MILLSAPS ATHLETE CARE CAMPER PATIENT AGREEMENT

I regard the patient-physician relationship with the utmost reverence, and I thank you for entrusting me with your health care. Communication is at the center of my care, and this Agreement explains how we will work together.

This Agreement is made between Millsaps Athlete Care LLC, a Georgia Limited Liability Company, doing business as MILLSAPS ATHLETE CARE ("Practice"), and You ("You" or "Patient"). Practice offers primary care services in exchange for certain fees paid by You as described in this Agreement on the terms and conditions described below.

AGREEMENT

1. Services. As used in this Agreement, the term Services means primary care services and certain amenities (collectively "Services"), which are offered by Practice.

a. Volume of Services. The number of in-person (at races in 2021 and others starting July 2022) and virtual visits you may receive is not limited by this Agreement.

b. Availability. Practice will make every effort to address Your medical needs in a timely manner, but we cannot guarantee availability, and we cannot guarantee that You will not need to seek treatment in an urgent care or emergency department setting or a specialist physician.

c. Included Services.

i. Your membership includes primary care, including well and sick care, and basic gynecological services (starting July 2022). Your physician will make an appropriate determination about the scope of primary care services offered by Practice on a case-by-case basis.

ii. Some services will be available in our office, such as rapid strep tests or urinalysis, are available at no additional cost to you starting July 2022.

iii. Some services, such as minor surgery, will be available in our office and incur an additional fee ("Itemized Charges"), materials only, starting July 2022.

d. Excluded Services. You may need the care of hospitalists, specialists, emergency rooms, urgent care centers, laboratory testing, radiologic testing, pathology studies, surgery and specialist consultations, and dispensed medications, including but not limited to vaccinations, that are outside the scope of this Agreement. We highly recommend that you maintain health insurance, which may or may not cover the costs of these services. Practice will endeavor to place orders for Excluded Services in a manner that is cost effective for you.

e. Controlled Substances. It is not the policy of Practice to prescribe chronic controlled substances on Your behalf, including commonly abused opioid medications, benzodiazepines, and other stimulants. If it is necessary to prescribe controlled substances for the treatment of your condition, you

will be required to separately sign our Controlled Substance Treatment Agreement starting July 2022.

f. After-Hours Visits & Out of Office Visits. Subject to the availability of our Physicians, we offer after-hours and out of office visits (track-side when available) at no additional cost to you.

2. Consent to Treat. You acknowledge and hereby authorize Practice to use and/or disclose Your health information which specifically identifies You, or which can reasonably be used to identify You, to carry out Your treatment, payment, and healthcare operations. Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the administration and use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable for treatment, including but not limited to diagnostic procedures, the taking and utilization of cultures, and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

3. Scheduling.

a. In order to best serve the needs of all our patients, we prefer that you schedule Your visit more than 24 hours in advance. Same day appointments are absolutely welcomed though.

b. Missed Appointments. We kindly request that you provide us with a minimum of 2 hours notice if you are unable to attend a scheduled appointment. Your advance notice helps us provide the best possible experience for all of our patients.

c. Further instructions for scheduling is provided on a separate document.

4. Fees. In exchange for Services, You agree to pay Practice a)the Monthly/Weekly fee; b) any additional Itemized Charges (collectively “Fees”). In order to remain financially viable, Practice must, and does, reserve the right to change its fees at any time with thirty (30) days’ notice to you after July 2023. If it is necessary for you to pause your membership due to an absence for more than three (3) months, please speak to Practice right away to make appropriate arrangements.

a. Practice requests a one week (short-stay camps) or monthly (up to 3 months) (long-stay camps) commitment and fees are due at registration for the camp or the charge will be $60 for an appointment.

b. Camp Fee. Your Camp Fee is based on the chart below. This fee is for primary care provided by Practice in the week/month for which the fee was received. Members who are considered additional family under the family plans must be true family (i.e. Spouse, Child, Parent/Guardian/Grandparent).

Your week/camp fee is due at the beginning of the week/month and is payable by automatic or manual debit from your bank or credit card account. You may pay through your patient portal or by telephone.

Camp Fees

Weekly	$30
Weekly Family (up to 3)	$75
Weekly Mechanic with paying rider	$20
Monthly (less than 6 months)	$75
Monthly Family (up to 3)	$125
Monthly Mechanic with paying rider	$30
Additional Family Member	$20

c. Itemized Charges. The fee for Itemized Charges (i.e. injections, sutures, splints) changes in response to our costs and we endeavor to make these services as affordable as possible. You will be made aware of the fees for these services in advance of the services being performed. Payment for these services can be paid at the time services are rendered or can be added to the next month's bill.

