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.

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.

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[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 a setting where the necessary support staff are present.

[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 not able to 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, certain sleep medicines (Ambien, Lunesta and Sonata). and some muscle relaxants (Soma). I prescribe these medications when necessary for short-term use (usually limited to 1 week duration)

[8] I only prescribe testosterone replacement therapy for primary hypogonadism as defined by the Endocrine Society.

[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.

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;

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

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[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.

[10] It is my responsibility to keep a written record of all professional medical advice that I provide to you. If you ask me to not record in my record specific parts of your protected health information, I will not provide you with professional medical advice regarding the excluded information.

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.

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

[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.

CONSENT FOR TELEHEALTH SERVICES

Telehealth services, which includes video conferencing, phone calls, and secure portal messaging, may be offered to provide you with greater convenience and flexibility. Before telehealth services can be provided to you, I (Dr. Benjamin Capper) am required under certain state laws to obtain a signed consent form. By signing this form, you give me (Dr. Benjamin Capper) permission to provide you with telehealth services as part of your care. Please review the following information carefully. By signing this form you attest to understand that:

[1] You may refuse or discontinue the delivery of telehealth services at any time without affecting your right to receive in-person care.

[2] All applicable confidentiality protections apply to telehealth services; and you will have access to all medical information resulting from telehealth services in accordance with applicable laws.

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[3] I may only provide telehealth services in the State of California. If you are NOT located in California the time of the visit, the appointment WILL need to be rescheduled.

[4] Participation in telehealth is voluntary and you have the option to in-person care at any time. You understand that virtual exams rely on video, images, and medical records which may produce inaccurate results. For this reason, it is my policy that care requiring vital signs and physical exam be done in-person.

[5] It is your choice to have someone else physically present during telehealth consultation and anyone who is physically present will have access to your protected health information ("PHI") and confidentiality cannot be guaranteed. This may include a family member, caregiver, or interpreter.

[6] You are responsible for having access to the necessary technology (e.g., a smartphone, tablet, computer, or other device) and a reliable internet connection to participate in telehealth consultations. Technical issues, such as poor connectivity and video/audio quality issues may occur during telehealth consultations. Such issues are beyond my control and may require the visit to be rescheduled.

[7] I am committed to protecting the confidentiality of your PHI and will take reasonable precautions to ensure privacy during telehealth consultations in compliance with HIPAA (Health Insurance Portability and Accountability Act). You acknowledge and accept the inherent risks to confidentiality associated with telecommunication technologies despite the use of security measures. You understand and agree your PHI will be kept within the United States for the period required by applicable federal and state law.

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;

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[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.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (PHI) is information that can be used to identify you as an individual. If your PHI is de-identified in accordance with HIPAA standards, it is no longer PHI. By law, I must:
(1) protect the privacy of your PHI;
(2) describe to you how your PHI will be used;
(3) tell you about your rights;
(4) tell you about my privacy practices;

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(5) notify you if there is a breach of your unsecured PHI; and
(6) notify you if there is a change to my Privacy Practices.

TREATMENT: I will share your PHI for you to receive medical treatment. This includes sharing it with other doctors, nurses, medical offices, imaging centers, hospitals, emergency departments, pharmacies, laboratories, home health companies, and providers of medical devices. EXAMPLE: Sending your lab results and my office notes to a physician specialist whom I have referred you to for evaluation and treatment.

PAYMENT: I will disclose your PHI to receive payment from your insurance company. EXAMPLE: Submitting my note from an office visit to your insurance company so they will pay me for the visit.

HEALTHCARE OPERATIONS: I will share your PHI as necessary during standard healthcare operations. I will NOT sell your information or use it for marketing without your written consent. EXAMPLES: quality of care reporting to Medicare.

