

PATIENT AGREEMENT

This is an Agreement entered into on _____, between Clover Esthetics, LLC, and _____ (Patient).

Background

The PRACTICE is a partial Direct Primary Care Practice (DPC), which delivers primary care in a membership model at 1125 Legacy Drive, Suite 220, Frisco, TX 75034. In exchange for certain fees, the PRACTICE, agrees to provide the Patient with the Services described in this Agreement under the terms and conditions contained in this Agreement.

Definitions

1. **Services.** In this Agreement, "Services" means the collection of medical and non-medical services, as described in Appendix A (attached and incorporated by reference), which are provided in exchange for certain fees as described within.
2. **Patient.** In this Agreement, "Patient," "Member," "You," or "Yours," means the persons for whom the Provider shall provide care, and who have signed this agreement or are listed on the document attached as Appendix B, which is attached and incorporated by reference.
3. **Provider.** In this Agreement, "Provider(s)," means the Physician, Physician Assistant, or Nurse Practitioner providing services to the Patient.

State Required Notice

3. THIS MEDICAL RETAINER AGREEMENT DOES NOT CONSTITUTE INSURANCE, IS NOT A MEDICAL PLAN THAT PROVIDES HEALTH INSURANCE COVERAGE FOR PURPOSES OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT AND COVERS ONLY LIMITED, ROUTINE HEALTH CARE SERVICES AS DESIGNATED IN THIS AGREEMENT.

Agreement

4. **Term.** This Agreement will last for one year, starting on the date executed by the Parties.
5. **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 cancellation notice.
6. **Termination.** Regardless of anything written within, You always have the right to cancel this agreement. Either party can end this agreement at any time by giving the other party 30 days written notice.
7. **Payment Amount and Methods.** In exchange for the Services described in Appendix A, You agree:
 1. To pay the Practice a periodic monthly fee in the amount that appears in Appendix C attached and incorporated by reference);
 2. Your periodic monthly fee (prorated to the first of the month), as well as any non-refundable enrollment fee, are due and payable upon execution of this Agreement. Your monthly periodic fee shall be due on the tenth day of each month thereafter.

3. The Parties agree that the required method of payment shall be electronic payment through a debit or credit card, or automatic bank draft.

4. You are responsible for all costs associated with any procedures, laboratory testing, or specimen analysis and any other service not personally provided by the Practice staff and/or not listed in Appendix A. Payment for such costs are due at the time of service to the appropriate company.

8. Early Termination

1. If the Practice cancels this Agreement before its termination date, We will refund You the unused portion of Your monthly fee on a per diem basis.

2. If You cancel this Agreement before its termination date, We will review and settle your account as follows:

- We will refund You the unused portion of your fees on a per diem basis; or
- If the fair market value of the Services you received during the time before you canceled the Agreement is more than the total amount that You paid in membership fees during the same period, You shall reimburse the Practice in the amount of the difference. The Parties agree that the fair market value of Services is equal to what the Practice's usual and customary fee-for-service charges. A copy of these fees is available on request.

9. Re-enrollment. Should Patient allow this Agreement to lapse or be terminated, and later wishes to reenroll, Patient will be accepted on a space-available basis, subject to a \$200 re-enrollment fee.

10. Non-Participation in Insurance. Your initials on this clause of the Agreement acknowledges the Patient's understanding that neither the PRACTICE, nor its Providers, participate in certain health insurance or HMO plans or panels the patient uses/has access too. We may do not bill insurance of any other third party payor for services provided with this membership. We do not provide Patients with invoices or receipts for individual services.

11. Medicare. By initialing the bottom of this clause where indicated, Patient certifies, they do not have or plan to bill Medicare.

12. This Is Not Health Insurance. Your initials at the bottom of this clause of the Agreement acknowledge Your understanding that this Agreement is not an insurance plan or a substitute for health insurance. You understand that this Agreement does not replace any existing or future health insurance or health plan coverage that You may carry. The Agreement does not include hospital services, or any services not personally provided by the PRACTICE, or its employees. You acknowledge that the PRACTICE has advised You to obtain or keep in full force, health insurance that will cover You for healthcare not personally delivered by the PRACTICE, and for hospitalizations and catastrophic events.

13. Communications. The Practice endeavors to provide Patients with the convenience of a wide variety of electronic communication options. And although We are careful to comply with patient confidentiality requirements, and make every attempt to protect Your privacy, communications by e-mail, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed to be secure or confidential methods of communications. You understand and acknowledge

the above and You agree that by initialing this clause of the Agreement and 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.

Initial to agree that you have read the above clause _____.

