SINGLE VISIT PATIENT AGREEMENT

This Single Visit Patient Agreement (this "**Agreement**") is entered into by and between Hometown Health PLLC, a Texas professional limited liability company ("**Practice**"), and you ("**You**" or "**Patient**").

Background

Practice provides healthcare services, including professional medical services, through its duly licensed and affiliated physicians (each, a "**Physician**" and collectively, the "**Physicians**"), including Darin Charles, M.D. ("**Dr. Charles**"). Dr. Charles is board certified in family medicine and delivers care on behalf of Practice in the Mansfield, Texas area. In exchange for certain fees paid by you, Practice, through its Physicians, agrees to provide you with the Services described in this Agreement on the terms and conditions set forth in this Agreement. The practice website is **www.myhometownhealth.org**.

Definitions

1. Patient.
The Patient is defined as those persons for whom the Practice will provide the Services and who are signatories to this Agreement or are listed on the Patient Enrollment Form, which form is incorporated by reference to this Agreement.

2. Services. Services shall mean a single virtual office visit, conducted by secure messaging, telephone or video, for the diagnosis and treatment of a medical condition. In-person examination or diagnostic testing (strep testing, flu testing, urinalysis, mono testing, urine pregnancy testing, finger-stick glucose) may be recommended, which will be subject to an additional charge. This agreement is not membership in Hometown Health's direct primary care practice, and does not include the benefits or services guaranteed to those members.

3. Consent to Treat. You acknowledge and hereby authorize Practice to use and/or disclose your health information which specifically identifies You, or which can reasonably be used to identify You, to carry out your treatment, payment and healthcare operations. Treatment includes, but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the administration and use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of the member, including but not limited to: diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the Physician may be considered medically necessary or advisable.

4. Fees. In exchange for the Services described herein, You agree to pay Practice, the amount of $50. Further, if in-office evaluation testing is recommended, You may choose to pay an additional $50 fee for that service. Any services performed in office, not mentioned under Services above, are subject to additional charges. Send-out lab orders will be billed directly to the Patient from the lab vendor. Fees will be collected directly from the Patient at the time Services are rendered. Patient will NOT submit any Practice fees to commercial insurance, or Medicare, for payment or reimbursement.

5. Non-Participation in Insurance. Patient acknowledges that neither Practice, nor the Physician, shall bill any health insurance or HMO plans for services provided under this agreement. The Practice has opted out of Medicare. 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 Agreement. Neither the Practice nor Physician 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. The Practice will not bill an insurance company for services for a Patient paying a membership fee. If Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient will sign the agreement (Hometown Health Medicare Opt Out Agreement), and incorporated by reference.

This Agreement acknowledges your understanding that Physician and Practice has opted out of Medicare, and as result, Medicare **CANNOT BE BILLED** for reimbursement for any such services.

6. Term. This Agreement will commence on the date it is signed by the Patient and will extend until the Services indicated above are completed.

7. Privacy & Communications. You acknowledge that communications with the Physician using e-mail, text, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. The practice will make an effort to secure all communications via passwords and other protective means and these will be discussed in an annually updated Health Insurance Portability and Accountability Act (HIPAA) “Risk Assessment.” The practice will make an effort to promote the utilization of the most secure methods of communication, such as software platforms with data encryption, HIPAA familiarity, and a willingness to sign HIPAA Business Associate Agreements. This may mean that conversations over certain communication platforms are highlighted as preferable based on higher levels of data encryption, but many communication platforms, including email or text, may be made available to the patient. 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 the Patient regarding PHI in the same format.

8. Patient Understandings:
By executing this Patient Agreement, Patient understands and agrees to all of the listed Patient Understandings below.

- ✓ *This Agreement is for a single medical visit and is **NOT** a medical insurance agreement.*
- ✓ *I do **NOT** have an emergent medical problem at this time. (Call 911 for emergencies)*
- ✓ *I do **NOT** expect the practice to file or fight any third party insurance claims on my behalf.*
- ✓ *In the event I have a complaint about the Practice, I will first notify the Practice directly.*
- ✓ *This Agreement does not meet the individual insurance requirement of the Affordable Care Act.*
- ✓ *I am enrolling for this service voluntarily.*

- ✓ *I may receive a copy of this document upon request.*
- ✓ *This Agreement is non-transferable.*
- ✓ *Any and all Practice Fees paid to Practice are nonrefundable.*
- ✓ *I Do NOT expect the Practice to prescribe controlled substances on my behalf.*
- ✓ *Electronic signature of this document is considered binding.*

Patient Printed Name: _____

Date: _____

Patient (or Guardian) Signature: _____