

## Patient Agreement

### Growing Kids Pediatrics, LLC (d/b/a) Growing Kids Concierge

This Patient Agreement (the **Agreement**) is between Growing Kids Pediatrics, LLC, doing business as Growing Kids Concierge, an Indiana Limited Liability Company located at 3321 Ballard Lane, New Albany, Indiana (the **Practice**), Dr. Christina Lane (the **Physician**) (collectively, **Us** or **We**) and (**Patient**, **Patient Representative**, **Member**, and **You, Your**).

### Background

The **Physician** specializes in pediatrics and provides primary care services to Patients on behalf of Practice. In exchange for certain fees paid by You, the Practice, through its Physician, agrees to provide Patient with the Program Services described in this Agreement on the terms and conditions set forth in this Agreement.

### Definitions

- A. **Patient**: means the individuals identified in Appendix 1 who will receive the Program Services from the Practice.
- B. **Program Services**: means uninsured medical, non-medical, and certain benefits provided to You by the Practice and specifically described in Appendix 3. Program Services exclude Covered Health Services.
- C. **Covered Health Services**: means any health care services provided by Us that are covered by Your private health insurance or Medicaid plan.
- D. **Fees**: means the membership fees identified in Appendix 2 that is payment for the Program Services provided to You during the term of this Agreement. NOTE: Existing Medicaid patients do not pay membership fees.

### Section 1: Services

1.1 **Membership Fees.** You agree to pay the Fees set forth in Appendix 2 as consideration for the Program Services provided under this Agreement. If an insurance co-pay is required for Covered Health Services provided by the Physician on behalf of the Practice, the Fees shall be used to offset such co-pay requirements.

1.2 **Insurance or Other Medical Coverage.** You acknowledge and understand that this Agreement is not an insurance plan and is not intended to replace any existing health insurance or other health plan coverage that You may carry. GKC is not an insurance company or broker. Except as may be expressly identified in a separate addendum, this Agreement will not cover any healthcare services not personally provided by Us. We have advised You to obtain or keep in full force such health insurance policy(ies) or plans that will cover Your general and emergency healthcare costs. GKC bills your insurance for covered services.

1.2 **Participation in Insurance.** You acknowledge that We do not participate in all health insurance or HMO plans or panels and, as a result, may be considered a non-participating or out-of-network provider for some plans. GKC will bill your insurance as an out of network

provider, but your insurance may not pay the full sum you owe. You retain full and complete responsibility for any out of network services provided by GKC. Nothing in this Agreement supersedes or modifies the terms or conditions of any agreements related to your health insurance. As a convenience to You, We will bill Your health insurer or Medicaid for all Covered Health Services. You agree to sign the required Medicaid and Medi-Gap Acknowledgment Form attached as Appendix 4 and any assignment of benefits required by any health insurer.

**1.3 Covered Health Care Services Excluded from Membership Fee.** The Fees cover the cost of the Program Services and not the cost of Covered Health Care Services. Further, Fees paid under this Agreement are not covered by your health insurance or Medicaid and are not designed or intended as compensation for the Covered Health Care Services covered by such plans.

**1.4 Outside Call Coverage.** During the Physician's absence for vacations, continuing medical education, illness, emergencies, or days off, the Practice may, at the discretion of the Physician or as required by law, arrange for call coverage with another provider for You. The Practice will make reasonable efforts to notify You prior to any such absence when dates are confirmed. During such time, any calls to the Physician, or to the Practice, will be directed to a provider who is "covering" for the Physician during this absence, and You will be given instructions on how to contact such healthcare provider. The Practice cannot guarantee that such coverage will include Concierge services in addition to meeting your basic pediatric care needs. If You have urgent concerns that cannot wait for the Physician's return, You should seek treatment at an urgent care or other suitable facility. Treatment provided by such outside facility or provider is not included in the Fees nor this Agreement. You may submit bills for such treatment to any health plan that You might have for reimbursement consideration.