5. Disclaimer of Non-Insurance. **Fees paid are not health insurance.** You acknowledge and understand that this Agreement is not a health insurance plan, and not a substitute for health insurance or other health plan coverage, such as participation in a Health Management Organization ("HMO"). This Agreement is solely for primary care services provided directly to You by Practice. We are required to notify you that some of the benefits you will receive under this Agreement (such as an annual wellness exam) might be included in some health insurance plans without an additional fee to you. **This Agreement does not cover hospital, specialist, or any services not directly provided by Practice.** It is highly recommended that You maintain health insurance for care you may need that is not part of our Services. You may use insurance for specialists or diagnostic tests.

6. Non-Participation in Health Insurance. You acknowledge that neither Practice, nor the Physician(s) participate in **any** private health insurance or HMO plans, including Medicaid program. Neither Practice nor its Physician(s) make any representations regarding third party insurance reimbursement of fees paid under this Agreement, and such reimbursement is not anticipated by this Agreement.

7. Non-Participation in Medicaid. You specifically acknowledge that pursuant to state law, Practice and its Physician(s) do not participate in Florida's or Georgia's Medicaid program. Under state law, non-participating healthcare providers cannot provide medical services to Medicaid recipients for reimbursement. This means that

Medicaid cannot be billed for **any** Services performed under this Agreement. Further, You agree not to bill Medicaid or attempt Medicaid reimbursement for any such services. By signing this Agreement, You specifically acknowledge and agree that you will not attempt to bill Medicaid and that you will need a Medicaid provider to order tests for reimbursement and referrals. Medications requiring prior authorization require authorization from a Medicaid provider.

8. Non-Participation in Medicare. You specifically acknowledge that pursuant to federal regulations, Practice and its Physician(s) have elected "opt out" status of Medicare participation. This means that Medicare cannot be billed for **any** Services performed under this Agreement. Further, You agree not to bill Medicare or attempt Medicare reimbursement for any such services.
If You are (or become) Medicare eligible you must immediately notify Practice so that we may uphold our legal obligations in this regard. If You are eligible for Medicare, or during the term of this Agreement You become eligible for Medicare, then Practice is required to confirm Your understanding of this by obtaining Your signature on our Notice of Non-Covered Services.

9. Term. This Agreement will commence on the date it is signed by the parties and shall have an initial term of one week, one month, two months, or three months based on the camp length, billed at the beginning of the camp in full. Upon the expiration of the initial term this Agreement payments shall cease.

10. Termination. Both You and Practice shall have the absolute and unconditional right to terminate the Agreement, without cause with seven (7) days notice.

a. While we value Your membership, You are under no obligation to continue receiving Services and You may terminate this Agreement, in writing via letter or e-mail, at any time with seven (7) days notice.

b. If you terminate your membership before the end of the week or month, Your bill will be for the total of that week or month and not be prorated based upon the number of days membership was provided to You. You will be responsible for any additional Itemized Charges incurred. Once your membership is terminated, you will not be eligible for any medical services through Practice, including medication refills.

c. Notwithstanding any other provision of this Agreement, if your decision to terminate is based on a grievance with Practice, You will give us an opportunity to make it right, prior to issuing Your written notice of termination or taking other action.

d. If Practice elects to terminate this Agreement, Practice will provide You with seven (7) days written notice.

e. Practice has a right to determine whom to accept as a patient, just as You have the right to choose Your physician. There are certain circumstances in which we may choose to terminate this Agreement. Such circumstances may include, but are not limited to the following:

i. You fail to pay fees and charges when they are due.

ii. You have performed an act that constitutes fraud.

iii. You fail to adhere to the recommended treatment plan.
iv. You are disruptive, abusive, or present an emotional or physical danger to the staff or other patients of Practice.
v. Practice discontinues operation.

11. Re-Enrollment. If You choose to discontinue Your membership and You later wish to re-enroll without prior agreed upon arrangement, Practice reserves the right to decline re-enrollment or require You to pay a re-enrollment fee that is equivalent to three (3) times the then existing Monthly Fee applicable to your membership, excluding discounts.

