RESTORATION
DIRECT PRIMARY CARE

# PATIENT AGREEMENT

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

## Background

The Practice, located at 306 McClanahan St. SW Suite C, Roanoke, Virginia 24014, 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.

**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. The Membership Fee shall be due on the first business day of every month

C. 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. 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 opting out of Medicare. As a result, both the Patient and the Practice shall be prohibited by law from seeking reimbursement from Medicare for any Services provided under this Agreement. Accordingly, the Patient agrees not to submit bills or seek reimbursement from Medicare for any such services. Furthermore, if the Patient is eligible or becomes eligible for Medicare during the term of this Agreement, the Patient agrees to immediately inform the Practice and sign the Medicare private contract as provided and required by law.

**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.

**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 provider; (ii) power outages; (iii) failure of electronic messaging software, or email provider; (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. Provider Absence.** From time to time, due to such things as vacations, illness, or personal emergency, the provider 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 practicable, and appointments shall be rescheduled at the Patient's convenience. If during provider'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

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

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 a 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 Virginia. 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: Restoration Direct Primary Care, PLLC**

By: Rachel A. Meadows NP-C
306 McClanahan St. SW Suite C,
Roanoke, Virginia 24014

Signature: _____ Date:_____

Patient's printed name:

_____

Signature: _____ 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 provider. 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 but not limited to:

- 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
- School physicals
- Weight loss
- Smoking cessation
- Healthy Lifestyle Counseling
- Removal of benign skin lesions / warts
- Simple dermatology procedures
- Injection of joints
- Abscess Incision and Drainage
- Wound repair and sutures
- Ear wax removal
- Casting
- Splinting

**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 provider 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 provider'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 provider immediately in person or by telephone, to call 911 or go to the nearest emergency medical assistance provider, 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 provider immediately upon arriving for a scheduled office visit or after only a minimal wait. If the provider 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 provider 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 provider.

- **Specialist Coordination**. The provider 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**

**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:

Total Adult:
Total Child:

**Primary Adult Patient 1 (account holder)**

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: _____

**Patient 2**

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number _____Email_____
Patient over 18?
□ YES
□ NO
If no Minor Consent Signed?

□ YES
□ NO

I agree to Text Communication: (check one below)
□ YES
□ NO

Printed Name: _____ Relationship to Patient: _____

**Patient 3**

Patient Name_____ Date of Birth_____

Patient over 18?
□ YES
□ NO

If no Minor Consent Signed?
□ YES
□ NO

Agree to Text Communication: (check one below)
□ YES
□ NO

Printed Name: _____ Relationship to Patient: _____

**Patient 4**

Patient Name_____ Date of Birth_____

Patient over 18?
□ YES
□ NO

If no Minor Consent Signed?
□ YES
□ NO

I agree to Text Communication: (check one below)
□ YES
□ NO

Printed Name: _____ Relationship to Patient: _____

**APPENDIX C**

**FEE ITEMIZATION**

**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 of $250

**Missed Appointment:**

We give grace for missed appointments as we know things happen but if an appointment is missed with a no call/no show there will be a $150 fee charged to you.

**Monthly Membership Fees**

| | | | |
|---|---|---|---|
| Individuals | $ 100 per month | X ____ Members | $_____ |
| Couple | $ 150 per month | X ____ Members | $ _____ |
| Family (up to 5 members) | $ 200 per month | X ___ Members | $ _____ |
| *Per Child with individual | $30 per month | X ___ Members | $ _____ |

Total Monthly Membership Fee $ _____

**Initial Payment**

Prorated Membership Fees $ _____

**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 Restoration Direct Primary 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)

DATE: _____

SIGNATURE: _____

**APPENDIX D**

**MEDICARE OPT-OUT AGREEMENT**

This agreement ("Agreement") is entered into by and between Restoration Direct Primary Care ("Provider"), whose principal medical office is located at: 306 McClanahan St. SW Suite C, Roanoke, Virginia 24014, and _____(Patient's Name), a beneficiary enrolled in Medicare Part B ("Beneficiary"), who resides at _____ _____(Patient's address).

**Introduction**

The Balanced Budget Act of 1997 allows Providers to "opt out" of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, Providers are required to file an affidavit with each Medicare carrier that has jurisdiction over claims that they have filed (or that would have jurisdiction over claims had the Provider not opted out of Medicare). In essence, the Provider must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years. This Agreement between Beneficiary and Provider is intended to be the contract Provider are required to have with Medicare beneficiaries when Providers opt-out of Medicare. This Agreement is limited to the financial agreement between Provider and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

**Provider Responsibilities**

(1) Provider agrees to provide Beneficiary such treatment as may be mutually agreed Upon and at mutually agreed upon fees.

