# DIRECT PRIMARY CARE PATIENT CONTRACT

This is an agreement between Med Afford (Practice), located at 635 Glynn Street North, Fayetteville, GA 30214, and _____ (Patient).

## Background

Providers providing services to the Practice (referred to collectively as Providers), deliver care on behalf of the Practice in Fayetteville, Georgia. The practice website is https://medaffordhealthcare.com/. In exchange for certain fees paid by You, Practice, through its Provider(s), agrees to provide the Patient with the Services described in this Agreement on the terms and conditions set forth in this Agreement.

## Terms and Conditions

**Practice's Acceptance of Patient**. A patient is defined as a person for whom the Practice and its Providers shall provide Services, as defined in Section 2. Upon receipt of this Agreement signed by the Patient along with the required fees, the Practice shall have the option in its sole discretion not to accept the Patient under the Program and to return Patient's payment. This Agreement is not executed until accepted and signed by the Practice.

**Services**. As used in this Agreement, the term Services, shall mean a package of ongoing primary care services, which are offered by Practice, and set forth in Appendix 1 attached hereto and incorporated herein by reference (collectively "Services"). The Patient will be provided with methods to contact the physician via phone and email. Providers at the Practice will make every effort to address the needs of the Patient in a timely manner, but cannot guarantee availability, and cannot guarantee that the patient will not need to seek treatment in the urgent care or emergency department settings.

**Fees**. In exchange for the Services, Patient agrees to pay Practice the amount as set forth in Appendix 2 attached and incorporated herein by reference. Patient acknowledges and understands that on the first day of each month under this Agreement, the Practice will have earned the full monthly fee. Applicable enrollment fees are payable upon execution of this agreement and earned upon receipt. **If Patient elects to terminate this Agreement prior to the completion of the twelve (12) month contract term, Patient agrees to pay an early cancellation fee equal to fifty percent (50%) of the total fees remaining for the unused months of the contract term, which shall be due and payable immediately upon termination.** Practice reserves the right to charge a re-enrollment fee to any individual who wishes to re-enroll after a prior enrollment has ended as specified in Appendix 2.

**Non-Participation in Insurance**. Patient acknowledges that neither Practice nor the Physicians participate in any health insurance or HMO plans. Physicians have opted out of Medicare. Patient acknowledges that federal regulations REQUIRE that Physicians opt out of Medicare so that Medicare patients may be seen by the Practice pursuant to this private direct primary care contract. Neither the Practice nor Physicians make any representations regarding third party insurance reimbursement of fees paid under this Agreement. The

Patient shall retain full and complete responsibility for any such determination. If the Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient will sign the agreement attached as Appendix 6 and incorporated by reference. This agreement acknowledges your understanding that the Physician has opted out of Medicare, and as a result, Medicare cannot be billed for any services performed for you by the Physician. You agree not to bill Medicare or attempt Medicare reimbursement for any such services.

**Insurance or Other Medical Coverage**. Patient acknowledges and understands that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services, or any services not personally provided by Practice, or its Physicians. Patient acknowledges that Practice has advised that Patient obtain or keep in full force such health insurance policy or plans that will cover Patient for general healthcare costs. Patient acknowledges that THIS AGREEMENT IS NOT A CONTRACT THAT PROVIDES HEALTH INSURANCE. This Agreement in isolation, does NOT meet the insurance requirements of the Affordable Care Act and is not intended to replace any existing or future health insurance or health plan coverage that Patient may carry. This Agreement is for ongoing primary care, and the Patient may need to visit the emergency room or urgent care from time to time. It is the responsibility of the Patient to determine if any fees paid under this Agreement are eligible for a Health Savings Accounts ("HSA"), Flexible Spending Accounts ("FSA"), Health Reimbursement Arrangement, or similar accounts or plans. The Practice recommends that the Patient discuss tax guidelines/law with their accountant or attorney. Members are responsible for ensuring that the insurance coverage they have will reimburse for filed claims or will honor the Provider's referrals and recommendations with expected reimbursements.

