DIRECT PRIMARY CARE PATIENT AGREEMENT

Matthew Fleig M.D.

This is an Agreement between Dr. Matthew Fleig and you, the patient.

Definitions

1. **Patient**: refers to you as the patient who will be receiving care and services by Dr. Matthew Fleig.

2. **Services**: covers the medical and non-medical care primary care services as detailed in Appendices 1 and 2. Dr. Matthew Fleig will make every effort to address the needs of Patient in a timely manner, but cannot guarantee immediate availability at all times, and cannot guarantee that the patient will not need to seek treatment in the urgent care or emergency department setting.

3. **Fees**: the Patient agrees to pay the practice of Dr. Matthew Fleig, the amount as set forth in Appendices 1 and 2. Applicable enrollment fees are payable upon the date of execution of this agreement. Fees will be prorated to a portion of the month as applicable to beginning or ending enrollment partway through the month, and as governed by Section 6 (Term), for services rendered to the Patient up to the date of termination.

4. **Non-Participation in Insurance**. The Patient acknowledges that the practice of Dr. Matthew Fleig does not participate in any health insurance or HMO plans. He has opted out of Medicare as well. The 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. Dr. Matthew Fleig's practice does not 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 Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, the Patient will sign the agreement attached as Appendix 3. 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 Dr. Matthew Fleig. You agree not to bill Medicare or attempt Medicare reimbursement for any such services.

5. **Insurance or Other Medical Coverage**. The 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 Dr. Matthew Fleig. The patient acknowledges that the practice has advised that **the patient obtain or keep in full force such health insurance policy(ies) or plans that will cover Patient for general healthcare costs**. Patient acknowledges

that THIS AGREEMENT IS NOT A CONTRACT THAT PROVIDES HEALTH INSURANCE. The agreement 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 Patient may need to visit the emergency room or urgent care from time to time. The physician will make every effort to be available at all times via appointments, phone, or electronic medical record portal, but Physician cannot guarantee 24/7 availability.

6. **Term**. This Agreement will commence on the date it is signed by the Patient and Physician below and will extend monthly thereafter. Notwithstanding the above, both Patient and Practice shall have the absolute and unconditional right to terminate the Agreement. Patient is permitted to terminate this Agreement by giving Practice thirty (30) days written notice, with the notice to state Patient's reason for termination, in order to receive monthly prorated refund of any unused program fees. Practice may terminate this Agreement by giving Patient thirty (30) days written notice and shall provide the patient with a resource to search for other primary care physicians in the community. The Agreement will automatically renew for successive monthly terms upon the payment of the monthly fee at the end of the contract month.

7. **Privacy & Communications**. You acknowledge that communications with Physician using electronic medical record portal, facsimile, video chat and cell phone are not guaranteed to be secure. The Practice will make an effort to secure all communications via passwords and other protective means. The Practice will also follow established standards for the most secure methods of communication, such as software platforms with data encryption, HIPAA familiarity, and a willingness to sign HIPAA Business Associate Agreements. 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 Patient regarding PHI in the same format. Patient acknowledges that all such communications may become a part of the medical record. The Patient agrees that:

(a) The practice is authorized to communicate with Patient by SMS regarding Patient's PHI unless otherwise specified in writing by Patient;

(b) SMS is not necessarily secure media for sending or receiving PHI and there is always a possibility that a third party may gain access;

(c) Although the practice will make all reasonable efforts to keep SMS communications confidential and secure, neither Practice nor the Physician can assure or guarantee the absolute confidentiality of SMS communications;

(d) At the discretion of the practice, SMS communications may be made a part of Patient's permanent medical record; and,

(e) Patient understands and agrees that SMS are not appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. In the event of an emergency, or a situation in which the Patient could reasonably expect to develop into an emergency, the Patient shall call 911 or go to the nearest emergency room and follow the directions of emergency personnel. If Patient does not receive a response to an SMS message within one day, Patient agrees to use another means of communication to contact the office of Dr. Matthew Fleig. The practice of Dr. Matthew Fleig will not be liable to Patient for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient as a result of technical failures, including, but not limited to, (i) technical failures attributable to any telephone or internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address SMS 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 use of SMS communications set forth in this paragraph.

8. **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.

9. **Change of Law**. If there is a change of any law, regulation or rule, federal, state or local, which affects this Agreement which are incorporated by reference in 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 including these Terms & Conditions. 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 change, then either party may immediately terminate the Agreement by written notice to the other party.

