medical practice in the state of California. The care delivered will be medically appropriate according to my clinical judgment based on the information available at the time of care;

[2] Listen to your concerns, answer your questions, and provide care with compassion;

INITIAL HERE: _____

[3] Explain your diagnosis and treatment options in understandable terms. I will help you to weigh treatment risks with their potential benefits.

[4] Respect your values, preferences, and right to participate in decisions about your care;

[5] Coordinate your care with other healthcare providers;

[6] Provide referrals to qualified specialists and facilities when you need or desire services that I do not provide;

[7] Maintain accurate, complete, and timely medical records. Those records will be retained in accordance with Federal and California law. You will be provided with timely access to those records upon request.

[8] Maintain the privacy and confidentiality of your protected health information in accordance with the "Notice of Privacy Practices"

[9] Provide care without discrimination based on race, color, national origin, age, sex, gender identity, sexual orientation, disability, religion, primary language, or other protected characteristics.

PATIENT RESPONSIBILITIES:

You (the patient or their legal healthcare agent) agree to:

[1] Provide complete and accurate information about your health history, symptoms, allergies, and medication;

[2] Ask questions when you do not understand something about your care;

[3] Follow the treatment plan we develop together, or communicate openly about concerns and barriers. This includes taking medicines as prescribed and reporting any side effects to me immediately. You are responsible for timely scheduling of your own appointments.

[4] Keep scheduled appointments or cancel at least 48 hours in advance. You must follow up at the intervals I recommend. The timing of each follow-up is carefully chosen to allow me to assess the effectiveness and monitor the safety of the treatment plan.

[5] Treat me with respect and kindness. Patients that make a gesture or communication (including verbal, physical, body language, and written) that is interpreted by me as threatening or intimidating, will be prohibited from receiving further care.

[6] Pay your portion of the bill at the start of the appointment.

INITIAL HERE: _____

[7] Inform me of any changes in your health status or medications prescribed by other providers. This is critical for safe medicine prescribing and so that my treatments do not conflict with those of another provider;

[8] Inform me if you or your partner plan to become pregnant, are pregnant, or are breastfeeding. This is critical so there can be a discussion of how the medicine and treatments you receive will impact fertility, and a developing embryo, fetus, and infant;

[9] The medical record constitutes the official documentation of care. You are responsible for notifying me of any perceived inaccuracies.

SHARED DECISION MAKING:

We will work together to:

[1] Establish realistic health goals and treatment objectives;

[2] Develop a treatment plan that considers your preferences and values balanced against the risks and potential benefits;

[3] Regularly evaluate whether the treatment plan is meeting our agreed-upon goals;

[4] Modify the treatment plan when goals are not being met or circumstances change;

[5] Openly discuss any concerns either of us has about the treatment plan.

SCOPE OF PRACTICE

I consider it important to provide transparency regarding services that fall outside of my scope of practice.

[1] There are no guarantees in medicine. The human body is fascinating and incredible, but alas, sometimes unpredictable. All treatments have potential risks. To justify the risks, they must be outweighed by the potential benefits. If I feel the risks of a treatment outweigh the potential benefits, I will not offer or continue the treatment.

[2] My practice focuses on the medical management of chronic conditions, guiding diagnostic evaluations, and care coordination with local specialists.

[3] I do not perform sensitive examinations (rectal exams, breast exams, genital exams) in my office. When a sensitive exam is necessary, you will be referred to setting where the necessary support staff are present.

INITIAL HERE: _____

[4] I do not provide urgent care, emergency care, hospital care, or home visits.

[5] There is no physician on-call outside of scheduled appointments. If you develop an urgent medical need that cannot wait for a scheduled appointment, you should be seen at a local urgent care. If you are experiencing a potential emergency, you should be seen at an emergency department. If you are unable get to an emergency department, you should call 911.

[6] I avoid unnecessary use of antibiotics to protect your microbiome and protect you from antibiotic resistant infections.

