EARL FAMILY MEDICINE, INC., P.A.
PATIENT AGREEMENT

This is an Agreement entered into on_____, 20___, between EARL FAMILY MEDICINE (Clinic, Us or We), and_____(Patient or You).

Background

The CLINIC is a Direct Primary Care (DPC) practice, which delivers primary care medical services (Services) through its physician(s) at 16234 S Metcalf Ave., Overland Park, KS 66085. In exchange for certain fees, the CLINIC, agrees to provide, and YOU agree to accept, the Services as described in this Agreement on the following terms and conditions:

Definitions

1. **Patient**. In this Agreement, "Patient" means the persons for whom the Physician shall provide care, and who have signed this agreement or are listed on the document attached as Appendix 2, which is a part of this agreement.

2. **Services**. In this Agreement, "Services", means the services, both medical and non-medical, to which you are entitled under this Agreement. These Services are described in Appendix 1, which is attached and is part of this Agreement.

Agreement

3. **Term**. This Agreement will last for one year, starting on the date which appears in this Agreement in the first sentence, above.

4. **Renewal.** The Agreement will automatically renew each year on the anniversary date of the agreement, unless one of the parties cancels the Agreement by giving 30 days written cancellation notice.

5. **Termination.** Regardless of the terms of this Agreement, You always have the right to cancel this agreement. Either party can end this agreement by giving the other party 30 days written notice (see Item 6 for details). A violation of EARL FAMILY MEDICINE policies can result in IMMEDIATE termination of this agreement.

6. **Amount and Method of Payment.** In exchange for the Services (listed in in Appendix 1), You agree to pay Us, a monthly fee in the amount that appears in Appendix 3, which is attached and is Part of this Agreement.

a) This monthly fee is payable when you sign the Agreement(prorated 50% if enrollment date is after the 15th of the month), and on the first business day of each month thereafter. There is also a one-time $75 enrollment fee payable when you sign up. Any additional charges (e.g.labs, medical supplies, etc.) will be billed the following month.

b) The Parties agree that the required method of monthly payment shall be through either automatic payment through a credit card, or automatic deduction on a debit card. If a patient's method of payment fails for two consecutive months, the patient's membership will be cancelled.

c) If this Agreement is canceled by either party before the Agreement ends, We will review and settle your account as follows:

(i) Any patient who wishes to cancel their membership must give us a verbal or written 30 day notice. The patient is then responsible for their membership payment for one full month after they give their notice, which will include any unpaid balances/charges. This provides each patient the opportunity to refill any necessary medications, follow-up any ongoing issues and to coordinate transition to their new PCP before their membership expires to ensure ongoing continuity of care.

(ii) An individual who was a previous member and left our clinic who would like to rejoin is responsible to pay one FULL-YEAR of membership(non-refundable) and the $75 enrollment fee. Any changes to this policy is at the physician's discretion.

7. Non-Participation in Insurance. You acknowledge that neither the CLINIC, nor its Physician(s), participate in any health insurance or HMO plans or panels and have opted out of Medicare. Neither make any representations that the fees paid under this Agreement are covered by the Patient's health insurance or other third party payment plans. It is the Patient's responsibility to determine whether reimbursement is available from a *private, non governmental* insurance plan or HSA and to submit any required billing.

8. Medicare. YOU acknowledge that the Physicians have opted out of Medicare, and as a result, Medicare cannot be billed for any services performed for the Patient by the Physician. The Patient agrees not to bill Medicare or attempt to obtain Medicare reimbursement for any such services. If the Patient is eligible for Medicare, or becomes eligible during the term of this Agreement, then s/he will sign the Medicare Opt Out and Waiver Agreement attached as Appendix 4 and incorporated by reference. The Patient shall sign and renew the Medicare Opt Out and Waiver Agreement **every two years**, as required by law.

9. This Is Not Health Insurance. You acknowledge that this Agreement is not an insurance plan or a substitute for health insurance. The Patient understands that this Agreement does not replace any existing or future health insurance or health plan coverage that Patient may carry. The Agreement does not include hospital services, or any services not personally provided by the CLINIC, or its employees. The Patient acknowledges that the CLINIC has advised the patient to obtain or keep in full force, health insurance that will cover the Patient for healthcare not personally delivered by the CLINIC, and for hospitalizations and catastrophic events.

10. Communications. The Patient acknowledges that although CLINIC shall comply with HIPAA privacy requirements, communications with the Physician using e-mail, facsimile, video chat, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communications. As such, **Patient expressly waives the Physician's obligation to guarantee confidentiality with respect to the above means of communication.** Patient further acknowledges that all such communications may become a part of the medical record.

