PHYSICIAN CONFIDENTIALITY AGREEMENT

REGARDING NORTHEAST PHO, INC.
PHYSICIAN FEE SCHEDULES

______________________________ (the "Physician") hereby agrees as follows regarding all information concerning Northeast PHO, Inc. physician fee schedules. The PHYSICIAN acknowledges that the fee schedule information provided by Northeast PHO, Inc. is confidential information. The PHYSICIAN agrees not to disclose or furnish any fee schedule information provided to PHYSICIAN by Northeast PHO, Inc. to any other party, without the prior written consent of Northeast PHO, Inc. The PHYSICIAN further agrees that he/she will use fee schedule information provided for the sole purpose of verifying payments from the contracts health plans.

The PHYSICIAN has authorized ________________ to be the PHYSICIAN's Designated Representative in connection with administration of the Policy and the Confidentiality Agreement. The undersigned designated PHYSICIAN Representative acknowledges that he/she is responsible for ensuring compliance by the PHYSICIAN with the Policy and this Confidentiality Agreement.

PHYSICIAN:

____________________________________ ____________________________
PHYSICIAN'S Name (print) PHYSICIAN'S Signature

____
Date

Provider Representative:

____________________________________ ______________________________
Designated Provider Representative Name (print) Provider Representative Signature

____
Title

____
Date