Check one regarding communication with e-mail, facsimile, video chat, cell phone, texting, and other electronic communication.

Yes, I agree with the using of these means of communication.

No, I decline using these means of communication.

14. Email and Text Usage. By providing an e-mail address to the Practice and initialing at the bottom of this clause the Patient authorizes the Practice and its staff to communicate with him/her by e-mail regarding the Patient's "protected health information" (PHI - as is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations). By providing a mobile/cell phone number to the Practice and initialing at the bottom of this clause the Patient consents to text message communication containing PHI through the number provided. Patient further acknowledges that:

1. E-mail 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;
2. Although the Practice and its staff shall make all reasonable efforts to keep e-mail and text communications confidential and secure, We cannot assure or guarantee the absolute confidentiality of these communications;
3. Patient is responsible for providing correct email and/or contact information and for updating such information in a timely manner.
4. You also understand and agree that e-mail and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information. In an emergency or a situation in which could reasonably be expected to develop into an emergency, You understand and agree to call 911 or go to the nearest emergency room, and follow the directions of emergency personnel. You further agree that if you use these methods, and do not receive a timely response you will contact the Provider or other staff by telephone. You acknowledge that We have advised you that the only appropriate means of communicating time-sensitive issues, or for disclosing sensitive information are either face to face or by telephone.
5. You agree that if You do not receive a response to an e-mail message or other electronic communication within 24 hours, You shall contact the Provider by telephone during regular business hours.

By placing your initials as indicated at the end of this clause, you verify that you understand this clause and agree to its statements and terms _____.

15. Technical Failure. Neither the PRACTICE, nor the Providers 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 PRACTICE'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 PRACTICE; or (v) Patient failure to comply with the guidelines for use of e-mail described in this Agreement.

16. Scope of Services. The Services included under this Agreement are limited to those specifically described in Appendix A. The Member is responsible for all costs and charges the Member may incur related to products or services that Member receives which are not personally provided by Practice staff and/or from any outside Provider including, but not limited to other physicians/providers, emergency room, charges for hospital services, diagnostic testing, specialty services and prescription drugs. Member understands and agrees that the Practice shall not reimburse the Member for any charges incurred for care received outside the Practice.

17. 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:

1. Member shall first discuss any complaints concerns or issues with Provider;
2. Provider shall respond to each of the Member's issues and complaints;
3. If, after such response, Member remains dissatisfied, the Parties shall enter into discussion and attempt to reach a mutually acceptable solution.

18. Fee Adjustments and Service Offerings. In the event that, prior to the termination of this Agreement the Practice finds it necessary to (a) increase/adjust monthly fees or (b) expand or eliminate certain Services contained in Appendix A, Practice shall give Patient 30 days written notice of any adjustment and if Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled monthly payment.

19. 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.

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

21. Reimbursement for Services Rendered. If this Agreement is held to be invalid for any reason, and the PRACTICE is required to refund fees paid by You, You agree to pay the PRACTICE 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.

22. **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.

23. **Assignment.** The Patient may not assign this Agreement, or any rights which flow from it to any third party.

24. **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.

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

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

27. **No Waiver.** In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce the other party's requirement or duty under this agreement (for example notice periods, payment terms, etc). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

28. **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 in Frisco, Texas.

29. **Notice.** All written notices must be sent to the e-mail address provided by each Party or by first class US mail sent to Practice, at the address written above; and to Patient, at the address appearing in Appendix B.

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

APPENDIX A

SERVICES

1. **Medical Services.*** Medical Services under this agreement are those medical services that the Providers are permitted to perform under the laws of the State of Texas, are consistent with Provider's training and experience, are usual and customary for a Family Medicine Provider to provide, and include the following:

- Acute and Non-acute Office Visits
- Well Care for Adults
- Pap Smear
- Newborn and Well-Child Care

- Pre-Employment and Pre-Participation Physical
- Limited Clinical Ultrasound
- Blood Pressure Monitoring
- Diabetic Monitoring
- Spirometry
- Electrocardiography (EKG)
- Breathing Treatments (nebulizer)
- IUD Insertion and Removal
- Urinalysis
- Urine Pregnancy Testing
- Removal of skin lesions/warts
- Simple aspiration/injection of joint
- Removal of Cerumen (ear wax)
- Nail Removal
- Wound Repair and Sutures
- Abscess Incision and Drainage
- Basic Vision Screening
- At the Providers' discretion, additional services may be offered for an additional fee. Drawing basic labs. Labs and testing that cannot be processed in-house will be offered at a discounted rate through select vendors: currently Quest is the in office lab provider.
- Patient is responsible for all the costs associated with any of the above procedures which are not personally provided by Practice staff (i.e, labs and biopsies which must be sent for analysis, etc.) Fees for the above shall be due at time of service. Patient shall be notified in advance if such additional charges will apply and Patient always retains the right to receive such services elsewhere at Patient's expense. A list of lab prices is available.