10. **Patient Understandings (initial each)**:

_____This Agreement is for ongoing primary care and is NOT a medical insurance agreement.

_____ In the event of a medical emergency, I agree to call 911 first.

_____I understand that neither Physician nor Practice is a Medicare provider. Therefore, Physician will not submit claims to Medicare for covered services for those who have MEDICARE coverage.

_____I do NOT expect the practice to file or appeal any third party insurance claims on my behalf.

_____I understand Physician will make every effort to be available but may not always be able to see me on a same-day basis. I may be referred to an urgent care for same-day service.

_____This Agreement does not meet the individual insurance requirement of the Affordable Care Act. I acknowledge my responsibility to maintain health insurance coverage that will cover care at hospitals, specialist offices, urgent care centers, etc.

_____I am enrolling in a membership-based practice that will bill me monthly.

_____I am enrolling (myself and my family if applicable) in the practice voluntarily.

_____I understand failure to pay the membership fee will result in termination from Practice.

_____I may receive a copy of this document upon request.

_____This Agreement is non-transferable

Patient Name

_____

Patient (or Guardian) Signature

_____

Matthew J. Fleig, MD

Physician Signature

_____

APPENDIX 1

FEE SCHEDULE

	MONTHLY FEE
AGES UP TO 40	$55.00
AGES 41-64	$75.00
AGES 65+	$95.00
COUPLES 18-40	$90.00
COUPLES 41-64	$130.00
COUPLES 65+	$170.00
ADD 1 CHILD	$30.00
ADD 2 CHILDREN	$50.00
ADD 3 CHILDREN	$65.00

Of note, a couple refers to a marries couple or a domestic couple

APPENDIX 2

Most services available in the office are available at no additional cost to you. Services that are included at no additional cost: dipstick urinalysis, fingerstick glucose, urine pregnancy test, EKG with interpretation, ear wax removal, joint injections, rapid strep test, nebulizer treatments, and stitches/wound care.

The monthly periodic fee schedule is listed on the practice website and is subject to change. Any fees incurred by the Practice as a result of insufficient funds on the part of the Patient shall be paid by the Patient.

Practice reserves the exclusive right to waive any or all fees as deemed appropriate. The periodic fee will be billed at the end of the month and the patient is entitled to leave the practice at any time as established in Section 6 (Term) and be assigned a prorated reimbursement based upon the date of withdrawal from the practice.

After-Hours Visits- There is no guarantee of after-hours availability. This agreement is for ongoing primary care, not emergency or urgent care.

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, as solely determined by the physician.

The practice may decline new patients pursuant to the guidelines proffered in Section 6 (Term), if the patient panel is full (capped at 700 patients or fewer), or if the patient requires medical care that does not fit within the Physician's scope of services. Scope of service and panel size are subject to change.

APPENDIX 3

Medicare Patient Understandings

This agreement is between Matthew Fleig MD and

Medicare Beneficiary:

_____

Who resides at:

_____

With Medicare ID #:

_____

The 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 their legal representative that Physicians at the Practice have opted out of the Medicare program. Dr. Matthew Fleig hasn't been excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or their legal representative agrees, understands and expressly acknowledges the following:

Initial each:

_____ Beneficiary or legal representative accepts full responsibility for payment of Physician's charge for all services furnished by Physician.

_____ Beneficiary or legal representative understands that Medicare limits do not apply to what Physician may charge for items or services furnished by Physician.

_____ **Beneficiary or legal representative agrees not to submit a claim to Medicare or to ask Physician to submit a claim to Medicare**.

_____ **Beneficiary or legal representative understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare** if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or legal representative enters into this contract with the knowledge that they have 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 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 legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or legal representative acknowledges that a copy of this contract has been made available to them.

Executed on: _____

By: _____

Medicare Beneficiary or legal representative_____

On behalf of Matthew Fleig MD

Authorization for credit card use

All information will remain confidential

Patient Name:

_____

Date of birth_____

Name on card_____

Billing Address

_____

Credit card type: Visa___ Mastercard___ Discover ___ Amex__ FSA/HSA__

Credit card number

_____

Expiration date_____

Card identification number _____ (3 or 4 digits on back of card)

Amount to be charged $_____ first day of the month

I authorize Matthew Fleig MD to charge the amount listed above to the credit card provided herein, I agree to pay this monthly fee in accordance with the issuing bank cardholder agreement.

Signature

_____

Date

_____

Print Name

_____