**Term and Termination**. This Agreement is effective on the date on which the following actions occur: (1) this Agreement is signed by the Patient and Practice; (2) the Patient pays the enrollment fee, or re-enrollment fee, as applicable; (3) and the Patient pays or guarantees payment for the first month ("Effective Date"). Services will commence the first day of the month following the Effective Date ("Commencement Date") and will continue for the remainder of that month, and will automatically renew for consecutive monthly terms until terminated in accordance with this section. Notwithstanding the above, Practice shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, in accordance with this section. For the Practice to terminate this Agreement, the Practice shall give at least thirty (30) days prior written notice to the Patient, which notice shall state the last date of the month on which this Agreement terminates. The Practice may terminate a patient without cause as long as the termination is handled appropriately (without violating patient abandonment laws). Examples of reasons the Practice may wish to terminate the agreement with the Patient may include but are not limited to:

(a) The Patient fails to pay applicable fees owed pursuant to Appendix 2;
(b) The Patient has performed an act that constitutes fraud;
(c) The Patient repeatedly fails to adhere to the recommended treatment plan,
(d) The Patient is abusive, or presents an emotional or physical danger to the staff or other patients of Practice; and
(e) The Practice discontinues operation.

**Privacy & Communications**. You acknowledge that communications with the Physician using e-mail, video chat, instant messaging, and cell phone are not guaranteed to be secure or

confidential methods of communications. The practice will make an effort to secure all communications via passwords and other protective means and these will be discussed in an annually updated Health Insurance Portability and Accountability Act (HIPAA) “Risk Assessment.” The practice will make an effort to promote the utilization of the most secure methods of communication, such as software platforms with data encryption, HIPAA familiarity, and a willingness to sign HIPAA Business Associate Agreements. This may mean that conversations over certain communication platforms are highlighted as preferable based on higher levels of data encryption, but many communication platforms, including email, may be made available to the patient. If the Patient initiates a conversation in which the Patient discloses “Protected Health Information (PHI)” on one or more of these communication platforms, then the Patient has authorized the Practice to communicate with the Patient regarding PHI in the same format. Patient accepts the risk inherent in the use of any of the above-indicated communication methods for diagnoses, treatment, or any other healthcare or business-related reasons. Patient expressly waives any obligation to guarantee confidentiality with respect to correspondence using such means of communication. Patient acknowledges that all such communications may become a part of Patient’s medical records. Patient authorizes the Practice and the Providers to communicate results, findings, and health care decisions to the Patient, individuals responsible for Patient’s care, and individuals designated by the Patient. Patient also acknowledges the following:

A. Email 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 Patient could reasonably expect to develop into an emergency, Patient understands and agrees to call 911, and follow the directions of emergency personnel.
B. If Patient does not receive a response to an e-mail/text message within 24 hours, Patient agrees that Patient will contact the Practice by telephone or other means. If it is an urgent issue and email/text messages have not been answered within one hour, Patient agrees to call the Practice using the phone number within one hour.
C. The Practice will not be liable for any loss, injury, or expense arising from a delay in responding to a Patient when that delay is caused by technical failure. Examples of technical failures include but are not limited to: (i) failures caused by an internet service provider, (ii) power outages, (iii) failure of electronic messaging systems or email providers (iv) failure of the Practice’s computers or computer network, or faulty telephone or cable transmission, or (v) any interception of email communications by a third party.

**Severability**. If for any reason 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 that 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.

**Reimbursement for Services if Agreement is Invalidated**. If this Agreement is held to be invalid for any reason, and if Practice is therefore required to refund all or any portion of the monthly fees paid by Patient, Patient agrees to pay Practice an amount equal to the fair market value of the Services actually rendered to Patient during the period of time for which the refunded fees were paid.

**Assignment**. This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient. This agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient. Any Patient who attempts to request treatment for a non-member will have their membership agreement terminated by the practice. (An example would be a Patient calling to see if a medication could be called in for a non-member spouse, child, or friend).