By providing an e-mail address on the attached Appendix 2, the Patient authorizes the CLINIC, and its Physician(s) to communicate with him/her by e-mail regarding the Patient's "protected health information" (PHI). The Patient further acknowledges that:

(a) E-mail is not necessarily a secure medium for sending or receiving PHI and, there is always a possibility that a third party may gain access;

(b) Although the Physician will make all reasonable efforts to keep e-mail communications confidential and secure, neither the CLINIC, nor the Physician can assure or guarantee the absolute confidentiality of e-mail communications;

(c) E-mail communications may be made a part of Patient's permanent medical record; and,

(d) You understand and agree that e-mail is not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. **In an emergency, or a situation that You could reasonably expect to develop into an emergency, You understand and agree to call 911 or the nearest Emergency room, and follow the directions of emergency personnel.**

(e) Email Usage. **If You do not receive a response to an e-mail message within 24 hours, You agree that you**

will contact the Physician by telephone or other means.

(f) Technical Failure. Neither the CLINIC, nor the Physician will be liable for any loss, injury, or expense arising from a delay in responding to Patient, when that delay is caused by technical failure. Examples of technical failures (i) failures caused by an internet service provider, (ii) power outages, (iii) failure of electronic messaging software, or e-mail provider (iv) failure of the CLINIC's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third party which is unauthorized by the CLINIC; or (v) Patient failure to comply with the guidelines for use of e-mail described in this Agreement.

11. Change of Law. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

12. Severability. If any part of this Agreement is considered invalid or unenforceable by a court of competent jurisdiction, it will be amended to the extent necessary to be enforceable and the remainder of the contract will stay in force as originally written.

13. Reimbursement for services rendered. If this Agreement is held to be invalid for any reason, and the CLINIC is required to refund fees paid by You, You agree to pay the CLINIC an amount equal to the fair market value of the medical services You received during the time period for which the refunded fees were paid.

14. Amendment. No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties. Except for amendments made in compliance with Section 11, above.

15. Assignment. This Agreement, and any rights You may have under it, may not be assigned or transferred by You.

16. Legal Significance. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that You have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

17. Miscellaneous. This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party that drafted this Agreement. Headings in this Agreement are used for convenience only and shall not limit, broaden, or qualify the text.

18. Entire Agreement. This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

19. No Waiver. The parties agree that from time to time, they may waive certain duties and requirements of the other party under this agreement, for example notice periods, payment terms, etc. But doing so shall not constitute a waiver of such duties and responsibilities in the future.

20. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Kansas. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the CLINIC in Overland Park, Kansas.

21. Service. All written notices are deemed served if sent to the address of the party written above or appearing in Appendix 2 by first class U.S. mail.

The parties may have signed duplicate counterparts of this Agreement on the date first written above.

I agree to the terms and conditions of this patient agreement with EARL FAMILY MEDICINE. I have reviewed and understand the medication and billing policies that are set forth by the practice. I have also reviewed and understand HIPAA policies. I understand that I will be able to obtain a copy of this agreement and HIPAA policies upon request.

_____

Signature of Patient/Guardian

_____

Printed Name of Patient/Guardian

_____

EARL FAMILYMEDICINE PHYSICIAN SIGNATURE

_____

Date

_____ _____

_____

APPENDIX 1
SERVICES AND PAYMENT TERMS

1. **Medical Services** Medical Services under this agreement are medical services that the Physician is permitted to perform under the laws of the State of Kansas, are consistent with Physician's training and experience, are usual and customary for a family medicine physician to provide including **evaluation and treatment of acute and chronic medical issues**.

Services offered in-clinic at no additional cost include:

- Urinalysis
- Urine pregnancy test
- Rapid test for strep throat
- Electrocardiogram (EKG)
- Breathing treatments (nebulizer)
- Blood glucose testing
- Acute illness/injury
- Chronic disease management (e.g. diabetes, high blood pressure, asthma/allergies, heart disease)
- Well-woman care/Pap smear*
- Newborn care/pediatric care/adolescent care
- Men's health
- Sports physical
- School physical
- Pre-employment physical
- Pre-op clearance
- Basic vision tests
- Removal of cerumen (ear wax)/ ear irrigation
- Repair of minor lacerations
- IUD removals
- Abscess incision and drainage
- Burn/wound care
- Simple fracture care/sprains & strains (splinting & casting*)
- Simple aspiration/injection of joint (knee and/or shoulder)*
- Toenail removal
- Trigger point injection
- Removal of benign skin lesions (skin tags)
- Cryotherapy (warts, sun-damage skin lesions)
- Simpleskin biopsy*
- Excision of skin neoplasm*
- Additional services and procedures as they become available in clinic

The Patient shall also be entitled to a personalized, **annual "wellness examination and evaluation,"** which shall be performed by the Physician, and may include the following, as appropriate:

- Detailed review of medical, family, and social history and review of all medical records;
- Personalized Health Risk Assessment utilizing current screening guidelines;
- Preventative health counseling, which may include: smoking cessation, behavior modification, stress management, etc.;
- Custom Wellness Plan to include recommendations for immunizations, additional screening tests/evaluations, fitness and dietary plans;

o Complete physical exam & form completion as needed.