[7] I do not prescribe potentially addictive substances for long term use (except for end-of-life care). Examples are: Benzodiazepines (Ativan, Xanax, Clonazepam) for anxiety, opioids (oxycodone, hydrocodone, dilaudid) for pain, stimulants (Adderall, Vyvanse) for ADHD, and some muscle relaxants (Soma). I prescribe these medications when necessary for short-term use (usually limited to 1 week duration)

[8] I do not manage Testosterone replacement therapy. Interested patients will be referred to a community specialist.

[9] Telemedicine is limited to those situations where vital signs and physical exam are not required for medical decision-making.

[10] I do not perform workers compensation evaluations or disability certifications.

SCHEDULING APPOINTMENTS

Appointments can be scheduled, rescheduled, and cancelled:

[1] In the "Booking" section of Elation Passport;

[2] By Texting me at 747-222-6501;

[3] By emailing me at ben@drcapper.com

NON-URGENT COMMUNICATION:

I will communicate with you through the patient portal (called Elation Passport). This is for a few reasons:

[1] It ensures that your personal health information is protected;

[2] It creates a written record of all communications;

INITIAL HERE: _____

[3] It allows me to send you communications, without being disruptive, that you may review at your convenience.

It is critical that you notify me if you are not receiving messages in Elation Passport. For NON-URGENT COMMUNICATIONS, please send messages through Elation Passport. This ensures your personal health information is protected. If you communicate via text, voicemail, or email, the protection of that information cannot be guaranteed.

URGENT, LIFE-THREATENING AND EMERGENCY SITUATIONS

By signing below, you attest to understand:

[1] I do not offer urgent care, emergency care, or hospitalization services

[2] I am not "on-call" outside of scheduled appointments.

[3] For urgent or emergent needs, you must seek care at a local urgent care center, emergency room, or a local hospital.

For URGENT MEDICAL CONCERNS, go to a local urgent care. A list of preferred partners will be provided upon request.

For LIFE THREATENING AND EMERGENCY SITUATIONS, go to your nearest emergency department or call 911. If you require hospitalization, you will be cared for by a hospital medicine physician and the on-call hospital consultants.

For MENTAL HEALTH CRISIS: If you are contemplating suicide, you agree that you will either:

[1] call 911 if there is an immediate threat to the life of you or someone else;

[2] call the Suicide and Crisis Lifeline at 988;

[3] Call the Ventura County Crisis Team at 1-866-998-2243.

PAYMENT FOR SERVICES

<u>PART B MEDICARE + MEDICARE SUPPLEMENT INSURANCE</u>

I “accept assignment” in Part B Medicare. This is the same as being “in-network” with a private insurance plan. It means that I accept the Medicare-approved amount as payment-in-full. Under this arrangement, Medicare determines the price of each service. After your deductible, Medicare pays 80% of the bill. If you have a Medicare supplemental insurance

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plan, they will pay the remaining 20% (minus your copay). If you do not, you will pay the remaining 20% at the start of the visit.

MEDICARE ADVANTAGE:

I am NOT "in-network" with Part C Medicare (also called Medicare Advantage) because under that arrangement, Medicare pays a private insurance company to administer ALL of your health benefits. I am not contracted with any of those private companies.

PRIVATE INSURANCE:

I am NOT in-network with any private insurance plan. I have a cash price per visit for people with private insurance who want to work with me.

MEDI-CAL (MEDICAID):

I am unable to care for patients with Medi-Cal (Medicaid) insurance.

DIRECT PAYMENT:

[1] Meet and Greet = FREE.

[2] New Patient Visit: $400.

[3] Established Standard Visit: $300.

