

From: Elizabeth Gannon

Re: Network Participation Agreement

Dear Practitioner,

Thank you for your interest in participating in N-CAM® PPO & Specialty Networks. N-CAM® has been the signature trademark of excellence in the creation, design and development of many successful turnkey business solutions, products and services for the Complementary and Alternative Medicine (CAM) industry.

We are committed to delivering the best in wellness services and we include CAM related products and services as a foundation for every plan, service and product. Our products have performed to the highest industry standards since 1994.

N-CAM® continues to be the market leader in innovation. We provide access to the most advanced information, technologies and systems-based products and services that enable the advancement of integrative medicine on the market today.

Enclosed please find our Participating Provider Agreement. Your participation will afford your practice access to additional services such as valuable tools for managing your practice and technology tools.

You may:

1. Fax your signed completed agreement to: 941-255-8800; or
2. Mail to: N-CAM® Provider Relations, 1365 Fargo Street, Port Charlotte, FL 33952.

Please contact your Provider Relations Specialist today at: 800-628-5407 with any questions, further assistance and information or visit us on the web at www.n-cam.com.

Sincerely,

Elizabeth Gannon, Founder/CEO
N-CAM®

Encl.

PARTICIPATING PROVIDER AGREEMENT

*I, _____, (“Practitioner”) a Participating Practitioner in good standing, hereby agrees to the terms and conditions set forth in this N-CAM Participating Provider Agreement and warrant that:

1. I am duly licensed and/or appropriately credentialed to practice _____ and my license and/or credentialing is in good standing. I participate in an active practice of Complementary and Alternative Medicine Services and have access to practice facilities and equipment as needed to support that practice.
2. My Employer ID # is: _____ NPI # _____
 (Social Security # or Federal Tax ID#) (National Provider Identifier #)

*If this application for participation is for a practice, please indicate the name of the practice and a list of provider names/info.

PROFESSIONAL LICENSING

Are you currently licensed in the State that you practice in? ___ Yes ___ No * License # _____
 Are you Board Certified? ___ Yes ___ No Specialty Certified & Date _____
 Are you Board Eligible? ___ Yes ___ No Specialty Eligible & Date _____
 Are you DEA Approved? ___ Yes ___ No Any restrictions? ___ Yes ___ No

PROFESSIONAL LIABILITY (Include Copy of Coverage)

Do you carry Professional Liability Ins.? ___ Yes ___ No/ Required by State? ___ Yes ___ No
 Any professional liability claims in the past five (5) years? ___ Yes ___ No
 (If yes give carrier, dates & explanation on separate sheet of paper)

All of the questions below must be answered. An explanation for any “yes” answer must be submitted on a separate paper with this application.

1. Have you ever been convicted of a crime relating to effect your licensure? _____
2. Has your license ever been denied, restricted, limited, suspended or revoked? _____
3. Has any action been taken by any state agency against your license/certification? _____
4. Have you ever been requested to resign a position? _____
5. Have you ever been barred from participation in a government run program? _____
6. Have any professional judgments been entered against you/your practice? _____
7. Has professional liability insurance ever been denied or revoked? _____
8. Has a report ever been made about you to the National Practitioner Data Bank? _____
9. Are you in treatment for or do you use illegal drugs in any form? _____
10. Have you ever been convicted of a crime or any pending charges? _____
11. Has your DEA/state registration ever been suspended, restricted or revoked? _____
12. Have hospital privileges ever been denied, revoked, suspended or reduced? _____
13. Has any institute ever taken disciplinary action against your license? _____

 Signature of Practitioner

 Practice Name

 Print Name, Degree

 Dated

THIS AGREEMENT is made and entered into by and between N-CAM® & PPO Specialty Networks (“N-CAM”), a provider of Complementary and Alternative Medicine (“CAM”) and Integrative Medicine Services hereafter

referred to as "Network", and) and the undersigned Practitioner (hereafter referred to as "Provider") who is duly qualified to practice healing arts within the scope of their license and/or certification (which is attached and made a part of this agreement), herein after jointly referred to as the "Parties" and individually as the "Party".