**Modifications**. The Practice reserves the right to modify this Agreement (including all Appendices) in any manner in its sole discretion by hand delivering to you, by sending information regarding the amendment to the email or physical address you provide, or posting the updated terms on the Practice's website. You shall be deemed to have accepted such amendments by continued use of the Services following fifteen days after such amendments have been sent to you or posted. Each time you use any of the Services in any manner or cause them to be provided, you reaffirm your agreement to this Agreement and any modification to this Agreement. You agree that the Practice shall not be liable to you or any third party for any harm resulting from modification(s) to this Agreement.

**Jurisdiction**. This Agreement shall be governed and construed under the laws of the State of Georgia and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice address in Fayetteville, Georgia.

**Payments**. The required method of payment is recurring monthly charge to debit card. Fees will be charged according to the billing policies and procedures set forth in Appendix 2. By signing this Agreement, the Patient hereby authorizes the Practice or its designee to bill the monthly fee installment amount payable at the beginning of each month of the term for 12 months to the following account:

_____

Name on Card

_____

Email Address

_____

Phone Number

_____

Card Number

_____ _____

Expiration Date CVV

_____

Patient's Billing Address (Street, City, State & Zip Code)

The Patient shall owe the Practice $20 for any charge attempt that is declined.

15. **Patient Understandings** (please initial each):

_____ I do NOT expect the practice to file or fight any third party insurance claims on my behalf.

_____ I do NOT expect the practice to prescribe chronic controlled substances on my behalf.

(These include commonly abused opioid medications, benzodiazepines, and stimulants).
_____ If I have a complaint about the Practice I will first notify the Practice directly.
_____ In the event of a medical emergency, I agree to call 911 first.
_____ I do NOT have an emergency medical problem at this time.
_____ I am enrolling (myself and my family if applicable) in the practice voluntarily.
_____ I may receive a copy of this document upon request.
_____ This Agreement is non-transferable and non-assignable.

I, the Patient (or Responsible Party) acknowledge that I have been given the opportunity to read and ask questions about the provisions and information contained in this Agreement, including all Appendixes attached hereto and incorporated herein by reference, and I affirm either that I have no questions or that all of my questions were answered to my satisfaction.

THIS AGREEMENT IS NOT HEALTH INSURANCE. PAYMENTS MADE BY A PROGRAM MEMBER DO NOT COUNT TOWARDS PROGRAM MEMBER'S HEALTH INSURANCE DEDUCTIBLES AND MAXIMUM OUT-OF-POCKET EXPENSES. THIS AGREEMENT DOES NOT QUALIFY AS MINIMUM ESSENTIAL COVERAGE TO SATISFY THE INDIVIDUAL SHARED RESPONSIBILITY PROVISION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, 26 U.S.C. S. 5000A. THIS AGREEMENT IS NOT WORKERS' COMPENSATION INSURANCE AND DOES NOT REPLACE AN EMPLOYER'S OBLIGATIONS UNDER CHAPTER 440. IT IS THE RESPONSIBILITY OF PROGRAM MEMBER TO DETERMINE IF ANY FEES PAID UNDER THIS AGREEMENT ARE ELIGIBLE FOR A HEALTH SAVINGS ACCOUNT, FLEXIBLE SPENDING ACCOUNT, HEALTH REIMBURSEMENT ARRANGEMENT, OR SIMILAR ACCOUNTS OR PLANS.

Signature of Program Member _____
(or Responsible Party)

Printed Name of Program Member _____
Responsible Party's relationship: □ Parent □ Guardian □ POA □ Other:_____

Signature of Practice: _*Med Afford*_____

Date: _____

**APPENDIX 1**
**Med Afford Services**

**Services**

Under this Agreement, the Practice will provide services generally consistent with ongoing primary care services. Examples of common conditions the Practice treats, procedures it offers, and medications its Providers prescribe are listed on our website and are subject to change. The Practice does not provide emergency services but will provide the below medical and non-medical services as appropriate to each Patient as determined in the Practice's and Providers' discretions.

