



PATIENT AGREEMENT

This Patient Agreement (Agreement) is between Simon Direct Primary Care (the Practice, Us or We), and _____ (Patient, Member, or You).

Background

The Practice, located at 3864 HWY 392, HARRISON AR 72601 provides ongoing primary care medicine to its Members in a direct pay, membership model (DPC). In exchange for certain periodic fees, the Practice agrees to provide You with the Services described in this Agreement under the terms and conditions contained within.

Definitions

- 1. Services.** In this Agreement, "Services" means the collection of services, medical and non-medical, which are described in Appendix A (attached and incorporated by reference), which We agree to provide to You under the terms and conditions of this Agreement.
- 2. Patient.** In this Agreement, "Patient," "Member," "You" or "Yours" means the persons for whom the Practice shall provide care, who have signed this Agreement, and/or whose names appear in appendix B (attached and incorporated by reference).

Agreement

- 3. Term.** This Agreement will last for one year, starting on the date it is fully executed by the parties.
- 4. Renewal.** The Agreement will automatically renew each year on the anniversary date of the Agreement unless either party cancels the Agreement by giving 30 days written notice.
- 5. Termination.** Either party can cancel this Agreement at any time by giving 30 days' written notice to the other of intent to terminate.
 - a. Grounds for termination
 - i. Failure to pay fees

- ii. Inappropriate or overuse of direct contact to staff or physician, warnings will be given indicating such and educating before termination.
- iii. Repeated no-shows to appointments
- iv. Abusive behavior towards staff

6. Payments and Refunds – Amounts and Methods.

- A. In exchange for the Services described in Appendix A, You agree to a monthly payment (or Membership Fee) in the amount which appears in Appendix C, which is attached and incorporated by reference;
- B. Upon Execution of this Agreement, You shall pay a one-time, nonrefundable, Enrollment Fee, in addition to the Monthly Membership Fee (which shall be prorated to the first of the month), in the amount as described in Appendix C.
- C. Thereafter, the Membership Fee shall be due on the agreed business day of every month.
- D. The Parties agree that the required method of payment shall be by automatic payment through a debit or credit card or automatic bank draft.

7. Early Termination. If You cancel this Agreement before its term ends, We will refund any unused portion of your membership fee on a per diem basis.

8. Non-Participation in Insurance. The Practice does not participate with any health plans, HMO panels, or any other third-party payor. As such, we may not submit bills or seek reimbursement from any third-party payors for the Services provided under this Agreement.

9. Medicare. The Patient understands that the Practice and staff are unable to provide care through the direct primary care model to any patient with Medicare as their primary insurance.

10. This Agreement Is Not Health Insurance. The Patient has been advised and understands that this Agreement is not an insurance plan. It does not replace any health coverage that the Patient may have, and it does not fulfill the requirements of any federal health coverage mandate. This Agreement does not include hospital services, emergency room treatment, or any services not personally provided by the Practice or its staff. This Agreement includes only those Services identified in Exhibit A. If a Service is not specifically listed in Appendix A, it is expressly excluded from this Agreement. The Patient acknowledges that We have advised them to obtain health insurance that will cover catastrophic care and other services not included in this Agreement. Patients are always personally responsible for

the payment of any medical expenses incurred for services not included under this Agreement.

- 11. Communications.** The Practice endeavors to provide Patients with the convenience of a wide variety of electronic communication options. Although We are careful to comply with patient confidentiality requirements and make every attempt to protect Your privacy, communications by email, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed secure or confidential methods of communications. By placing Your initials at the end of this Clause, You acknowledge the above and indicate that You understand and agree that by initiating or participating in the above means of communication, you expressly waive any guarantee of absolute confidentiality with respect to their use. You further understand that participation in the above means of communication is not a condition of membership in this Practice; that you are not required to initial this clause; and that you have the option to decline any particular means of communication. _____ **(Initial)**

- 12. Email and Text Usage.** By providing an email address on the attached Appendix B, the Patient authorizes the Practice and its staff to communicate with him/her by email regarding the Patient's "protected health information" (PHI).¹ By providing a cell phone number in Appendix B and checking the "YES" box on the corresponding consent question, the Patient consents to text message communication containing PHI through the number provided. The Patient further understands and acknowledges that:

- A. Email and text message are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access;
- B. Email and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information. Therefore, in an emergency or a situation that could reasonably be expected to develop into an emergency, the Patient agrees to call 911 or go to the nearest emergency care facility and follow the directions of personnel.

- 13. Technical Failure.** Neither the Practice nor its staff will be liable for any loss, injury, or expense arising from a delay in responding to the Patient when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service physician;

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

(ii) power outages; (iii) failure of electronic messaging software, or email physician; (iv) 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 which is unauthorized by the Practice; or (v) Patient's failure to comply with the guidelines for use of email or text messaging, as described in this Agreement.