RECITALS

Whereas The Network seeks to provide its Subscribing Members and their dependents access to low cost/reduced fee-for-service healthcare benefits, which encompasses CAM specialties and Integrative Medicine; and

Whereas The Network seeks to expand its base of Subscribing Members with one of the incentives for new members being the access to CAM benefits, which may or may not be available to them through their current health plan; and

Whereas The Provider seeks to build his/her practice and recognizes that an affiliation with The Network could result in referrals of new patients to their office; and

Whereas Both The Network and Provider recognize the national trend toward the integration of Complementary and Alternative Medicine therapies into traditional care. The Network has the potential to allow access to its Providers offering of CAM benefits. This Agreement will be of mutual benefit to both parties as well as The Network's Subscribing Members and their dependents. The Network does not, however, guarantee that the Provider will receive patients as a result of this Agreement.

NOW, THEREFORE, in consideration for the mutual covenants herein contained and for other good and valuable consideration, it is hereby agreed as follows:

AGREEMENT

- 1. RENDITION OF CARE:** Provider agrees to render medical care and/or attention in specialty, or field of practice, to the subscribing members and dependents of The Network, upon request. With respect to such services, Provider agrees to discount the sums and amounts and provide N-CAM a minimum of discount of 20% off scheduled billing charges or as otherwise set forth in Schedule "A" or as provided by attaching Provider Fee Schedule to this Agreement as full compensations for such services. Additional arrangements may be requested/made, from time to time and on a case-by-case basis by the Network for which Provider shall be notified for participation under a client specific fee schedule. Provider agrees to honor this contract when participating eligible members present for services bearing proper eligibility identification.
- 2. PAYMENT TO PROVIDER:** Provider agrees that contracted discounted rate and payment thereof is the complete payment responsibility of the subscribing member/patient and that the Provider is entitled to bill and has the responsibility to collect from each subscribing member/patient the entire discounted fee as set forth in Schedule "A". Any third party payment arrangements for fee for service or insurance reimbursement shall be based on the same discounted fee in this agreement.
- 3. INSURANCE / THIRD PARTY PAYOR:** Any medical or health insurance/coverage that The Network subscribing members may have shall have no effect upon this agreement nor shall this Agreement imply that any insurer or third party payer will provide any benefits. If any insurer or third party payer is billed for insurance or health benefits, the full amount billed by Provider shall be the amounts set forth in Schedule "A" Fee Schedule. The Network may participate in insurance reimbursable contracts through contract secured by The Network and The Network agrees to give notice to Provider of any said participation. Provider must notify The Network in writing within ninety (90) days Provider elect to decline further participation.
- 4. ELIGIBILITY:** The eligibility status of all subscribing members shall be determined by The Network. Each subscribing member is provided with a Membership Identification Card, which may or may not include an expiration date. Provider hereby agrees to verify eligibility as directed by The Network at the Point of Service (POS) and not provide agreed upon discounts to members who are not currently verified as eligible. Provider shall direct any ineligible members to The Network.