Medical Services: Medical Services means those medical services provided by the Practice that the Providers are licensed and permitted to perform under the laws of the State of Georgia and that the Providers determine are appropriate for the Patient in the Provider's sole discretion. Membership in the Practice may include the following Medical Services:

1. Primary HealthCare Services. Examples of such services may include the following:

    a. Well/preventive office visits, which are visits for the preservation of physical and mental wellness, discussion of preventative guidelines, nutrition and exercise following recommended guidelines by the American College of Physicians, American Board of Internal Medicine and the US Preventive Services Task Force.

    b. Evaluation of new problems, including but not limited to treatment of sore throats, coughs, colds, other minor illness and injury, certain minor procedures, and any other services within the scope of Nurse Practitioner Training.

    c. Follow-up visits for the management of long-term medical conditions including, but not limited to, asthma, hypertension, diabetes, hypothyroidism, and other chronic conditions/illnesses within the scope of Family Medicine.

    d. Care coordination to assist other health team members by organizing and forwarding pertinent information from primary exams for use by specialists including progress notes, laboratory results, and imaging reports.

2. Specialist Care/Referrals. If the Provider treating the Patient feels a healthcare need is outside of the scope of primary care, referral to a specialist will be warranted. Membership in the Program does not preclude medically necessary specialist evaluation or referral as deemed appropriate by the Provider treating the Patient. If the Patient does not agree to follow through on a recommendation for specialist referral by the Provider, the Patient will be asked to sign an Against Medical Advice form and the Practice reserves the right to terminate the Patient's membership in the Program. Although the Practice may help procure specialist cash pricing for the Member, it is not the responsibility of the Practice to guarantee discounted specialist pricing. If the Practice does not have information providing specialist cash pricing on hand, it will be the Patient's responsibility to obtain such pricing at the specialist's office.

Non-Medical Services: The Practice shall also provide Patient with the following Non-Medical Services:

1. Email Access. The Patient shall be able to communicate with the Practice through a non-secure platform using office email addresses. These emails will be provided upon enrollment.

2. Video Visits. Video visits are accomplished through a secure platform using the electronic health record.

**APPENDIX 2**
**Med Afford Fees**

**Fee Schedule**

Enrollment Fee – The enrollment fee is a one-time fee of $100 per member enrolled for Services at the Practice. This is charged when the Patient enrolls with the Practice and is nonrefundable. This fee is subject to change. There is a $50 enrollment fee for each additional spouse or child. If a patient discontinues membership and wishes to re-enroll in the practice we reserve the right to decline re-enrollment. Should re-enrollment occur, a re-enrollment fee of $450 will be required. This is in place to discourage frequent disenrollment and re-enrollment.

Monthly Fee and Visits – Monthly fee is based on the patient's age upon enrollment, which will be verified by the patient's state issued ID. 0-19 years old: $20/month, 20-39 years old: $40/month, 40-59 years old: $60/month and 60 and older: $80/month. The patient agrees to a 12 month contract. This fee is for ongoing primary care services. Many services available in our office are available at no additional cost to you. Items available at no additional cost will be listed on our website and are subject to change.

**Early Cancellation Fee** - If Patient elects to terminate this Agreement prior to the completion of the twelve (12) month contract term, Patient agrees to pay an early cancellation fee equal to **fifty percent (50%) of the total fees remaining for the unused months** of the contract term. This amount shall be due and payable immediately upon termination.

Corporate Plan – $40/month per employee with at least 10 employees enrolled. One flat, company wide enrollment fee of $500.

Amendments to Monthly Fee – The monthly periodic fee is listed on the website per month and is subject to change. The Practice may change the periodic fee by the 15th day of the month preceding when the change will go into effect. It is the Patient's responsibility to check the Practice's website before the end of each month to see any changes to the periodic fee. The periodic fee will be billed at the beginning of each month of this Agreement.

