HOMETOWN
FAMILY CLINIC

PATIENT AGREEMENT

This Patient Agreement (Agreement) is between **HOMETOWN FAMILY CLINIC PLLC** (the Practice, Us or We), and _____ (Patient, Member, or You).

Background

The Practice, located at **2222 WEST HWY 377 STE. 14 BROWNWOOD, TX 76801** provides ongoing primary care medicine to its Members in a direct pay, membership model (DPC). In exchange for certain periodic fees, the Practice agrees to provide You with the Services described in this Agreement under the terms and conditions contained within.

Definitions

1. **Services**. In this Agreement, "Services" means the collection of services, medical and non-medical, which are described in Appendix A (attached and incorporated by reference), which We agree to provide to You under the terms and conditions of this Agreement.

2. **Patient.** In this Agreement, "Patient," "Member," "You" or "Yours" means the persons for whom the Practice shall provide care, who have signed this Agreement, and/or whose names appear in appendix B (attached and incorporated by reference).

Agreement

3. **Term**. This Agreement will last for one year, starting on the date it is fully executed by the parties.

4. **Renewal.** The Agreement will automatically renew each year on the anniversary date of the Agreement unless either party cancels the Agreement by giving 30 days written notice.

5. **Termination.** Either party can cancel this Agreement at any time by giving 30 days' written notice to the other of intent to terminate.

6. **Payments and Refunds – Amounts and Methods.**

A. In exchange for the Services described in Appendix A, You agree to a monthly payment (or Membership Fee) in the amount which appears in Appendix C, which is attached and incorporated by reference;

B. Thereafter, the Membership Fee shall be due on the first business day of every month.

C. The Parties agree that the required method of payment shall be by automatic payment through a debit or credit card.

7. **Early Termination.** If You cancel this Agreement before its term ends, We will refund any unused portion of your membership fee on a per diem basis.

8. **Non-Participation in Insurance.** The Practice does not participate with any health plans, HMO panels, or any other third-party payor. As such, we may not submit bills or seek reimbursement from any third-party payors for the Services provided under this Agreement.

9. **Medicare – not opted out**
Medicare. The Patient understands that the Practice and staff **have not opted out** of Medicare at this time. This means that the Practice is prohibited from entering into a private DPC healthcare agreement with current Medicare beneficiaries or enrollees. Until such time as the Practice formally terminate their Medicare Nurse Practitioner agreement, all Medicare enrollees seeking to join the membership of this DPC will be put on a "call list". As soon as the Practice receives written notification from CMS that the Practice's Medicare provider agreement has been terminated, each individual on the call list will be contacted and informed that Medicare enrollees can now be accepted for DPC membership.
If a current member of this DPC practice becomes eligible for Medicare during the term of this membership agreement, the Patient agrees to immediately notify the Practice.

10. **This Agreement Is Not Health Insurance**. The Patient has been advised and understands that this Agreement is not an insurance plan. It does not replace any health coverage that the Patient may have, and it does not fulfill the requirements of any federal health coverage mandate. This Agreement does not include hospital services, emergency room treatment, or any services not personally provided by the Practice or its staff. This Agreement includes only those Services identified in Exhibit A. If a Service is not specifically listed in Appendix A, it is expressly excluded from this Agreement. The Patient acknowledges that We have advised them to obtain health insurance that will cover catastrophic care and other services not included in this Agreement. Patients are always personally responsible for the payment of any medical expenses incurred for services not included under this Agreement.

11. **Communications**. The Practice endeavors to provide Patients with the convenience of a wide variety of electronic communication options. Although We are careful to comply with patient confidentiality requirements and make every attempt to protect Your privacy, communications by email, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed secure or confidential methods of communications. By placing Your initials at the end of this agreement, You acknowledge the above and indicate that You understand and agree that by initiating or participating in the above means of communication, you expressly waive any guarantee of absolute confidentiality with respect to their use. You further understand that participation in the above means of communication is not a condition of membership in this Practice; that you are not required to initial this clause; and that you have the option to decline any particular means of communication.

12. **Email and Text Usage.** By providing an email address on the attached Appendix B, the Patient authorizes the Practice and its staff to communicate with him/her by email regarding the Patient's "protected health information" (PHI).[1] By providing a cell phone number in Appendix B and checking the "YES" box on the corresponding consent question, the Patient consents to text message communication containing PHI through the number provided. The Patient further understands and acknowledges that:

    A. Email and text message are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access;

    B. Email and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information. Therefore, in an emergency or a situation that could reasonably be expected to develop into an emergency, the Patient agrees to call 911 or go to the nearest emergency care facility and follow the directions of personnel.