5. **REFERRALS TO PROVIDERS:** The Network shall actively promote program to recruit new subscribers, which will subsequently become new patients for participating providers. The Network shall provide each subscribing member with a Directory of Participating Providers via on-line provider look ups and a geographic sampling for their geographical area, which will include the contact information and discounts offered by each provider. All arrangements for services are made by the subscribing member to the provider of choice.
6. **RECRUITMENT OF NEW SUBSCRIBERS:** The Network shall offer special programs to recruit new subscribing members. Provider authorizes Network to act on behalf of the Provider to contract with entities on Providers' behalf as set forth in this Agreement.
7. **DURATION OF AGREEMENT:** This Agreement shall continue in effect after the date set forth and thereafter until terminated by either party, effective (90) ninety days after written notice of intention to terminate is sent by registered or certified mail. Such termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination and any continuing obligations under termination as set forth herein.
8. **STANDARD OF CARE:** Provider agrees to perform their obligation(s) under this Agreement in accordance with high standards of competence, care and concern for the welfare and needs of the subscribing members and in a manner consistent with the high standards of medical care.
9. **PROVIDER/PATIENT RELATIONSHIP:** Provider shall maintain a provider/patient relationship with the subscribing members and shall be solely responsible to the subscribing member for medical advice and treatment. It is expressly agreed between the parties that the Provider is an independent contractor and that The Network shall have no dominion or control over the Provider's practice, the provider/patient relationship, the provider's personnel or facility.
10. **AMENDMENT OF AGREEMENT:** Both parties reserve the right to amend this Agreement by mutual agreement or to terminate it in the manner herein provided, without notice to, or the consent of, any member or third party beneficiary.
11. **INDEMNIFICATION:** Network will indemnify and hold harmless Provider and its officers, directors, agents, and employees, against any losses, claims, damages or liabilities, joint or several, including attorneys' fees and court costs, (hereinafter "claims" or "claim") incurred in connection with such claims, excepting claims caused by the negligence or misconduct of the Provider or its agents, contractors, servants or employees of Provider.
12. **INDEMNIFICATION:** Provider will indemnify and hold harmless Network and its officers, directors, agents, and employees, against any losses, claims, damages or liabilities, joint or several, including attorneys' fees and court costs, (hereinafter "claims" or "claim") incurred in connection with such claims, excepting claims caused by the negligence or misconduct of the Network or its agents, contractors, servants or employees of Network.
13. **TERMINATION:** In the event this contract is terminated by either party, in accordance with the procedure set forth herein, the Provider agrees that at the time the subscribing member seeks an appointment, the Provider will notify such member prior to giving services that this Agreement is no longer in effect. In the event such notice is not given to the subscribing member, the Provider agrees to accept payment for services at a rate no more than set forth in the applicable schedule(s).
14. **CREDENTIALING/QUALITY ASSURANCE PROGRAMS:** Provider agrees to cooperate with and participate in Credentialing/Quality Assurance programs as set forth by the Network. Provider represents that the information set forth in the Agreement is true and complete. Provider agrees to participate in the re-credentialing process as set forth by the Network.
15. **ASSIGNABILITY OF AGREEMENT:** This Agreement is intended to secure the personal services of the Provider and shall not be assigned or transferred without the written permission of The Network.
16. **MALPRACTICE INSURANCE/PROFESSIONAL LIABILITY:** The Provider shall carry appropriate and adequate malpractice insurance/professional liability in accordance with the standards of their specific specialty/area of practice.

- 17. INDEPENDENT CONTRACTOR STATUS:** The Provider is an independent contractor and no authority implied or expressed is granted on behalf of The Network to the Provider to act on its behalf except as expressed in writing by The Network.
- 18. OSHA:** Provider shall meet OSHA Standards for blood-borne pathogens, have appropriate sanitation and waste control and disposal procedures, in compliance with applicable Federal and State statute/regulations.
- 19. NOTICES:** All notices and other communications hereunder shall be deemed to have been duly given if mailed to the address indicated herein, unless any party gives written notice of another address.
- 20. FURTHER ASSURANCES:** The parties hereunder will execute such additional instruments as may be reasonably required in order to carry out the purposes and intent of this Agreement and to fulfill the obligations of the parties hereunder.
- 21. MODIFICATION:** This Agreement may not be modified or terminated orally and no modification, termination or attempted waiver shall be valid unless in writing signed by the party against whom the same is sought to be enforced.
- 22. COUNTERPARTS:** This Agreement may be executed in counterparts, each one of which shall be deemed an original, but all of which together shall constitute one and the same instrument.
- 23. GOVERNING LAW:** This Agreement shall be deemed to be made in the State of Florida at The Network's corporate headquarters and shall be governed by the laws of the State of Florida.
- 24. INVALID PROVISIONS:** Invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and the Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.
- 25. TERM & TERMINATION:** This Agreement may be terminated by either Provider or Network upon sixty (60) days written notice to the other Party or, shall terminate immediately if the Provider no longer meets the standards of the Network, or shall terminate immediately on the occurrence of any one of the following events: (1) Occurrence of circumstances that make it impossible or impractical for Provider to continue in business; (2) Death of Provider; (3) Loss of Provider of legal capacity; (4) Willful breach or habitual neglect of duty by Provider under this Agreement; (5) Undermining this Agreement by offering same discounted fee schedules as usual rates to public or to non-Network patients.
- 26. CONFIDENTIALITY:** Provider agrees to keep confidential the terms and conditions of this Agreement and Amendments thereto. All information and materials provided by The Network to Provider shall remain proprietary to The Network, including but not limited to agreements and any other operations materials. Provider shall not disclose any such information or materials or use them except as may be required to carry out Provider's obligations hereunder, or unless required to disclose them at the request of The Network or its assignee of this Agreement or under court order. This paragraph shall survive this Agreement for a period of twelve (12) months from the date of termination.
- 27. HEADINGS:** The headings in this Agreement are inserted for convenience or reference only and are not to be considered in construction of the provisions hereof.
- 28. CONTAINMENT OF THE ENTIRE AGREEMENT HEREIN:** This Agreement supersedes any and all other agreements, either oral or in writing, between the parties hereto and contains all of the covenants and Agreement between the parties. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any party, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding.