12. Privacy & Communications.

a. Limited Disclosure. Practice will not disclose your Protected Health Information ("PHI") for reasons unrelated to the delivery of Services, or the provision of other health care services on Your behalf.

b. Your Privacy Rights. Practice will adhere to its obligations regarding your privacy rights as identified in Practice's Patient Notice of Privacy Practices.

c. Methods of Communication. You acknowledge that Practice communications may include e-mail, facsimile, video chat, instant messaging, patient portal messaging, and cell phone, and such communications by their nature cannot be guaranteed to be secure or confidential. If You initiate a conversation in which You disclose PHI on any of these communication platforms except for the patient portal messenger, then You authorize Practice to communicate with You regarding all PHI in the same format. All patient portal communications are secure and confidential.

13. Miscellaneous.

a. Amendment. No amendment or variation of the terms of this Agreement shall be valid unless in writing and signed by both Parties.

b. Anti-Referral Laws. Nothing in this Agreement, nor any other written or oral agreement, nor any consideration in connection with this Agreement, contemplates or requires or is intended to induce or influence the admission or referral of any patient to or the generation of any business between Practice and any other person or entity. This Agreement is not intended to influence any Physician's professional judgment in choosing the appropriate care and treatment of patients.

c. Assignment. This Agreement, and any rights You may have under it, are not assignable or transferable by You.

d. Authorization for Agreement. The execution and performance of this Agreement by Practice and You have been duly authorized by all necessary laws, resolutions, and corporate or partnership action, and this Agreement constitutes the valid and enforceable obligations of the parties in accordance with its terms.

e. Captions and Headings. The captions and headings for each provision of

this Agreement are included for convenience of reference only and are not to be considered a part hereof, and shall not be deemed to modify, restrict or enlarge any of the terms or provisions of this Agreement.

f. Entire Agreement. This Agreement constitutes the entire agreement between the Parties with respect to the subject matter hereof, and supersedes any and all other agreements, understandings, negotiations, or representations, oral or written, between them.

g. Governing Law. This Agreement shall be subject to and governed by the laws of Florida or Georgia, without regard to any conflicts of law provisions therein contained. All disputes arising out of this Agreement shall be settled by binding arbitration. The provider of arbitration services shall be made solely at Practice's discretion and costs of arbitration shall be borne equally by the parties.

h. No Waiver. No waiver of a breach of any provision of this Agreement will be construed to be a waiver of this Agreement, whether of a similar or different nature, and no delay in acting with regard to a breach shall be construed as a waiver of that breach.

i. Non-Discrimination. Under no circumstances will Practice discriminate against You, or terminate this Agreement, on the basis of sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status, or any other protected status. However, Practice reserves the right to accept or decline patients based upon our capability to appropriately manage the primary care needs of our patients.

j. Notices. Any notices or payments required or permitted to be given under this Agreement shall be deemed given when in writing, by electronic transmission, hand delivered, or with proof of deposit in the United States mail. All notices shall be deemed delivered on the date of actual delivery, as evidenced by the return receipt or courier record, or by verified digital date stamp in the case of electronic transmission.

k. Severability. If any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and the offending provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable. If this Agreement is held to be invalid or unenforceable for any reason, and if Practice is therefore required to refund all or any portion of the Monthly Fees paid by You, You agree to pay Practice an amount equal to the fair market value of the Services actually rendered to You during the period of time for which the refunded fees were paid commensurate with prevailing rates in the Practice area.

l. Survival. Any provisions of this Agreement creating obligations extending beyond the term of this Agreement shall survive the expiration or termination of this Agreement, regardless of the reason for such termination.

PATIENT ACKNOWLEDGEMENTS

Please read each line carefully, by signing this agreement, you agree with the following statements.

_____ You acknowledge that Practice has advised You to maintain health insurance for coverage of all Services not specifically provided for in this Agreement and You further acknowledge that this agreement is not a contract that provides health insurance.

_____ You acknowledge that You do not expect Practice to file or issue any third party insurance claims on Your behalf including Medicare.

_____ You acknowledge that Practice and its Physician(s) have elected "opt out" status of Medicare participation.

_____ You acknowledge that if you are a Medicaid recipient, then you will likely require a separate Medicaid physician to place orders and referrals you wish to have insurance cover.

_____ You acknowledge that You do not have an emergent medical problem at this time. In the event of a medical emergency, You agree to call 911 first.