AS REQUIRED BY LAW: In the following situations, I will disclose your PHI to the appropriate authorities under California law without your consent:

[1] EXPRESSION OF HOMICIDAL OR SUICIDAL INTENT. If you tell me that you intend to hurt yourself or another person, I am required by law to disclose that information to prevent or lessen that threat;

[2] PUBLIC HEALTH REPORTING: I am required by law to reports certain diseases and conditions to the Ventura County Health Department. This includes: (A) all sexually transmitted infections, (B) tuberculosis, (C) births and deaths, (D) communicable diseases. A complete list can be found on the Ventura County of Public Health website: https://hca.venturacounty.gov/public-health/disease-reporting-forms/;

[3] LAPSES OF CONSCIOUSNESS AND DEMENTIA: I am required by law to report lapses of consciousness (seizures, fainting) to the CA DMV.

[4] ELDER/DEPENDENT ABUSE AND NEGLECT: The abuse can take many forms including physical, sexual, financial, abandonment, isolation, and deprivation of goods and services that are necessary to avoid physical harm and emotional suffering;

[5] SEXUAL ASSAULT;

[6] DOMESTIC VIOLENCE INJURIES;

[7] HUMAN TRAFFICKING;

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[8] LEGAL PROCEEDINGS: information will be disclosed in response to a court order, subpoena, or other lawful process;

[9] ANIMAL BITES;

[10] CORONERS AND FUNERAL DIRECTORS: I may disclose PHI to a coroner or medical examiner to permit identification of a body, determine cause of death, or for other official duties. I may also disclose PHI to funeral directors.

CALIFORNIA-SPECIFIC PROTECTIONS: California law provides additional protections for certain types of information. We will obtain your written authorization before disclosing:

[1] Psychotherapy notes (with limited exceptions);
[2] Abortion-related services;
[3] HIV/AIDS test results (except the required report to the department of public health);
[4] Genetic test results;
[5] Substance use disorder treatment records (as required by federal and state law);
[6] California law may provide stricter standards than federal law. When this occurs, we follow the stricter standard.

INTERPRETER SERVICES: Interpreter services can be arranged if needed. Professional medical interpreters are required by law to protect patient confidentiality. If you choose your own interpreter, confidentiality cannot be guaranteed.

USE OF ELECTRONIC HEALTH RECORDS: I maintain your health records in within an electronic health record operated by Elation Health. It has all the appropriate administrative, technical, and physical safeguards to protect your information.

HEALTH INFORMATION EXCHANGE: Within my electronic health record I utilize a secure, electronic, health information exchange called “Carequality.” It allows me to access some of your records that are kept by other doctors and hospital systems. You can learn more at carequality.org. The alternative to a system such as this is to fax your records back and forth between physician offices. This carries the risk that information could be accidentally faxed to the wrong location. If you initial below in the box that says "Do Not Use," then I will NOT obtain or share your records using Carequality.

_____ DO NOT USE

ELATION NOTE ASSIST: I use an AI software tool called “Elation Note Assist” within my electronic health record to make it easier to write my medical notes. It helps me spend more time focused on you and your story and less time on the computer. It also helps me to make sure I capture all the relevant details accurately. This tool listens to our conversation and convert it into a written summary in the visit note within the electronic health record. After the visit, I will review and edit for accuracy. The audio is permanently deleted as soon

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as the written summary is generated. A written transcript of the conversation is available to me for 14 days after which it is permanently deleted. Your medical information will stay private and only shared with those you allow. If you initial below where it says "Do Not Use," then I will not use this tool during your visits and I will take notes on my computer instead.

_____ DO NOT USE

CHANGES TO THIS NOTICE: I may change this Notice and my privacy practices at any time. Any revisions will apply to both past, present, and future health information about you. You will promptly be notified of any changes and asked to sign the new Notice. You may revoke your authorization for me to use your information at any time.

BREACH NOTIFICATION: If your unsecured protected health information is compromised, I will notify you as required by law.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with:

Our Practice Privacy Officer Benjamin Capper M.D.
Address: 1000 Newbury Rd, Ste 105, Newbury Park, CA, 91320.
Email: ben@drcapper.com.