IN WITNESS WHEREOF, the Parties have duly executed this Agreement as of the date set forth below.

_____ N-CAM®	_____ Provider Signature
_____ Dated	_____ Printed Name & Date

N-CAM® Specialty Networks

Congratulations on your choice to participate! A Provider Relations Specialist may be contacting you.

N-CAM® Business Solutions

Participation in N-CAM® Plans affords more than national access to new patients. We offer business solutions for your practice. N-CAM® is dedicated to working with our participating providers to provide the business tools necessary to insure best practice participation. www.n-cam.com

N-CAM® supports providers' rights to practice within the scope of their practice at all times, even when billing insurance. N-CAM® now offers access to ABC Coding Solutions and ZipClaims.com at special discounted pricing for our network providers; should you have an existing billing system we can provide specialized updates or if you need a system, we can provide access to fully HIPAA compliant Practice Management Software, designed specifically to fill the needs of CAM and Integrative Medicine practitioners. To enroll and for information on all business solutions visit: www.IntegrativeHealthcareSystems.com

N-CAM® has developed several national marketing platforms to secure business and new patient acquisition programs for the N-CAM® PPO network. Under National Health Services, we provide access to our network of providers in addition to many current trends in healthcare payer solutions. www.n-h-s.com

My Healthy Lifestyle® is marketed nationally directly to consumers for a wellness & lifestyle savings program. Participating members have access to our networks of providers. www.myhealthylifestyle.com

Or

_____ I am interested in more information about N-CAM® Business Solutions, please contact me.

_____ I am newly in practice and interested in exploring more ways to increase my revenue.

_____ I am interested in joining an integrative practice. Please send me information on opportunities.

A Business Solutions Consultant will contact you shortly.

SCHEDULE " A "

*It is hereby agreed that Provider agrees to accept a minimum of 20% Discount for services rendered.

*Please indicate maximum discount: _____ 20% or _____ Other (**Must exceed the minimum 20%**)

Provider: Please attach a current fee schedule, which shall become "Exhibit A", or complete Exhibit "A" and a current copy of your professional license included in this document. Provider hereby warrants that the usual fees listed in Exhibit "A" are uniformly charged to all patients/clients and are noted and made part of this Agreement. And further understands that THE NETWORK has relied on this warranty as a material representation which has induced THE NETWORK to enter into this Agreement.

*Providers supplying greater discounts than the minimum requirement have seen a greater return on new patients.

EXHIBIT " A "

Please indicate your usual charges for the services you provide and attach a fee schedule or a brochure stating your normal fees in lieu of completing this section.

<u>Service</u>	<u>*Fee Schedule</u>
Initial Consultation	_____
Follow-up Visit/Treatment	_____

*Please attach your fee schedule for our records. You MUST supply an email address for participation for the purposes of cost effective and timely communication; we will NOT share your email address with another entity.

DIRECTORY LISTING: Please complete the following as you wish it to appear in Directory/Database
* Mandatory

Practice/Business Name: _____

*Name of Provider: _____ *Degrees Held: _____
(i.e.: MD, LAc, LMT, PhD)

*Address: _____

*City _____ *State _____ * Zip _____ County _____

*Primary Phone: _____

Alternate Phone: _____ *Fax: _____

*E-mail: _____ Website: _____

Specialty(s): *Primary _____ Secondary _____

Other _____ Other _____

Comments: _____
