PATIENT AGREEMENT

Tailored Pediatric Medicine, PC

This is an Agreement between TAILORED PEDIATRIC MEDICINE, PC (**Practice**), a New Hampshire Professional Corporation located at 500 Market Street, Unit 2B, Portsmouth, NH 03801, and _____ (**Patient** or Patient's Guardian if Patient < 18yo).

Background

Practice is a Direct Primary Care general pediatric practice that delivers care at 500 Market Street, Unit 2B, Portsmouth, NH 03801, and within the home of the **Patient**. In exchange for certain fees, **Practice** agrees to provide **Patient** 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 **Practice** shall provide care, and who have signed this agreement or are listed on the document attached as Appendix C, which is a part of this agreement.
2. **Services.** In this Agreement, "Services" means the collection of medical services and non-medical amenities offered to **Patient** by **Practice** listed in Appendix A, which is attached to and a part of this Agreement.

Agreement

3. **NOTICE**: THIS AGREEMENT DOES NOT CONSTITUTE HEALTH INSURANCE AND **PRACTICE** WILL NOT FILE ANY CLAIMS AGAINST **PATIENT'S** HEALTH INSURANCE POLICY OR PLAN FOR REIMBURSEMENT OF ANY PRIMARY CARE SERVICES COVERED BY THE AGREEMENT. FURTHER, THIS AGREEMENT IS NOT WORKERS' COMPENSATION INSURANCE AND DOES NOT REPLACE AN EMPLOYER'S OBLIGATIONS UNDER N.H. RSA 281-A.

4. **Term.** This Agreement shall commence on the "Start Date" agreed to by the parties in Appendix C and shall continue month-to-month, automatically renewed until termination.

5. **Fees.** In exchange for the Services described herein, **Patient** agrees to pay **Practice** the amounts set forth in Appendix B. The monthly fee:

   a. is due upon signing the Financial Authorization (Appendix C).

b. is due on the first or 15th day of each month (as elected by **Patient** in Appendix C). (A prorated fee shall be paid until such date, as calculated in Appendix B.)

c. shall be paid automatically, through a debit or credit card on file with **Practice**.

6. **Termination**. **Patient** and **Practice** each have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving 30 days prior written notice to the other party. If the Agreement is terminated by either party before the end of a billing cycle, then **Practice** shall refund **Patient's** prorated share of the fees remaining after deducting individual charges for services rendered to **Patient** in the same billing cycle up until termination. In no case shall **Practice** refund fees covering the 30 days during which termination notice has been given.

Examples of reasons the **Practice** may wish to terminate the agreement with the **Patient** may include but are not limited to:

(a) The **Patient** fails to pay applicable fees owed pursuant to Appendix B in this Agreement;
(b) The **Patient** has performed an act that constitutes fraud;
(c) The **Patient** repeatedly fails to adhere to the recommended treatment plan;
(d) The **Patient** fails to comply with the controlled substance policy;
(e) The **Patient** is abusive, acts in a threatening or disrespectful behavior, or presents an emotional or physical danger to any staff or other patients of the **Practice**;
(f) The **Patient** repeatedly violates the Communication Policy, Patient Expectation Policy, Appointment Policy or other such policies adopted by the **Practice**;
(g) The **Patient** refuses to comply with potentially lifesaving treatment; or
(h) The **Practice** discontinues operation

7. **Renewal**. Unless previously terminated as set forth above, the Agreement will automatically renew for successive monthly terms upon the payment of the monthly fee at the start of the billing cycle.

8. **Non-Participation in Insurance**. **Patient** acknowledges that neither **Practice** nor its providers participate in any health insurance or HMO plans. **Practice** makes no representations that any fees that **Patient** pays under this Agreement are covered by **Patient's** health insurance or other third-party payment plans. It is **Patient's** responsibility to determine whether reimbursement is available from a private, non-governmental insurance plan and to submit any required billing.

9. **Not Insurance**. **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). This Agreement will not cover hospital services, nor any services not

personally provided by **Practice**. This Agreement in isolation does NOT meet the insurance requirements of the Affordable Care Act.