METHOD OF PAYMENT:

You may pay via:

[1] Zelle

[2] Check

[3] Cash

[4] Credit Card (+ 3.95% merchant fee)

CONSENT TO TREAT

You (the undersigned) voluntarily present yourself to receive evaluation and treatment from me (Dr. Benjamin Capper M.D.), under the umbrella of my California Professional Medical Corporation legally named Capper Medical Corp. You (the undersigned) are at least 18 years of age and are either: 1) the patient or 2) the legal healthcare agent of the patient. You hereby authorize me to conduct the necessary examinations, tests, and treatments related to the care you seek. You understand that this consent does not replace any specific

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informed consent for particular treatments. You will be provided with information about the potential benefits, known risks, limitations, and alternatives associated with any recommended treatment plan before it is finalized. You acknowledge the following:

[1] that medical practice is not an exact science, and no specific outcomes can be guaranteed;

[2] all medical tests have a possibility of yielding inaccurate results;

[3] you must be an active participant in your healthcare.

Accurate and appropriate medical diagnosis and treatment relies on the accuracy and completeness of patient-reported information. Failure to do so negatively impacts care and outcomes. This includes ensuring that I have a complete, accurate and updated:

[A] Personal medical history;

[B] List of the OTHER people providing you with healthcare services;

[C] List of all medications, supplements, and alternative treatments you take;

[D] List of foods, substances, and medication intolerances, sensitivities, and allergies.

It also requires you to:

[1] Keep me updated to any changes in your health or life which may interfere with the treatment plan (such as, but not limited to, plans to become pregnant or travel);

[2] Ask questions when you do not fully understand and making me aware of any concerns you have about your care;

[3] Take responsibility for following up on any test results and understanding that if you do not receive or do not understand any results, it is your responsibility to contact me for clarification;

[4] Share relevant medical records with ALL of your healthcare providers to ensure that ALL treatments are appropriate, comprehensive, and do not negatively interact.

You have the right to refuse any specific examination, test, treatment, or procedure, but in doing so, you acknowledge that:

[A] Delaying or not completing recommended tests, imaging, and referrals may result in worsening of known and unknown medical conditions;

[B] Such worsening may affect your treatment options and my ability to provide care;

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[C] Delaying or not taking recommended medical treatments may result in worsening of the underlying medical condition for which they were recommended;

[D] Failure to attend appointments or follow medical instructions may result in care delays and adverse medical outcomes.

Additionally:

[1] Due to the sensitive nature of the care provided, photography and audio/video recordings by patients or visitors in public spaces at the clinic are strictly prohibited.

[2] As an independent physician, I cannot control and am not responsible for the acts, omissions, or clinical outcomes of the other providers who care for you.

RIGHT TO MODIFY OR WITHDRAW CONSENT

You have the right to withdraw or modify your consent at any time. However, any care you have already received will not be affected by the withdrawal of consent. To modify or withdraw your consent to the activities discussed in this document, notify Dr. Capper in writing at: ben@drcapper.com.

TERMINATION OF THE RELATIONSHIP

If our relationship is not working well, we agree to discuss concerns openly. If we cannot resolve our differences, we both reserve the right to terminate the patient-physician relationship.

If you terminate the relationship, you agree to provide written documentation either by email or Elation Passport message. Medication refills will be provided for 30 days after this message. Your medical records will be forwarded to your next physician upon your request.

If I terminate the relationship, you will receive a certified letter from USPS at the mailing address you provided. Care for urgent needs will continue to be provided for 30 days after letter delivery as documented by USPS. After 30 days, no additional professional medical services will be provided. Your medical records will be forwarded to your next doctor upon request.

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By Signing this you acknowledge that you read, understand and agree to this Patient Services Agreement. You have asked any questions that you have and I have answered them to your satisfaction. You consent to receive treatment under the terms of this agreement.

SIGNATURE: _____

NAME OF PATIENT/LEGAL HEALTHCARE AGENT: _____

DATE: _____

RELATIONSHIP TO PATIENT (mark one):

_____ SELF

_____ MEDICAL POWER OF ATTORNEY

INITIAL HERE: _____