**1.5 Acceptance of Patients.** We reserve the right to accept or decline patients based upon our capability to appropriately handle the patient's primary care needs and our capacity for taking new patients. We may decline new patients because the Physician's panel of patients is full, or because the patient requires medical care not within the Physician's scope of services.

**1.6 Fee and Services Adjustments.** If the Practice finds it necessary to increase or adjust Fees or Program Services before the termination of the Agreement, Practice shall give sixty (60) days written notice of any such modifications. If You do not consent to the modification, You may terminate the Agreement in writing prior to the next scheduled payment of Fees.

**1.7 Multi Child Households where not all children are covered by Medicaid.** In the case of a household where there are one (1) or more child(ren) covered by Medicaid and one (1) or more child(ren) not covered by Medicaid, fees shall only apply to the child(ren) who are not Medicaid members. Concierge fees are not applicable to Medicaid insureds.

## **Section 2. Communications**

**2.1 Communications.** You acknowledge that communications with Us using Email, facsimile, video chat, instant messaging, text messages, and cellular phones are not guaranteed to be secure or confidential communication methods unless both parties are using a

HIPAA compliant program or app. If you contact the Physician through a non-HIPAA compliant method, you are expressly waiving the Physician's obligation to guarantee confidentiality with respect to correspondence via such means of communication. All communications with Physician become a part of your medical record. By providing Your email address on the attached Appendix 1, You authorize Us to communicate with You by Email regarding Your "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations). You acknowledge that:

- Email is not necessarily a secure medium for sending or receiving PHI and there is always a possibility that a third party may gain access.
- Although We will make reasonable efforts to keep email communications confidential and secure, We cannot assure or guarantee the absolute confidentiality.
- You understand and agree that Email is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information because Physician may not see it within a defined timeframe. In the event of an emergency, or a situation in which You could reasonably expect to develop into an emergency, You shall call 911 or the nearest Emergency room and follow the directions of emergency personnel.
- If You do not receive a response to an Email message within one day, You agree to use another means of communication to contact Us. We will not be liable to You for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to You as a result of technological failures, including, but not limited to, (i) technological failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address email messages, (iii) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of email communications by a third party; or (v) Your failure to comply with the guidelines regarding the use of email communications set forth in this paragraph.

### **Section 3. Miscellaneous**

3.1 **Term.** This Agreement will begin on the date listed in Appendix 1 and will renew automatically for successive one-year terms at each anniversary unless earlier terminated as set forth below.

3.2 **Termination.** Both parties, GKC and You shall have the absolute and unconditional right to terminate the Agreement, with or without cause for termination, upon giving thirty (30) days prior written notice to the other party.

3.3 **Notice.** Any communication required or permitted to be sent under this Agreement (other than communications referenced in Section 2) will be in writing and sent via facsimile, recognized overnight courier or certified mail, return receipt requested, to the addresses set forth below:

**3.4 Change of Law.** If there is a change of any law, regulation or rule, federal, state, or local, which affects the Agreement, or the activities of either party under the Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights, obligations or operations associated with the Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of the Agreement. If the parties are unable to reach an agreement concerning the modification of the Agreement within forty-five (45) days after the effective date of the change, then either party may immediately terminate the Agreement by written notice to the other party.

**3.5 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.

**3.6 Reimbursement for Services Rendered.** If this Agreement is held to be invalid for any reason, and if We are therefore required to refund all or any portion of the membership fees paid by You, You agree to pay Us an amount equal to the reasonable value of the Program Services actually rendered to You during the period of time for which the refunded fees were paid.

**3.7 Jurisdiction and Venue.** This agreement is governed by Indiana law, regardless of choice of law provisions. Venue for any matter resulting from or related to this Agreement will be had in the state or federal courts covering Floyd County, Indiana.