**The patient will be responsible for any lab charges if specimen sent for analysis as well as any medical supplies necessary. All reasonable attempts will be made to utilize labs, supplies and services at pre negotiated, discounted rates.*

2. Non-Medical, Personalized Services The CLINIC shall also provide Patient with the following non medical services ("Non-Medical Services"):

(a) ***After Hours Access*****.** Patient shall be given a phone number where patient may text the Physician directly for guidance regarding urgent concerns that arise unexpectedly outside of office hours. Video chat may be utilized when the Physician and Patient agree that it is appropriate.

(b) ***Physician Absence*** From time to time, due to vacations, illness, or personal emergency, the Physician may be temporarily unavailable to provide the services referred to above. The Clinic will notify Patients of any planned Physician absences as soon as the dates are confirmed. If needed, Patients may be given instructions on how to contact a covering physician. Such physician shall be available to Patient to the same extent as would the Physician. Treatment rendered by the substitute physician may or may not be covered under this contract.

(c) ***E-Mail Access*****. Patient shall be given the Physician's e-mail address to which non-urgent communications can be addressed**. Such communications shall be dealt with by the Physician or staff member of the CLINIC in a timely manner. **Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that Patient could reasonably expect may develop into an emergency.** Patient agrees that in such situations, when a Patient cannot speak to Physician immediately in person or by telephone, that Patient shall call 911 or the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

(d) ***No Wait or Minimal Wait Appointments.*** Reasonable effort shall be made to assure that Patient is seen by the Physician immediately upon arriving for a scheduled office visit or after only a minimal wait. If Physician foresees a minimal wait time, Patient shall be contacted and advised of the projected wait time.

(e) ***Same Day/ Next Day Appointments for urgent medical needs.*** When Patient calls or e-mails the Physician prior to noon on a normal office day (Monday through Friday) to schedule an urgent appointment, every reasonable effort shall be made to schedule an appointment with the Physician on the same day. If the patient calls or e-mails the Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with the Physician on the following normal office day.

(f) Visitors. Family members temporarily visiting a Patient from out of town may, for a two-week period, take advantage of the services described in subparagraphs (a), (c), and (d) of this paragraph. Medical services rendered to Patient's visitors shall be charged on a fee-for-service basis. After the 2 week period, any further services and payment is at the discretion of the physician.

(g) Specialists Coordination The CLINIC and Physician shall refer Patient to specialists if desired, and

coordinate medical care with patient's specialists and clinicians, in order to maintain continuity of care. Specialist's fees and any other fees for services delivered by medical professionals other than the CLINIC Physician may be submitted to Patient's health insurance. However, it is understood and agreed that such fees are not covered under this agreement, and are the Patient's responsibility.

APPENDIX 2

PATIENT

ENROLLMENT

Fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the EARL FAMILY MEDICINE, INC., P.A. Patient Agreement Form.

Printed Name	Date of Birth (MM/DD/YYYY)	Age

Street Address	City, State, Zip

Home Phone	Work Phone	Cell Phone	Preferred email

Responsible Party	Date of Birth (MM/DD/YYYY)	Age

Home Phone	Work Phone	Cell Phone	Preferred email

Dependents to Whom this Agreement Applies:

Print Name	Date of Birth (MM/DD/YYYY)	Age
~~Print Name~~	~~Date of Birth (MM/DD/YYYY)~~	~~Age~~

Preferred Payment Method*

□ Yearly (Credit/Debit Card)

□Monthly (Credit/Debit Card, charged on the first business day of each month/ Check) *All patients must have a credit or debit card on file to cover the cost of membership and any incidentals not covered under the Agreement.

I certify that I have read, understand, and agree to the terms set forth in the EARL FAMILY MEDICINE Medical Agreement Form. I further certify that I have received a copy of this form.

Signature: _____

APPENDIX 3

FEE

ITEMIZATION

0-17 years of age	$25 per month (with at least one adult member) $65/month without adult member
18-22 years of age	$45 per month
23-39 years of age	$65 per month
40-59 years of age	$85 per month
60 years of age and over	$105 per month
3+ children	$20/child/month (with at least one adult member)
Registration Fee	$75 per adult member, *waived if paying for year in full*
After hours visit	$100 per visit
Visitor treatment	$200 initial visit then $50(*within 2 weeks)*

Credit/Debit card number _____

Expiration date _____CVV _____Zip code _____

Name on card _____

Signature _____

PATIENT PRIVACY INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of a patient's Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to patients. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov We have adopted the following policies: 1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks in preparation for shredding and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff.

You agree to the normal procedures utilized within the office for the handling of charts, patient records,

PHI and other documents or information. 2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. 3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. 4.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties. 5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor. 6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services. 7. We agree to provide patients with access to their records in accordance with state and federal laws. 8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient. 9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____

_____date_____do hereby consent and acknowledge my agreement to the terms set forth in the PATIENT PRIVACY INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.