(2) Provider agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.

(3) Provider agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.

(4) Provider agrees to provide Beneficiary with a signed copy of this document before

items or services are furnished to Beneficiary under its terms. Provider also agrees to retain a copy of this document for the duration of the opt-out period.

(5) Provider agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS) upon the request of CMS.

**Beneficiary Responsibilities**

(1) Beneficiary agrees to pay for all items or services furnished by Provider and understands that no reimbursement will be provided under the Medicare program for such items or services.

(2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Provider for such items or services.

(3) Beneficiary agrees not to submit a claim to Medicare and not to ask Provider to submit a claim to Medicare.

(4) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Provider that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

(5) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered Items and services from Provider and practitioners who have not opted out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other Providers or practitioners who have not opted out of Medicare.

(6) Beneficiary understands that Medigap plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make Payments for such items and services not paid for by Medicare.

(7) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

**Medicare Exclusion Status of Provider**

Beneficiary understands that Provider has not been excluded from participation under the Medicare program under section 1128, 1156, 1892, or any other sections of the Social Security Act.

**Duration of the Contract**

This contract becomes effective on _____. Either party may terminate treatment with a 30-day notice to the other party. Notwithstanding this right to terminate treatment, both Provider and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

By: Rachel Meadows NP-C
Restoration Direct Primary Care, PLLC

Patient's Signature: _____ Date: _____

## Appendix E

## Delegation of Authority

Delegation of Authority to consent to health care for a minor or other person not capable of providing consent for health care to facilitate medical care and treatment of **_____, ("Patient"), DOB:_____** by Restoration Direct Primary Care, PLLC, undersigned parent or legal guardian of the Patient hereby states as follows: I am a parent or legal guardian of the Patient and am authorized to make health care decisions on behalf of the Patient. I appoint the adult(s) listed below to give consent for all Health Care for the Patient in my absence. "Health Care" means any care, treatment, service or procedure to maintain, diagnose, or treat the Minor Patient's physical or mental condition.

**Name (Print) _____ Relationship to Patient _____ Name (Print) _____ Relationship to Patient _____ Name (Print) _____ Relationship to Patient _____**

As long as the Health Care to be rendered is in accordance with generally accepted standards of medical practice for the condition being treated, I impose no specific limitations or probations regarding the type of Health Care rendered, except as follows (if none, please state "none"):

_____

I understand that this Delegation of Authority is valid for two (2) years from the date signed below. I understand this Delegation is voluntary and I have the right to revoke it at any time prior to its expiration date by written notification to Restoration Direct Primary Care, PLLC and/or its affiliated companies. I have carefully read and considered this Delegation of Authority before signing it.

**Print Name_____**

**Signature _____**

**Relationship to patient_____**

**Date _____**

Appendix F

**Billing / Membership Fee Policy**
**Restoration Direct Primary Care**

**Statement of Purpose**
This policy is established to ensure the effective management of billing at Restoration Direct Primary Care. It is designed to maintain financial stability while treating members with fairness and respect.

**Member Responsibility**
Members are expected to pay all monthly fees by their selected due date. Should any remaining balance remain unpaid after a member's due date, members are expected to pay any remaining balance immediately.

**Billing Process**
Invoices will be generated and sent to members on a regular basis (monthly, annually, etc.) for outstanding balances. These statements will clearly display the amount owed, the due date, and the contact information for billing inquiries.

**Grace Period**
As previously stated, all balances are to be paid on the selected due date. In an effort to accommodate unforeseen financial hardships, a reasonable grace period of 30 days (from the first day of the month) will be provided for members to pay any outstanding balance. In the event that any outstanding balance remains following the 30 day grace period, membership will be terminated.

**Payment Options**
Members will have the following options for making payments:
a. In-person at our office
b. Online through our secure payment portal
c. Mail-in payments

**Reminder Notifications to Members**
a. If payment is not received by the due date, members will receive a reminder notice.
b. Members will receive a final communication notifying them of a termination of service date should they fail to pay outstanding balance.

**Collection Agency**
If payment remains outstanding and communication efforts have failed, the account may be referred to a collection agency. Any costs associated with collections will be the responsibility of the member.

**Legal Action**

In cases of extreme delinquency, legal action may be considered, but it will be a last resort after all other efforts have been exhausted.

**Record Keeping**
All communication and actions related to overdue balances will be documented in the member's file.

**Compliance**
This policy will adhere to all applicable federal and state regulations, including patient (member) confidentiality and privacy laws.

**Review and Updates**
This policy will be periodically reviewed and updated to reflect changes in regulations and best practices.

**Member Relations**
Members will be treated with respect and courtesy throughout the entire process, and efforts will be made to maintain open and transparent communication.