13. **Technical Failure.** Neither the Practice nor its staff will be liable for any loss, injury, or expense arising from a delay in responding to the Patient when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service outages; (ii) power outages; (iii) failure of electronic messaging software, or email

[1] As that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations.

outages of physician; (iv) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission; (iv) any interception of email communications by a third party which is unauthorized by the Practice; or (v) Patient's failure to comply with the guidelines for use of email or text messaging, as described in this Agreement.

14. **Nurse Practitioner Absence.** From time to time, due to such things as vacations, illness, or personal emergency, the Nurse Practitioner may be temporarily unavailable. When the date/s of such absences are known in advance, the Practice shall give notice to Patients so that they may schedule non-urgent care accordingly. During unexpected absences, Patients with scheduled appointments shall be notified as soon as practicable, and appointments shall be rescheduled at the Patient's convenience. If during provider's absence, the Patient experiences an acute medical issue requiring immediate attention, the Patient should proceed to an urgent care or other suitable facility for care. Charges from Urgent Care or any other outside provider are not included under this Agreement and are the Patient's responsibility. The Patient may, however submit such charges to their health plan for reimbursement consideration or request that the outside provider do the same. The Patient is responsible for understanding the coverage rules of their health plan, and We cannot guarantee reimbursement.

15. **Dispute Resolution**. Each party agrees not to make any inaccurate or untrue and disparaging statements, oral, written, or electronic, about the other. We strive to deliver only the best of personalized patient care to every Member, but occasionally misunderstandings arise. We welcome sincere and open dialogue with our Members, especially if we fail to meet expectations, and We are committed to resolving all Patient concerns.

Therefore, in the event that a Member is dissatisfied with, or has concerns about, any staff member, service, treatment, or experience arising from their membership in this Practice, the Member and the Practice agree to refrain from making, posting or causing to be posted on the internet or any social media, any untrue, unconfirmed, inaccurate, disparaging comments about the other. Rather, the Parties agree to engage in the following process:

A. Member shall first discuss any complaints, concerns, or issues with their Nurse Practitioner;

B. The Nurse Practitioner shall respond to each of the Member's issues or complaints;

C. If, after such response, Member remains dissatisfied, the Parties shall enter into discussion and attempt to reach a mutually acceptable

solution.

16. **Monthly Fee and Service Offering Adjustments.** In the event that the Practice finds it necessary to increase or adjust monthly fees or Service offerings before the termination of the Agreement, the Practice shall give 30 days' written notice of any adjustment. If Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled monthly payment.

17. **Change of Law.** If there is a change of any relevant law, regulation or rule, which affects the terms of this Agreement, the parties agree to amend it only to the extent that it shall comply with the law.

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

19. **Amendment.** Except as provided within, no amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties.

20. **Assignment**. Neither this Agreement nor any rights arising under it may be assigned or transferred without the agreement of the Parties.

21. **Legal Significance**. The Patient acknowledges that this Agreement is a legal document that gives the parties certain rights and responsibilities. The Patient agrees that they are suffering no medical emergency and has had reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and is satisfied with the terms and conditions of the Agreement.

22. **Miscellaneous.** This Agreement is to be construed without regard to any rules requiring that it be construed against the drafting party. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

23. **Entire Agreement.** This Agreement contains the entire Agreement between the parties and replaces any earlier understandings and agreements, whether written or oral.

24. **No Waiver.** Either party may choose to delay or not to enforce a right or duty under this Agreement. Doing so shall not constitute a waiver of that duty or responsibility and the party shall retain the absolute right to enforce such rights or duties at any time in the future.

25. **Jurisdiction.** This Agreement shall be governed and construed under the

laws of the State of Texas. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice.

26. **Notice**. Written Notice, when required, may be achieved either through electronic means at the email address provided by the party to be noticed or through first-class US Mail. All other required notices must be delivered by first-class US mail to the Practice at: **2222 WEST HWY 377 STE. 14 BROWNWOOD, TX 76801** and to the Patient, at their address provided in Appendix B.

