**PATIENT AGREEMENT**

**[insert practice name]**

This is an Agreement entered into on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, between [insert practice name], a [insert state] Limited Liability Company (Practice, Us or We) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Patient or You).

**Background**

The Practice is a direct pay primary care practice (DPC), which delivers primary care services through its physician, [insert physician’s name] (Physician), at [insert practice address]. In exchange for certain fees, the PRACTICE 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.** The Agreement will automatically renew each year on the anniversary date of the Agreement unless either party cancels the Agreementby 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 first 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) Patient is responsible for all costs associated with any procedures, laboratory testing, or specimen analysis. These fees are due at the time of service.

(d) If this Agreement is cancelled 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 the Value of the Services you received over the term of the Agreement exceeds the amount You paid in membership fees, You shall reimburse the PRACTICE 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 PRACTICE’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 thatneither the PRACTICE, nor its Physician, participate in any health insurance or HMO plans or panels and have opted out of Medicare. Neither make any representations that the fees paid under this Agreement are covered by the Patient’s 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 or HSA and to submit any required billing. **\_\_\_\_\_\_ (Initial)**

**8. Medicare.** Your initials on this clause of the Agreement acknowledges Patient’s understanding that the Physician has opted out of Medicare, and as a result, Medicare cannot be billed for any services performed for the Patient by the Physician. The Patient agrees not to bill Medicare or attempt to obtain Medicare reimbursement for any such services. If the Patient is eligible for Medicare, or becomes eligible during the term of this Agreement, then s/he will sign the Medicare Opt Out and Waiver Agreement attached as Appendix D and incorporated by reference.The Patient shall sign and renew the Medicare Opt Out and Waiver Agreement every two years, as required by law. **\_\_\_\_\_\_ (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. The Patient understands that this Agreement does not replace any existing or future health insurance or health plan coverage that Patient may carry. The Agreement does not include hospital services, or any services not personally provided by the PRACTICE, or its employees. The Patient acknowledges that the PRACTICE has advised the Patient to obtain or keep in full force, health insurance that will cover the Patient for healthcare not personally delivered by the PRACTICE, and for hospitalizations and catastrophic events. **\_\_\_\_\_\_ (Initial)**

**10. Communications**. The Patient acknowledges that although PRACTICE 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 PRACTICE, 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 PRACTICE 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 hours, You agree that you will contact the Physician by telephone or other means.**

(f) Technical Failure. Neither the PRACTICE, nor the Physician will be liable for any loss, injury, or expense arising from a delay in responding to Patient when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service provider; (ii) power outages; (iii) failure of electronic messaging software, or e-mail provider; (iv) failure of the PRACTICE’s computers or computer network, or faulty telephone or cable data transmission; (iv) any interception of e-mail communications by a third party which is unauthorized by the PRACTICE; or (v) Patient’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, PRACTICE 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. Any treatment rendered by the substitute 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 Agreement 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 PRACTICE is required to refund fees paid by You, You agree to pay the PRACTICE an amount equal to the fair market value of the medical services You received during the time period for which the refunded fees were paid.

**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 Pennsylvania. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the PRACTICE in Montgomery County, Pennsylvania.

**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.

[insert physician’s name and credentials], for

[insert practice name]

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 [insert state], 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

· Well-Woman Care/ Pap Smear\*

· Well-Baby/Well-Child Care, excluding vaccinations

· Electrocardiogram (EKG)

· Blood Pressure Monitoring

· Diabetic Monitoring

· Breathing Treatments (nebulizer or inhaler with spacer)\*

· IUD Removals

· Urinalysis\*

· Rapid Test for Strep Throat\*

· Removal of benign skin lesions/warts\*

· Simple aspiration/injection of joint

· Removal of Cerumen (ear wax)

· Wound Repair and Sutures\*

· Abscess Incision and Drainage

· Basic Vision/Hearing Screening

· At Physician’s discretion, additional services may be offered for an additional fee.

· Drawing basic labs. Labs and testing that cannot be performed in-house will be offered at a discounted rate through select vendors.\*

· The convenience of access to many commonly prescribed prescription medications at greatly reduced prices, dispensed on premises.\*\*

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

\*\*Prescription medications and DME dispensed by the PRACTICE pharmacy are subject to an additional charge, for which the Patient is responsible.

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**. PRACTICE shall also provide Patient with the following non-medical services (“Non-Medical Services”), which are complementary to our members in the course of care:

(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 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 PRACTICE in a timely manner. **Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that Patient could reasonably expect may develop into an emergency.** Patient agrees that in such situations, when a Patient cannot speak to 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, PRACTICE shall make every reasonable effort to schedule an appointment for the Patient on the same day that the request is made.

(e) ***Specialists Coordination.*** PRACTICE and Physician shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. **Patient understands that fees paid under this Agreement do not include and do not cover specialist’s fees or fees due to any medical professional other than the PRACTICE Physician.**

**Appendix B**

**Patient Enrollment**

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

**Appendix C**

**FEE ITEMIZATION**

0-18 years of age $19 per month\*

0-18 years of age $39 per month\*\*

19-49 years of age $59 per month

50-64 years of age $79 per month

65-99 years of age $99 per month

100+ years of age $1 per month

Enrollment Fee $100 per person,

up to $250 per household\*\*\*

Re-Enrollment Fee $250 per person,

up to $600 per household\*\*\*

\*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, the re-enrollment fee must be paid for membership to become active.

Patient 1 $

Patient 2

Additional Patients

TOTAL RATE $

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

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