Comprehensive Wellness Evaluation. The Patient is also entitled to a personalized, annual, in-depth "wellness examination and evaluation," which shall be performed by a Provider, and may include the following, as appropriate:

- Detailed review of medical, family, and social history and update of medical record;
- Personalized Health Risk Assessment utilizing current screening guidelines;
- Preventative health counseling, which may include: weight counseling, smoking cessation, behavior modification, stress management, etc.;
- Custom Wellness Plan to include recommendations for immunizations, additional screening tests/evaluations, fitness and dietary plans;
- Complete physical exam & form completion as needed.

2. Non-Medical, Personalized Services. PRACTICE shall also provide Patient with the following nonmedical services ("Non-Medical Services"), which are complementary to our members in the course of care:

- **After Hours Access.** Patient shall have direct telephone access to a Provider seven days per week. Patient shall be given a phone number where patient may reach a Provider directly for guidance regarding concerns that arise unexpectedly after office hours. Video chat and text messaging may be utilized when the Provider and Patient agree that it is appropriate.

- After hours office visits may be available for an additional charge at the discretion of the Provider as most concerns can be cared for in the office during open hours.
- **Provider Absence.** From time to time, due to vacations, illness, or personal emergency, a Provider may be temporarily unavailable to provide the services referred to above in this paragraph one. In order to assist Patients in scheduling non-urgent visits, Practice will notify Patients of any planned Provider absences as soon as the dates are confirmed. In the event that an urgent need arises during a Provider's unplanned absence, Patient should proceed to an urgent care or such other alternate provider. Patient should request that medical record for such visit be provided to the Practice and Provider shall see Patient upon Provider's return. The Costs for any treatment rendered by such alternate provider is not included in this Agreement and are Patient's responsibility, but may be submitted to Patient's health plan if applicable.
- **E-Mail Access.** Patient shall be given a Provider's e-mail address to which non-urgent communications can be addressed. Such communications shall be dealt with by a Provider or staff member of PRACTICE 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 a Provider 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.
- **No Wait or Minimal Wait Appointments.** Reasonable effort shall be made to assure that Patient is seen by a Provider rapidly upon arriving for a scheduled office visit or after only a minimal wait. If Provider foresees a more than 30 minute wait time, Patient shall be contacted and advised of the projected wait time. Patient will then have the option to keep the appointment or reschedule the visit at Patient's convenience.
- **Same Day/Next Day Appointments.** When a Patient with an urgent need contacts the Practice for an office appointment every reasonable effort shall be made to schedule Patient's appointment on the same or next day. In any case, Practice shall make every reasonable effort to schedule all of Patient's appointment requests on the date requested.
- **Specialists Coordination.** PRACTICE and Providers shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. **Patient understands that fees paid under this Agreement do not include or cover specialist's fees or fees due to any medical professional other than the PRACTICE Providers.**

APPENDIX B

PATIENT ENROLLMENT

The fees as set out in the attached Appendix C, shall apply to the following Patient(s), who by signing below, certify that they have read, understand, and agree to the terms set forth in the Clover Family Medicine patient agreement, and have received a copy of the agreement.

Patient Name: _____ Patient Date of Birth: _____.

Child/Children/Dependents to Whom this Agreement Applies - complete once per family account.



1125 Legacy Drive, Suite 220, Frisco, TX 75034

Office: (469)294-0210

Fax: (469)548-7525

info@cloveresthetics.com

www.cloverfamilymedicine.com

(Adults over 18 years need to complete their own Membership Agreement)

Child Name: _____ Date of Birth: _____.

I, the above named legal guardian of the children whose names appear on this document, consent to receiving communications regarding such children from the practice by email or text message to the phone numbers and email address provided to the Practice.

APPENDIX C

FEE ITEMIZATION FOR MEMBERSHIPS

Adults 18 years and older: \$120

Children 0 - 17 years: \$75

Family Plan: \$220 (up to 3 children)

One time Initial Enrollment Fee \$100 per household

Re-Enrollment Fee \$200 per household***

***Non-refundable fee. Should your membership lapse or be terminated, a re-enrollment fee must be paid for membership to become active (on a space-available basis).

Pricing for employer groups has been established based on the mutually agreed-upon terms in the employer agreement.

Patient Signature _____ Date _____.

Provider Signature _____ Date _____.