14. Physician Absence. From time to time, due to such things as vacations, illness, or personal emergency, the physician may be temporarily unavailable. When the date/s of such absences are known in advance, the Practice shall give notice to Patients so that they may schedule non-urgent care accordingly. During unexpected absences, Patients with scheduled appointments shall be notified as soon as possible, and appointments shall be rescheduled at the Patient's convenience. If during physician's absence, the Patient experiences an acute medical issue requiring immediate attention, the Patient should proceed to an urgent care or other suitable facility for care. Charges from Urgent Care or any other outside provider are not included under this Agreement and are the Patient's responsibility. The Patient may, however submit such charges to their health plan for reimbursement consideration or request that the outside provider do the same. The Patient is responsible for understanding the coverage rules of their health plan, and We cannot guarantee reimbursement.

15. Dispute Resolution. Each party agrees not to make any inaccurate or untrue and disparaging statements, oral, written, or electronic, about the other. We strive to deliver only the best of personalized patient care to every Member, but occasionally misunderstandings arise. We welcome sincere and open dialogue with our Members, especially if we fail to meet expectations, and We are committed to resolving all Patient concerns.

Therefore, in the event that a Member is dissatisfied with, or has concerns about, any staff member, service, treatment, or experience arising from their membership in this Practice, the Member and the Practice agree to refrain from making, posting or causing to be posted on the internet or any social media, any untrue, unconfirmed, inaccurate, disparaging comments about the other. Rather, the Parties agree to engage in the following process:

- A. Member shall first discuss any complaints, concerns, or issues with their physician;
- B. The physician shall respond to each of the Member's issues or complaints;
- C. If, after such response, Member remains dissatisfied, the Parties shall enter into discussion and attempt to reach a mutually acceptable solution.

- 16. Monthly Fee and Service Offering Adjustments.** In the event that the Practice finds it necessary to increase or adjust monthly fees or Service offerings before the termination of the Agreement, the Practice shall give 30 days' written notice of any adjustment. If Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled monthly payment.
- 17. Change of Law.** If there is a change of any relevant law, regulation or rule, which affects the terms of this Agreement, the parties agree to amend it only to the extent that it shall comply with the law.
- 18. Severability.** If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part shall be amended to the extent necessary to be enforceable, and the remainder of the Agreement will stay in force as originally written.
- 19. Amendment.** Except as provided within, no amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties.
- 20. Assignment.** Neither this Agreement nor any rights arising under it may be assigned or transferred without the agreement of the Parties.
- 21. Legal Significance.** The Patient acknowledges that this Agreement is a legal document that gives the parties certain rights and responsibilities. The Patient agrees that they are suffering no medical emergency and has had reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and is satisfied with the terms and conditions of the Agreement.
- 22. Miscellaneous.** This Agreement is to be construed without regard to any rules requiring that it be construed against the drafting party. The captions in this Agreement are only for the sake of convenience and have no legal meaning.
- 23. Entire Agreement.** This Agreement contains the entire Agreement between the parties and replaces any earlier understandings and agreements, whether written or oral.
- 24. No Waiver.** Either party may choose to delay or not to enforce a right or duty under this Agreement. Doing so shall not constitute a waiver of that duty or responsibility and the party shall retain the absolute right to enforce such rights or duties at any time in the future.
- 25. Jurisdiction.** This Agreement shall be governed and construed under the laws of the State of Arkansas. All disputes arising out of this Agreement

shall be settled in the court of proper venue and jurisdiction for the Practice.

26. Notice. Notice, as required under Paragraph 16 above, may be achieved either through electronic means at the email address provided by the party to be noticed or through first-class US Mail. All other required notice must be delivered by first-class US mail to the Practice, at the address written above and to the Patient, at the address provided in Appendix B.

The Parties agree that throughout this agreement and it's attachments, checking the appropriate box next to their name will constitute an electronic signature and shall be valid to the same extent as a handwritten signature.

For: SIMON DIRECT PRIMARY CARE

☐ By _____MD _____ Date

Patient:

☐ _____
Printed Name Date

APPENDIX A

SERVICES

1. Medical Services

Medical Services offered under this Agreement are those consistent with the physician's training and experience, and as deemed appropriate under the circumstances, at the sole discretion of the physician. The Patient is responsible for all costs associated with any medications, laboratory testing, and specimen analysis related to these Services unless otherwise noted. The specific Medical Services provided under this Agreement include the following:

- Acute and Non-acute office visits
- Chronic disease management (e.g. diabetes, high blood pressure, asthma, heart disease)
- Preventive care
- Wellness visits
- Well-woman care
- Well-child care
- Sports physicals
- Weight loss (added fee for multiple appointments)
- Smoking cessation
- Healthy Lifestyle Counseling
- Removal of benign skin lesions/warts
- Simple dermatology procedures
- Abscess Incision and Drainage
- Ear wax removal
- Splinting
- Casting
- Aspiration and/or injection of joints
- Wound repair and sutures
- Trigger point injection

2. Non-Medical, Personalized Services. The Practice shall also provide Members with the following non-medical services:

- **After-Hours Access.** Subject to the limitations of paragraph 14, Members shall have direct telephone access to the physician for guidance in regard to urgent concerns that arise unexpectedly after office hours.