Patient acknowledges that **Practice** has advised **Patient** to obtain or keep in full force such health insurance policy(s) or plans that will cover **Patient** for healthcare not personally delivered by **Practice** (including specialists), for hospitalizations, and for catastrophic events.

10. **Privacy of Communications.** **Patient** acknowledges that communication with **Practice** using email, facsimile, app, telehealth, text messaging, and cell phone are not guaranteed to be secure or confidential methods of communication. As such, **Patient** expressly waives any obligation on the part of **Practice** to guarantee confidentiality with respect to correspondence using such means of communication. **Patient** acknowledges that all such communications may become a part of **Patient's** medical records. **Practice** will make an effort to secure all communications via passwords and other protective means (e.g. promote the utilization of the most secure methods of communication such as software platforms with data encryption, and HIPAA familiarity). If **Patient** initiates a conversation in which **Patient** discloses "protected health information" (PHI), as that term is defined by HIPAA, on one or more of these communication platforms, then **Patient** has authorized **Practice** to communicate with **Patient** regarding PHI in the same format. The **Practice** provides Notice of Privacy Practice and HIPAA Policies that are current with federal and state regulations and are available via print or the patient portal.

11. **Time-Sensitive Communications.** **Patient** understands and agrees that email, text and other means of electronic communication are not an appropriate means of communication in an emergency. In the event of an emergency, or situation that **Patient** could reasonably expect to develop into an emergency, **Patient** shall call 911 or proceed to the nearest emergency department and follow the directions of emergency personnel. **Practice** 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 internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address email messages, (iii) failure of **Practice's** computer or computer network, telephone or cable data, (iv) any interception of email communications by third-party, or (v) **Patient's** failure to comply with the guidelines regarding use of email, text, or other electronic communications set forth in this paragraph.

12. **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.

13. **Reimbursement for Services if Agreement is Invalidated.** If this Agreement is held to be invalid for any reason, and if **Practice** is therefore required to refund all or any portion of the monthly fees paid by **Patient**, **Patient** agrees to pay **Practice** an amount equal to the reasonable value of the Services actually rendered to **Patient** during the period of time for which the refunded fees were paid.

14. **Amendment.** No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties. Notwithstanding the foregoing, **Practice** may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending **Patient** 30 days advance written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by **Practice**, except that **Practice** may require **Patient** to initial any such changes. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

15. **Assignment.** This Agreement, and any rights **Patient** may have under it, may not be assigned or transferred by **Patient**.

16. **Legal Significance. Patient** acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Patient also acknowledges having had a reasonable time to seek legal advice regarding the Agreement and has either chosen not to do so or has done so and is satisfied with the terms and conditions of the Agreement.

17. **Miscellaneous.** This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted.

18. **Entire Agreement.** This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

19. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of New Hampshire and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for **Practice's** address in Portsmouth, New Hampshire.

20. **<u>Patient Understandings</u> (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 do NOT expect **Practice** to file or fight any third-party insurance claims on my behalf.

_____ I do NOT expect **Practice** to prescribe chronic controlled substances on my behalf, aside from the potential use of stimulant prescription medication for the treatment of ADHD. (These include commonly abused opioid medications and benzodiazepines.)

_____ In the event I have a complaint about **Practice**, I will first notify **Practice** directly.

_____ This Agreement in isolation does NOT meet the individual insurance requirement of the Affordable Care Act.

_____ I may receive a copy of this document upon request.

_____ This Agreement is non-transferable.

Patient Name(s) _____

Patient (18yo+) or Guardian Signature _____

Physician Name _____

Physician Signature _____

APPENDIX A

Services Provided by Practice

Medical Services.

As used in this Agreement, the term Medical Services shall mean those medical services that **Practice** is permitted to perform under the laws of the state of New Hampshire and that are consistent with the training and experience of a general pediatric physician. **Patient** shall be entitled to routine wellness examinations following the schedule recommended by the American Academy of Pediatrics. Other medical services shall be performed by **Practice**, and include the following:

