PATIENT AGREEMENT
AFFIRMHD, LLC

This is an Agreement entered into on _____, 20___, between AffirmHD, an Ohio Limited Liability Company (Clinic, Us or We), and _____ _____ (Patient or You).

Background

The CLINIC is a Direct Pay primary care practice (DPC), which delivers primary care services through its physician, Dr. Ebunoluwa Wion (Physician), whose mailing address is P.O. Box 850, Pataskala, Ohio 43062. In exchange for certain fees, the CLINIC agrees to provide You with the Services described in this Agreement on the terms and conditions contained in this Agreement.

Definitions

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

2. Services. In this Agreement, "Services" means the collection of services, offered to you by Us in this Agreement. These Services are listed in Appendix A(1), which is attached and a part of this Agreement.

Agreement

3. Term. This Agreement will last for one year, starting on _____.

4. **Renewal.** This 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.

5. Termination. Regardless of anything written above, 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.

6. Payments and Refunds – Amount and Methods. In exchange for the Services (see Appendix A(1)), You agree to pay Us, a monthly fee in the amount that appears in Appendix C, which is attached and is part of this Agreement.

a) This monthly fee is payable when you sign the Agreement, and is due no later than the 15th day of each month thereafter.

b) The Parties agree that the required method of monthly payment shall be by automatic payment through a debit or credit card, or automatic bank draft.

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

(i) We will refund to You the unused portion of your fees on a per diem basis; or

(ii) If Value of the Services you received over the term of the Agreement exceeds the amount You paid in membership fees, You shall reimburse the CLINIC in an amount equal to the difference between the value of the services received and the amount You paid in membership fees over the term of the Agreement. The Parties agree that the value of the services is equal to the CLINIC's usual and customary fee-for-service charges. A copy of these fees is available on request.

7. Non-Participation in Insurance. Your initials on this clause of the Agreement acknowledges the Patient's understanding that neither the CLINIC, nor its Physician, participate in any health insurance or HMO plans or panels and cannot accept Medicare-eligible patients. We make no representations that any fees that You pay under this Agreement are covered by your health insurance or other third-party payment plans. It is the Patient's responsibility to determine whether reimbursement is available from a *private, non-governmental* insurance plan and to submit any required billing. CLINIC cannot provide itemized bills for the purposes of insurance reimbursement. _____ **(Initial)**

8. WE CANNOT Accept Medicare Patients. Your initials on this clause of the Agreement acknowledges the Patient's understanding that at this time, Medicare Patients are not eligible to be treated by the CLINIC or its Physician, and Medicare cannot be billed for any services performed by the same. Therefore, Patient acknowledges that s/he is neither a Medicare beneficiary nor Medicare eligible. The Patient agrees that if s/he will become eligible during the term of this Agreement, s/he will notify the CLINIC within 60 days of becoming eligible and this agreement will be terminated upon Medicare eligibility. Any excess fees will be refunded to Patient, and the CLINIC will make every effort to provide the Patient with names and contacts for primary care alternatives. _____ **(Initial)**

9. This Is Not Health Insurance. Your initials on this clause of the Agreement acknowledges 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 CLINIC, or its employees. You acknowledge that the CLINIC has advised You to obtain or

keep in full force, health insurance that will cover You for healthcare not personally delivered by the CLINIC, and for hospitalizations and catastrophic events. **_____ (Initial)**

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

By providing an e-mail address and cell phone number on the attached Appendix B, the Patient authorizes the CLINIC, and its Physicians to communicate with him/her by e-mail or text message regarding the Patient's "protected health information" (PHI).[1] The Patient further acknowledges that:

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

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

(c) At the discretion of the Physician, e-mail and/or text communications may be made a part of Patient's permanent medical record; and

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

(e) Email/Text Messaging Usage. **If You do not receive a response to an e-mail or text message within 24-48 hours, You agree that you will contact the Physician by telephone or other means.**

(f) Technical Failure. Neither the CLINIC, nor the Physician will be liable for any loss, injury, or expense arising from a delay in responding to Patient, when that delay is

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

caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service provider; (ii) power outages; (iii) failure of electronic messaging software, or e-mail provider; (iv) failure of the CLINIC's computers or computer network, or faulty telephone or cable data transmission; (iv) any interception of e-mail communications by a third party which is unauthorized by the CLINIC; or (v) Patient's failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

11. Physician Absence. From time to time, due to vacations, illness, or personal emergency, the Physician may be temporarily unavailable to provide the services referred to in Appendix A. In order to assist Patients in scheduling non-urgent visits, CLINIC will notify Patients of any planned Physician absences as soon as the dates are confirmed. In the event of the Physician's unplanned absences, Patients will be given the name and telephone number of an appropriate provider for the Patient to contact. In some circumstances, Patient may be directed to the nearest emergency room or urgent care clinic. Any treatment rendered by a non-CLINIC provider is not covered under this Agreement, but may be submitted to Patient's health plan.