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Right.
[1] You may file this complaint using their online portal at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf;
[2] Sending an email to OCRComplaint@hhs.gov;

[3] Mailing a completed “Civil Rights Discrimination Complaint Form Package" to:

Centralized Case Management Operations -
U.S. Department of Health and Human Services -
200 Independence Avenue, S.W., Room 509F HHH Bldg.,
Washington, D.C. 20201.

You will not be retaliated against for filing a complaint.

PAYMENT FOR SERVICES

PART B MEDICARE + MEDICARE SUPPLEMENT INSURANCE:
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 OUT-OF-NETWORK with Part C Medicare (also called Medicare Advantage) plans.

PRIVATE INSURANCE:
I am IN-NETWORK with Curative. I am OUT-OF-NETWORK with ALL other private insurance plans. 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)

DISCLOSURE OF PATIENT RIGHTS

You have the following rights:

[1] The right to considerate and respectful care that is free of discrimination on the basis of sex, gender identity/expression, sexual orientation, marital status, age, genetic information, economic status, educational background, race, color, religion, ancestry, national origin, citizenship, primary language, disability, and medical condition.

[2] The right to have personal privacy respected.

[3] The right to confidential treatment of all communications and records pertaining to your care.

[4] The right to receive care in a safe setting, free from abuse, neglect, exploitation, and harassment.

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[5] The right to receive information about your health status in terms you can understand and to participate in the development and implementation of your plan of care. You will receive as much information as you need in order to give informed consent or refusal to the medical treatments offered to you.

[6] The right to accept or refuse treatment (assuming you have the capacity to make an informed medical decision).

[7] The right to refuse to participate in experimental clinical trials and research projects.

[8] The right to formulate advance directives. You have the right to have another person make medical decisions on your behalf if you have granted them medical power of attorney.

[9] The right to request restrictions on certain uses and disclosures of your protected health information for the purposes of treatment, payment or healthcare operations. I am not required to agree, except when you request that I not disclose information to your health plan regarding services you paid for in-full out-of-pocket. If you do this, expect that your insurance company will not pay for the associated costs of treatment. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction and to whom you want the restriction to apply.

[10] The right to access and copy your protected health information. Under federal law, however, you may not access or copy the following records: psychotherapy notes; information to be used in a civil, criminal, or administrative proceeding. If you believe your information is incorrect or incomplete, you may request a correction or amendment. You may request of me an accounting of to whom I have released your medical records in the last 6 years.

[11] The right to receive confidential communications from me by alternative means or at an alternative location. For example, you may request lab results be mailed to a PO Box instead of your home address.

[12] The right to appropriate assessment and management of your pain including information about pain and pain relief measures. This does not include the right to treatment with opioids or other controlled and potentially addictive substances.

[13] The right to examine and receive an explanation of your bill regardless of the source of payment.

[14] The right to file a complaint with the California Department of Public Health. The California Department of Public Health's phone number is 800-228-5234 and address is 681 S Parker St., Suite 200 Orange, CA 92868.

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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 informed consent for particular treatments. 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 medical diagnosis and appropriate treatment relies on your doctor having update and complete information about your health. You must keep me updated to any changes in your health, medications, and allergies. Take responsibility for following up on any test results and understanding that if you do not receive or do not understand a result, it is your responsibility to contact me for clarification. Share with me any and all medical records in your possession.

[4] You have the right to refuse any specific examination, test, treatment, or procedure, but in doing so, you acknowledge that: Delaying or not completing recommended tests, imaging, and referrals may result in worsening of known and unknown medical conditions. Such worsening may affect your treatment options and my ability to provide care. Delaying or not taking recommended medical treatments may result in worsening of the underlying medical condition for which they were recommended. 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

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withdraw your consent to the activities discussed in this document, notify Dr. Capper in writing at: ben@drcapper.com.

TERMINATION OF THE RELATIONSHIP

[1] 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.

[2] 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.

[3] 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.

By Signing this document you acknowledge that you read, understand and agree to this Patient Services Agreement, which includes a Consent to Treat, Notice of Privacy Practices, Payment Policies, Consent for Telehealth Services, a Disclosure of Patient Rights, and Patient Responsibilities. 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: _____