- **Email Access.** Subject to the limitations of paragraph 12, above, The Patient shall be given the physician's email address to which non-urgent communications can be addressed. The Patient understands and agrees that neither email nor the internet should be used to access medical care in the event of an emergency or any situation that could reasonably develop into an emergency. The Patient agrees that in this situation, when s/he cannot speak to the physician immediately in person or by telephone, to call 911 or go to the nearest emergency medical assistance physician, and follow the directions of emergency medical personnel.
- **Same Day/Next Day Appointments.** When a Patient contacts the Practice prior to noon on a regular office day to request a same-day appointment, every reasonable effort shall be made to schedule the Patient for that same day; or if this is not possible, Patient shall be scheduled for the following office day (subject to the limitations of paragraph 14).
- **No Wait or Minimal Wait Appointments.** Every reasonable effort shall be made to assure that the Patient is seen by the physician immediately upon arriving for a scheduled office visit or after only a minimal wait. If physician foresees more than a minimal wait time, Patient shall be contacted and advised of the projected wait time. Patient shall then have the option of seeing the physician at the later time or reschedule at a time convenient to the Patient.
- **Telehealth.** Telehealth (virtual visits) will be available when desired and deemed appropriate by the Patient and physician.
- **Specialists Coordination.** The physician shall coordinate care with medical specialists and other practitioners to whom the Patient needs referral. The Patient understands that fees paid under this Agreement do not include specialist's fees or fees due to any medical professional other than the Practice staff.

APPENDIX B

PATIENT ENROLLMENT FORM

PATIENT ENROLLMENT FORM

CHECK YES WHERE INDICATED ONLY IF YOU AGREE TO TEXT MESSAGE COMMUNICATION. PROVIDE EMAIL ADDRESS ONLY IF YOU AGREE TO EMAIL COMMUNICATION.

THE FEES AS SET OUT IN THE ATTACHED APPENDIX C, SHALL APPLY TO THE FOLLOWING PATIENT(S), WHO BY SIGNING BELOW (OR AS LEGAL REPRESENTATIVE), CERTIFY THAT THEY HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT:

Patient 1

Print Patient Name _____ Date of Birth _____

Street Address _____

City, State, Zip _____

Cell Phone _____ Alternate Number _____ Email _____

I Agree to Text Communication: (check one below)

- ☐ Yes
☐ No

Printed Name: _____ Relationship to Patient: _____

Patient 2

Patient Name _____ Date of Birth _____

Cell Phone _____ Alternate Number _____ Email _____

I agree to Text Communication: (check one below)

- ☐ YES
☐ NO

Printed Name: _____ Relationship to Patient: _____

Patient 3

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number_____ Email_____

Agree to Text Communication: (check one below)

☐ YES

☐ NO

Printed Name: _____ Relationship to Patient: _____

Patient 4

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number _____ Email_____

I agree to Text Communication: (check one below)

☐ YES

☐ NO

Printed Name: _____ Relationship to Patient: _____

Patient 5

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number _____ Email_____

I agree to Text Communication: (check one below)

☐ YES

☐ NO

Printed Name: _____ Relationship to Patient: _____

APPENDIX C
FEE ITEMIZATION

Enrollment Fee.

One time initial enrollment fee to cover the cost of record request and data entry for new charting of \$25 per member.

Re-enrollment fee.

If, after allowing membership to lapse or be terminated, Patient desires to re-join the practice, the Patient shall be accepted on a space-available basis, subject to a \$ 150 re-enrollment fee.

Monthly Membership Fees

18 years and under	\$ 40 per month	____ Members	\$ _____
19 to 34 years	\$ 70 per month	____ Members	\$ _____
35 to 64 years	\$ 90 per month	____ Members	\$ _____
65 years +	\$100 per month	____ Members	\$ _____

Total Monthly Membership Fee	\$ _____
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Total Initial Enrollment Fee	\$ _____
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Initial Payment

Prorated Membership Fees	\$ _____
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Total Due on Signing

\$ _____

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Upon approval, you will have the option to make

monthly payments or set up a monthly auto-deduction. Payments are made directly through our secure link accessed through your electronic statement sent to your email. Your statement will include monthly fees and incidental charges which you will receive prior to any payments or deductions.

Customer(s)Name(s):_____

PAYMENT INFORMATION

I authorize Simon Direct Primary Care, to automatically bill the card listed below as specified: Amount: \$_____ for monthly subscription and Incidental Charges;

Frequency:

Monthly Start billing on: ____/____/____

End billing when: Customer provides written cancellation

CREDIT/DEBIT CARD INFORMATION:

Credit card type: ☐ Visa, ☐ MasterCard, ☐ American Express, ☐ Discover

Credit card number: _____ Expires: ____/____

Cardholder's name: As shown on credit card CVC(Security code)

Customer's signature:

AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

DATE

SIGNATURE

