Professional SOLUTIONS | INSURANCE COMPANY

Physician Retainer Practices Supplemental Application

A. APPLICANT INFORMATION

Name: ____
First Name / Middle / Last Name

Name of employer: ____

PSIC policy number (If applicable): ____

B. RETAINER PRACTICES INFORMATION

For the purposes of this supplemental application, Retainer Practice is defined as the practice of medicine in a non-traditional model in which a limited number of patients are offered the opportunity to pay additional distinct fees from the cost of medical care in exchange for a package of enhanced services, access or amenities. The term Retainer Practice includes but is not limited to practices commonly called Direct Primary Care, Concierge, Boutique and/or Private Medicine.

1. Have you reviewed with legal counsel the following as they relate to Federal (including but not limited to HIPAA), state and private insurance rules/laws in an effort to prevent violation and to be in compliance with all applicable rules and laws?
   - Consent forms.......... ❑Yes ❑No
   - Marketing materials.......... ❑Yes ❑No
   - Office policies and procedures.......... ❑Yes ❑No
   - Patient disclosure information.......... ❑Yes ❑No
   - Patient contracts detailing fees and services.......... ❑Yes ❑No
   - Advanced beneficiary notices.......... ❑Yes ❑No
   - Franchise agreements.......... ❑Yes ❑No

   If no, please explain: ____
2. Are you aware of and in compliance with the AMA Ethical Guidelines for Retainer Practices?.......... ❑Yes ❑No

   If no, please explain: ____
3. How many years have you operated a retainer practice model? ____
4. What percentage of your practice is based on the retainer practice model? ____%
5. What is your current total patient count in the retainer practice model? ____
6. What is the maximum number of patients you will accept? ____
7. What is your annual patient retention percentage? ____%
8. Is your practice utilizing a franchise relationship providing management and administrative services?.......... ❑Yes ❑No

   If yes, please attach a copy of the franchise agreement to this form.
9. Do you continue to accept and bill insurance or Medicare?.......... ❑Yes ❑No

   Do you clearly define what uncovered services are the patient's responsibility and therefore not billed to insurance?.......... ❑Yes ❑No

   Do you have patients sign an Advanced Beneficiary Notice (ABN) whenever non-covered services are provided?.......... ❑Yes ❑No

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B. RETAINER PRACTICES INFORMATION (continued)

10. Has the retainer practice transitioned from a standard medical practice?............ ❑Yes ❑No

    If yes, please provide details of the transition steps you undertook for the transition and explain the following:

    Does your plan to maintain continuity of care for patients who choose not to join your practice include:

    An offer to refer to a new physician, continuing care from your office until they find a new physician?.......... ❑Yes ❑No

    How much time to you allow patients to find a new physician?: ______________________

11. Have policies and procedures been instituted, and are you and your staff aware of how to respond in the following circumstances? (*Please explain any "no" answers.)*

    If membership ceases, how continuity of care will be handled? .... ❑Yes ❑No

    If no, please explain: ______________________

    If potential conflicts of interest arise as a result of third party remuneration? .... ❑Yes ❑No

    If no, please explain: ______________________

    If additional services outside your agreement are required, such as: hospitalizations, use of specialists, ER care or when a patient is traveling? .... ❑Yes ❑No

    If no, please explain: ______________________

    Locum care when the doctor is not available?............ ❑Yes ❑No

    If no, please explain: ______________________

12. Do you use a qualified non-physician provider to assist in each patient encounter?............ ❑Yes ❑No

    If no, who handles schedules, prepares and monitors the encounter for quality and safety? ______________________

13. Has your staff been educated as to the scope of services to be provided?............ ❑Yes ❑No

    Please attach a list of those services to be performed.

14. Do you have equipment and maintenance protocols in place with your vendors, as well as business associate agreements? .... ❑Yes ❑No

C. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

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C. SIGNATURE REQUIRED (continued)

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

For residents of all states except North Carolina: By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

For North Carolina residents: By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate.

For residents of all states except Oklahoma:
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Oklahoma residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

______________________________	______________________________
Signature of Applicant	Date
______________________________	______________________________
Signature of Agent	Date

Mail to:
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Questions:
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