The Parties agree that throughout this agreement and its attachments, checking the appropriate box next to their name will constitute an electronic signature and shall be valid to the same extent as a handwritten signature.

For: HOMETOWN FAMILY CLINIC PLLC

☐ By Christopher Sutton APRN, FNP-C _____
Date

Patient:

☐ _____ _____
Printed Name Date

APPENDIX A

SERVICES

1. Medical Services

Medical Services offered under this Agreement are those consistent with the physician's training and experience, and as deemed appropriate under the circumstances, at the sole discretion of the Nurse Practitioner. The Patient is responsible for all costs associated with any medications, laboratory testing, and specimen analysis related to these Services unless otherwise noted. The specific Medical Services provided under this Agreement include the following:

- Acute and Non-acute office visits (e.g. colds, pink eye, rashes, STI testing, UTIs)
- Chronic disease management (e.g. diabetes, high blood pressure, asthma, high cholesterol)
- Preventive care
- Wellness visits
- Well-child care
- Sports physicals
- School physicals
- Weight loss
- Healthy Lifestyle Counseling
- Simple dermatology procedures
- Abscess Incision and Drainage
- Wound repair and sutures
- Ear wax removal
- Splinting

2. Non-Medical, Personalized Services. The Practice shall also provide Members with the following non-medical services:

- **After-Hours Access**. Subject to the limitations of paragraph 14, Members shall have direct telephone access to the Nurse Practitioner for guidance in regard to urgent concerns that arise unexpectedly after office hours.

- **Email Access.** Subject to the limitations of paragraph 12, above, The Patient shall be given the Nurse Practitioner's email address to which non-urgent communications can be addressed. The Patient understands and agrees that neither email nor the internet should be used to access medical care in the event of an emergency or any situation that could reasonably develop into an emergency. The Patient agrees that in this situation, when s/he cannot speak to the

Nurse Practitioner immediately in person or by telephone, to call 911 or go to the nearest emergency department, and follow the directions of emergency medical personnel.

- **Same Day/Next Day Appointments**. When a Patient contacts the Practice prior to noon on a regular office day to request a same-day appointment, every reasonable effort shall be made to schedule the Patient for that same day; or if this is not possible, Patient shall be scheduled for the following office day (subject to the limitations of paragraph 14).

- **No Wait or Minimal Wait Appointments.** Every reasonable effort shall be made to assure that the Patient is seen by the Nurse Practitioner immediately upon arriving for a scheduled office visit or after only a minimal wait. If The Nurse Practitioner foresees more than a minimal wait time, Patient shall be contacted and advised of the projected wait time. Patient shall then have the option of seeing the Nurse Practitioner at the later time or reschedule at a time convenient to the Patient.

- **Telehealth.** Telehealth (virtual visits) will be available when desired and deemed appropriate by the Patient and Nurse Practitioner.

- **Specialists Coordination**. The Nurse Practitioner shall coordinate care with medical specialists and other practitioners to whom the Patient needs referral. The Patient understands that fees paid under this Agreement do not include specialist's fees or fees due to any medical professional other than the Practice staff.

APPENDIX B

PATIENT ENROLLMENT FORM

CHECK YES WHERE INDICATED *ONLY* IF YOU AGREE TO TEXT MESSAGE COMMUNICATION. PROVIDE EMAIL ADDRESS *ONLY* IF YOU AGREE TO EMAIL COMMUNICATION.

THE FEES AS SET OUT IN THE ATTACHED APPENDIX C, SHALL APPLY TO THE FOLLOWING PATIENT(S), WHO BY SIGNING BELOW (OR AS LEGAL REPRESENTATIVE), CERTIFY THAT THEY HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT:

Patient 1

Print Patient Name_____ Date of Birth_____

Street Address_____

City, State, Zip_____

Cell Phone_____ Alternate Number _____Email_____

I Agree to Text Communication: (check one below)

- ☐ Yes
- ☐ No

Printed Name: _____ Relationship to Patient: _____

Patient 2

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number _____Email_____

I agree to Text Communication: (check one below)

- ☐ YES
- ☐ NO

Printed Name: _____ Relationship to Patient: _____

Patient 3

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number_____ Email_____

Agree to Text Communication: (check one below)

- ☐ YES
- ☐ NO

Printed Name: _____ Relationship to Patient: _____

Patient 4

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number _____ Email_____

I agree to Text Communication: (check one below)

- ☐ YES
- ☐ NO

Printed Name: _____ Relationship to Patient: _____

APPENDIX C

FEE ITEMIZATION

Re-enrollment fee.