12. 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.

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

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

15. Amendment. No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties. Except for amendments made in compliance with Section 12, above.

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

17. 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.

18. 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.

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

20. **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.

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

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

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

_____

Ebunoluwa Wion, DO, for
AFFIRMHD, LLC

_____ _____

Signature of Patient Name of Patient (printed)

_____

Date

APPENDIX A
SERVICES

1. **Medical Services.*** Medical Services under this agreement are those medical services that the Physician is permitted to perform under the laws of the State of Ohio, are consistent with Physician's training and experience, are usual and customary for a family medicine physician to provide, and include the following:[2]

- Acute and Non-acute Office Visits
- Blood Pressure Monitoring
- Diabetic Monitoring*
- Dipstick Urinalysis*
- Rapid Test for Strep Throat*
- Removal of benign skin lesions/warts*
- Simple aspiration/injection of joint*
- Removal of Cerumen (ear wax)*
- Simple Wound Repair*
- Abscess Incision and Drainage*
- Basic Vision Screening
- Labs and testing that cannot be performed in-house will be offered at a discounted rate through select vendors.*

*Patient is responsible for all costs associated with any procedure, laboratory testing, and specimen analysis.

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

- Detailed review of medical, family, and social history and update of medical record;
- Personalized Health Risk Assessment utilizing current screening guidelines;
- Preventative health counseling, which may include: weight management, 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**. CLINIC shall also provide Patient with the following non-medical services ("Non-Medical Services"), which are complementary to our members in the course of care:

[2] As deemed appropriate and medically necessary by the Physician.

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

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

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

d. ***Same Day/Next Day Appointments*.** When Patient calls or e-mails the Physician prior to noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule an appointment with the Physician on the same day. If Patient calls or e-mails the Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with the Physician on the following normal office day. In any event, however, CLINIC shall make every reasonable effort to schedule an appointment for the Patient on the same day that the request is made.

e. ***Specialists Coordination.*** CLINIC and Physician shall, with Patient's assistance, 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 and do not cover specialist's fees or fees due to any medical professional other than the CLINIC Physician.**

APPENDIX B
PATIENT ENROLLMENT – MEDICAL AGREEMENT FORM

Monthly fees, as set out in Appendix C, shall apply to the following Patient(s):

Printed Name	Date of Birth (MM/DD/YYYY)		Age
Street Address		City, State, Zip	
Home Phone	Work Phone	Cell Phone	Preferred email
Spouse Name	Date of Birth (MM/DD/YYYY)		Age
Home Phone	Work Phone	Cell Phone	Preferred email

Child/Children to Whom this Agreement Applies:

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

Preferred Payment Method*

□ Yearly (Credit/Debit Card/Bank Draft)

□ Monthly (Credit/Debit Card/Bank Draft)

*All patients must have a credit or debit card on file to cover the cost of membership and any incidentals not covered under the Agreement.

I certify that I have read, understand, and agree to the terms set forth in this Medical Agreement Form.

Signature: _____

APPENDIX C
MEMBERSHIP FEE ITEMIZATION

0-21 years of age	$20 per month*
0-21 years of age	$40 per month**
21-64 years of age	$40 per month
65+ years of age	$60 per month****
Enrollment Admin Fee	$25 per person at enrollment only
Re-enrollment Fee	$40 per person***
Office Visit Fee	$10 per person per visit

*With the enrollment of at least one adult member.
**Without a fully enrolled adult member.
***Non-refundable fee. Should your membership lapse or be terminated, a re-enrollment fee must be paid and your account must be brought up to current if there are outstanding balances for membership to become activated.
****Applies only to non-Medicare eligible or covered persons. Per Medicare rules we are currently not allowed to enroll Medicare beneficiaries.

Patient 1	$_____
Patient 2	_____
Additional Patients	_____
TOTAL RATE	$_____