**Direct Itemized Fees**

In-Office Procedures included with your Direct Primary Care Plan include: ear lavage, laceration repair, incision and drainage and EKG. These are subject to change.

Laboratory Studies included with your Direct Primary Care Plan are yearly lab screenings including: CBC, A1C, CMP, Thyroid Panel, Lipid Panel and Vitamin D. Men over the age of 40 also get a yearly PSA laboratory screening.

Obstetric Services included with the Direct Primary Care Plan of women over the age of 21 includes a yearly PAP Smear. This is subject to change. No other obstetric services are included.

**APPENDIX 3**
**Med Afford Notice of Privacy Practices**

By signing the Agreement, I hereby give my consent for Med Afford to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO) as described in full Notice of Privacy Practices. Med Afford reserves the right to revise these practices at any time. A revised Notice of Privacy Practice may be obtained by written request to the office privacy officer.

This consent allows Med Afford to call my home or other alternative location and leave a message on a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care including laboratory and test results among others.

This consent allows Med Afford to email my home, or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder card and patient statements. I have the right to request that Med Afford restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. If the practice does agree it is bound by this agreement.

By signing this form, I am consenting to Med Afford use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Patient Name (Printed):

_____
Patient Signature:

_____
Date:

**APPENDIX 4**
**Med Afford Consent to Treatment**

MEDICAL AND SURGICAL CONSENT: When I am in the office, hospital, assisted living facility, independent living facility or nursing home, I permit my Med Afford provider(s) to treat me in the ways they judge to be beneficial to me. I understand that this consent includes care which may consist of ordering or performing X-ray examination, laboratory procedures, anesthesia, medical, or surgical, or other hospital services rendered to me under the general and special instructions of the physician.

ASSIGNMENT OF INSURANCE BENEFITS: In the event that I am entitled to physician care benefits arising out of any policy of insurance insuring the patient or any other party liable to the patient, those benefits are to be filed for reimbursement by the patient directly. Med Afford does not file for insurance reimbursement for services directly. The undersigned and/or the patient is fully responsible for charges not covered by the assignment. State disability benefits are assigned where applicable as well.

GUARANTEE OF PAYMENT: In consideration of medical services extended to this patient, I/We do hereby assume responsibility for the payment of all charges for such services in accordance with the financial level of benefits available. Health insurance and Medicare only pay for covered items and services. The fact that the entities may not pay for any particular item or service does not mean you should not receive it. Your provider may have good reason to recommend it. Any and all deductibles and balances arising from covered or uncovered services are payable immediately upon receipt of the Practice’s bill. I/We hereby guarantee Med Afford L.L.C. payment of all charges. I certify that I have read and understands the foregoing, and am the patient or is duly authorized by the patient as the patient's general agent/representative to execute the above and accept its terms.

By signing the Agreement, I also consent to and acknowledge receiving the Med Afford Consent to Treatment.

**APPENDIX 5**
**Med Afford Release of Protected Health Information Authorization**

GEORGIA HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

_____ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

_____ All physical, occupational and rehab requests, consultations and progress notes.

_____ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

_____ All employment, personnel or wage records.

_____ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

_____ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

_____ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period requested.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
You are authorized to release the above records to Med Afford in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records.

I understand the following: See CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This

authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____

Signature of Patient or Legally Authorized Representative

_____

Date

_____

Name and Relationship of Legally Authorized Representative to Patient

_____

Date

**APPENDIX 6**

**Med Afford Medicare Patient Understandings**

(only for medicare eligible individuals or enrollees)

This agreement is between Med Afford, and
Medicare Beneficiary: _____
Who resides at: _____
With Medicare ID #: _____

Patient is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Practice has informed beneficiary or his/her legal representative that Physicians at the Practice have opted out of the Medicare program. The Physicians in the Practice have not been excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.
_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the Physician.
_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.
_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper A Medicare claim had been submitted.
_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.
_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Name: _____

Signature: _____