If, after allowing membership to lapse or be terminated, Patient desires to re-join the practice, the Patient shall be accepted on a space-available basis, subject to a $ 150 re-enrollment fee.

Monthly Membership Fees

3 months to 17 years	$ 45 per month	X ____ Members	$_____
18 to 64 years	$ 75 per month	X ____ Members	$ _____
The College Plan*	$ 50 per month	X ___ Members	$ _____
The Family Plan**	$ 179 per month	X ___ Members	$ _____
The Married Couples Plan	$100 per month	X ___ Members	$ _____

*With a valid college I.D.
** "The Family Plan" includes only two (2) legal dependents and is limited to two (2) adults.

Total Monthly Membership Fee $ _____

Initial Payment

Prorated Membership Fees $ _____

Total Due on Signing

$ _____

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Upon approval, you will have the option to make monthly payments or set up a monthly auto-deduction. Payments are made directly through our secure link accessed through your electronic statement

sent to your email. Your statement will include monthly fees and incidental charges which you will receive prior to any payments or deductions.

Customer(s)Name(s):_____
__

PAYMENT INFORMATION

I authorize Hometown Family Clinic PLLC, to automatically bill the card listed below as specified: Amount: $_____ for monthly subscription and Incidental Charges;

Frequency:

Monthly Start billing on: ____/____/____

End billing when: Customer provides written cancellation

CREDIT/DEBIT CARD INFORMATION:

Credit card type: **[ ]** Visa, **[ ]** MasterCard, **[ ]** American Express, **[ ]** Discover

_____ _____ _____/_____
Credit card number:
Expires:

_____ _____
Cardholder's name: As shown on credit card
CVC(Security code)

Customer's signature: Date:

_____
AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

_____
DATE

_____
SIGNATURE

Hometown Family Clinic PLLC

FEE FOR SERVICE

MEDICAL AGREEMENT

Print Patient Name_____ Date of Birth_____

Street Address_____

City, State, Zip_____

Cell Phone_____Email_____

I Agree to Text and email Communication:

- ☐ Yes
- ☐ No

Patient or Guardian: _____ Relationship to Patient: _____

1. Medical Consent: I consent to any medical treatments or procedures which may be performed on an outpatient basis (excluding emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the nurse practitioner, staff, or other health care providers of **Hometown Family Clinic PLLC** assisting my care.

2. Financial Obligation: I understand that all Fee For Service (FFS) charges are due at the time of service. I agree to pay **Hometown Family Clinic PLLC** for all charges for healthcare services and professional services provided to me by nurse practitioners and other healthcare professionals. The Fee For Service charges are as follows:

Acute care visit $85 per visit*

DOT physical Exam $75

Non-DOT Physical $65

School/Sports Physical $25

*Acute care visits are subject to additional fees for any testing provided or ordered agreed upon by the Nurse Practitioner and patient at the time of service

3. Acceptable forms of payment include Cash, Visa, MasterCard, Discover and Debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service.

4. **Non-Participation in Insurance.** The Practice does not participate with any health plans, HMO panels, or any other third-party payor. As such, we will not submit bills

or seek reimbursement from any third-party payors for the Services provided under this Agreement.

6. Release of Medical Information: I hereby authorize **Hometown Family Clinic PLLC** to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in the care of the above-named patient.

7. The undersigned certifies that he/she has read and agree to the above and foregoing, and received a copy thereof, and is the duly authorized to enter this FFS agreement.

Patient or Guardian Signatures: _____Date: _____

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Payments are made directly through our secure link accessed through your electronic statement sent to your email.

Customer(s)Name(s):_____

PAYMENT INFORMATION

I authorize **Hometown Family Clinic PLLC** to automatically bill the card listed below as specified: Amount: $_____ for Fee for Service;

Billing on: ____/____/____

CREDIT/DEBIT CARD INFORMATION:

Credit card type: **[ ]** Visa, **[ ]** MasterCard, **[ ]** American Express, **[ ]** Discover

_____ _____ _____/_____

Credit card number:
Expires:

_____ _____

Cardholder's name: As shown on credit card CVC(Security code) _____

Customer's signature: Date: _____

HOMETOWN FAMILY CLINIC

AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

_____

DATE

_____

SIGNATURE