**3.8 Arbitration Clause.** Any dispute, controversy, or claim arising out of or relating to this agreement, or the breach thereof, shall be settled by binding arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. The place of arbitration shall be in the state of Indiana County of Floyd. The arbitration shall be conducted by a single arbitrator, unless the parties agree otherwise. The parties agree that the arbitrator shall have the authority to award any relief that a court of competent jurisdiction could award, including the costs of arbitration, attorney's fees, and punitive damages, to the extent such damages would be available under the applicable law. The parties understand and agree that, by entering into this agreement, they are waiving their right to a trial by jury or to participate in a class action or representative action. If any provision of this arbitration clause is found to be invalid or unenforceable, the remaining provisions shall continue to be valid and enforceable.

**3.9 Entire Agreement.** This Agreement contains the entire agreement between the parties and supersedes all prior oral and/or written understandings and agreements regarding the subject matter of this Agreement.

## Appendix 1: Patient Information

### CHILD/CHILDREN TO WHOM THIS AGREEMENT APPLIES:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Patient PARENT OR GUARDIAN:** (Provide email address only if you agree to Email communication)

Street  
Address \_\_\_\_\_

City, State,  
Zip \_\_\_\_\_

Preferred Contact Number: \_\_\_\_\_ Cell Phone:  
\_\_\_\_\_

Email: \_\_\_\_\_  
\_\_\_\_\_

DO YOU AGREE TO TEXT AND EMAIL MESSAGE COMMUNICATION REGARDING  
THE HEALTH CARE CONCERNS OF THE ABOVE-NAMED CHILDREN? (CHECK  
ONE)

YES NO

Your signature indicates acceptance of the terms of the Patient Agreement

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient(s): \_\_\_\_\_

## Appendix 2: Membership Fees

	Annual	Quarterly	Monthly
First child	\$1,800	\$450	\$150
Second child	+ \$900	+ \$225	+ \$75
Third child	+ \$600	+ \$150	+ \$50
Family maximum	\$3,600	\$900	\$300

You will pay the applicable Fees of \$\_\_\_\_\_ (based on number of Patients identified in Appendix 1) at the following frequency: (Select One)

\_\_\_ Annually

\_\_\_ Quarterly

\_\_\_ Monthly

*Monthly or Quarterly payments of Fees require completion of Authorization of Automatic Billing via ACH or Debit/Credit Card.*

Signature \_\_\_\_\_

Signature Date \_\_\_\_\_

Full Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

### **Appendix 3: Program Services**

a. **Enhanced Access.** You shall have enhanced access to Physician. This includes extended office visits with minimal wait times as well as the Physician's personal cell phone number, email address, and a HIPPA secured digital messaging application to contact the Physician.

- You understand that use of the Physician's personal cell phone number after office hours should only be used for guidance regarding urgent concerns that arise unexpectedly after office hours.
- You understand that email is reserved for non-urgent communications only, and that the Practice shall deal with such communications in a timely manner.
- You understand and agree that email and digital messaging should never be used to access medical care in the event of an emergency, or any situation that You could reasonably expect may develop into an emergency.
- You agree that in such situations, You should speak directly to the Practice during business hours or directly to Physician over the phone during nonbusiness hours. If a phone conversation with the Physician cannot occur in a timely fashion, You or Your family members agree to call 911 or go to the nearest emergency medical provider.

b. **Non-Wait or Minimal Wait Appointment.** Every effort shall be made to assure that You are seen by the Physician immediately upon arriving for a scheduled office visit or after a minimal wait. If the Physician or Practice staff foresee a wait time longer than expected, You will be contacted and advised of the projected wait time when practicable.

d. **Same Day/Next Day Appointments.** We will make every reasonable effort to provide same/day or next day access to Physician for sick visits or urgent needs. This excludes emergent care defined in above. If same day appointment is not possible, We will make an appointment with the Physician on the next normal business day. Should the request occur during the time noted in "Outside Call Coverage", every attempt will be made to see You the next day by a covering provider if the Physician's absence will be longer than what medically necessary to take care of Your specific concern.

e. **Specialists.** We shall coordinate care with medical specialists to whom You are referred, to assist You in obtaining specialty care. You understand 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 Us.