NOTICE OF PATIENT PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed, as well as your access to this information. Please review this notice carefully. Practice is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please let us know. Understanding Your Health Record and Information Each time you are seen by our Practice, a record of your care is made that contains health and financial information. Typically, this record contains information about your condition, the treatment we provide, and payment for these services. We may use and/or disclose this information in order to:

• Plan your care and treatment

• Communicate with other health professionals involved in your care

• Document the care you receive

• Educate health professionals

• Provide information to public health officials

• Evaluate and improve the care we provide

• Obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps to:

• Ensure it is accurate

• Better understand who may access your health information

• Make more informed decisions when authorizing disclosure to others

How We May Use and Disclose Your PHI

The following categories describe the way that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of these categories.

For Treatment. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Practice personnel who are involved in taking care of you. For example, a doctor treating you for a leg wound may need to know if you have diabetes because diabetes may slow the healing process. We may also share health information about you in order to coordinate your care and provide you with medication, lab work, and x-rays. We may also disclose health information about you to people outside the Practice who may be involved in your medical care. This may include referrals to specialists or other healthcare providers, imaging or other diagnostic services providers, or your family members or care givers.

For Payment. We may use and disclose health information about you so that the treatment and services you receive may be billed to you, an insurance company, or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for our day-to-day health care operations. Your health information may be used and disclosed for the business management and general activities of the Practice including resolution of internal grievances, customer service, and due diligence in connection with a sale or transfer of the Practice. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients.

Other Allowable Uses of Your Health Information

Affiliate Providers. Some services may be provided to you by our affiliate providers. If so, we may use or disclose your health information to them to enhance your care.

As Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

Business Associates. There are some services provided in our Practice through contracts with business associates. Examples include our electronic health record provider, medical supply vendors, and our attorney. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

Individuals Involved in Your Care or Payment for Your Care. With your written permission, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort.

Law Enforcement. We may disclose health information when requested by a law enforcement official. Should you become an inmate of a correctional institution, we may disclose to the institution, or its agents, health information necessary for your health and the health and safety of others.

Military and Veterans. If you are, or were, a member of the armed forces, we may disclose health information about you as required and if requested by military authorities or agencies. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

National Security and Intelligence Activities. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Organ and Tissue Donation. If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.

Reminders and Health-Related Benefits & Services. We may contact you to provide appointment reminders or other health-related benefits and services that may be of interest to you.

Reporting. Federal and state laws may require or permit the Practice to disclose certain health information.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Public Health Risks. We may disclose health information about you for public health purposes, including:

- Prevention or control of disease, injury or disability
- Reporting births and deaths
- Reporting child abuse or neglect
- Reporting reactions to medications or problems with products
- Notifying people of recalls of products
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease
- Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with

patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave the Practice.

Threats to Health or Safety. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

Treatment Alternatives. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.

Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs if requested or required.

Other Uses of Health Information
Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights Regarding Health Information About You
Although your health record is the property of the Practice, the information belongs to you. You have the following rights regarding your health information:
Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations. You must submit your request in writing and Your request must state a time period, not longer than seven (7) years from the date of the request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Amendments. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Practice. You must submit your request in writing and you must provide a reason for your request.
We may deny your request for an amendment if it is not in writing or does not include a

reason to support the request. In addition, we may deny your request if you ask us to amend information that:

• Was not created by us, unless the person or entity that created the information is no longer available to make the amendment

• Is not part of the health information kept by or for the Practice

• Is accurate and complete.

Copies of Your Health Records. With some exceptions, you have the right to review and copy your health information. You must submit your request in writing and we may charge a fee for the costs of copying, mailing or other costs associated with your request.

Copy of this Notice. You have the right to a paper copy of this Notice of Privacy Practices, even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

Right to Request Alternate Communications. You have the right to request that we communicate with you about medical matters in a confidential manner or using a specific method. For example, you may ask that we only contact you via e-mail. You must submit your request in writing and Your request must specify how you wish to be contacted and we will try to accommodate all reasonable requests.

Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend. However, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with urgent or emergency treatment. You must submit your request in writing and Your request must indicate:

• What information you want to limit

• Whether you want to limit our use, disclosure or both

• To whom you want the limits to apply, for example, disclosures to your spouse.

Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will make a copy of any revised Notice available in our office, on our website, or both.

Complaints

If you believe your privacy rights have been infringed, we want to know and we want to make it right. If you believe this is the case, please immediately notify us. You will not be penalized in any way for filing a complaint.

IN WITNESS WHEREOF, the Parties hereto or their duly authorized representatives have executed this Agreement as of the Effective Date first written below.

Printed Name of Patient: _____

_____

Signature of Patient/Parent/Legal Guardian/Authorized Representative Date

Signing into the patient portal and electronically signing this document renders this contract valid.