(a) Routine well child care and sports physicals
(b) Newborn care, lactation support, and weight checks
(c) Chronic care consultations, behavioral health consultations
(d) Management of chronic conditions including but not limited to asthma, allergies, exercise, ADHD, anxiety/depression, or obesity
(e) Care coordination with medical specialists, therapist, educators, and care takers
(f) Acute care services including certain point of care testing and minor procedures
(g) Vision and hearing screening
(h) Psychosocial, mental health screening
(i) Screening lab work such as Hemoglobin and Lead
(j) Point of care testing such as urinalysis, Rapid Strep, Influenza
(k) Positive parenting support, education, and anticipatory guidance

Practice providers may rarely, from time to time, due to vacations, sick days, and other similar situations, be unavailable to provide the services referred to above. During such times, **Patients'** calls to **Practice** will be directed to a physician who is "covering" for **Practice** during the absence at no additional cost to **Patient**. **Practice** will make every effort to arrange for coverage but cannot guarantee such coverage.

Non-Medical Amenities.

Practice shall provide **Patient** with the following non-medical amenities, which are detailed in the Communication Agreement provided to **Patient**. **Patient** shall read, initial, and abide by the Communication Agreement. A summary of the non-medical amenities provided by **Practice** are as follows:

(a) **24-Hour Communication.** Patient shall have access to **Practice** providers via phone 24-hours per day for urgent/emergent concerns. Phone, secure text messaging via Spruce app, video chat, and secure email via the portal, including after business hours under the terms of the Communication Agreement.

(b) **No Wait or Minimal Wait Appointments.** Every effort shall be made to assure that **Patient** is evaluated by **Practice** providers immediately upon arriving for a scheduled office visit or after only a minimal wait. If **Practice** foresees a longer wait time, **Patient** shall be contacted and advised of the projected wait time.

(c) **Same Day/Next Day Appointments.** When **Patient** calls or texts **Practice** prior to noon on a business office day to schedule an appointment, every reasonable effort shall be made to schedule an appointment with **Practice** on that same day. If **Patient** calls or texts **Practice** after noon on a business office day to schedule an appointment, every reasonable effort shall be made to schedule **Patient's** appointment on that day or the following business office day.

(d) **Home Visits.** Home visits for infants less than two months old are included at no extra charge. Home visits for older patients are available for an extra fee.

(e) **Simplified Billing. Patient** will receive no unexpected bills from **Practice** and will not be required to pay co-pays or deductibles. All healthcare needs covered by **Practice** are included within the monthly fee (see Appendix B). Healthcare needs not covered by **Practice**—such as specialist appointments, x-rays and studies, labs not performed in the office, surgeries or procedures, and emergency room-related care—are not included within the monthly fee. If there are services that the **Practice** provides that are not covered under the monthly fee-such as molecular testing for infections, ear piercing, tongue tie release and circumcision-the **Patient** will be clearly notified of the cost prior to testing or the procedure and given the opportunity to consent for or decline the service.

(f) **Specialists. Practice** 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 cover specialist fees.

APPENDIX B

Fee Calculator

Patient's Age*	Rate**
Newborn – 23 months of age	$200 per month
2 years – high school graduation	$150 per month
After high school graduation	$100 per month

*Rate will be reduced automatically when patient enters next age bracket.
**Rate, and additional fees noted below, subject to change with 30-day notice.

Additional notes:

- There is a $100 one-time non-refundable administrative New Family enrollment fee
- $500 per month maximum per family
- Home visits for children older than 2 months are available for $100/visit
- Rapid molecular testing for COVID during office hours: patients- $50, family members of patients- $75, all others- $100
- Procedures available for additional fee: ear piercing- $100, tongue tie release- $200, male circumcision- $400

Recurring fees to be paid monthly:

Patient 1 $_____

Patient 2 $_____

Patient 3 $_____

Patient 4 $_____

Family Plan $_____ **TOTAL RATE $_____ per month**

Prorate of Current Month $_____ for dates _____ through _____

One-time enrollment fees:

New Family Enrollment Fee $_____

APPENDIX C

Financial Authorization

The following children shall be enrolled as Patients with Tailored Pediatric Medicine, PC:

Patient's Name	Patient's Date of Birth (MM/DD/YYYY)	Patient's Age	Start Date
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Patient's Name	Patient's Date of Birth (MM/DD/YYYY)	Patient's Age	Start Date
Patient's Name	Patient's Date of Birth (MM/DD/YYYY)	Patient's Age	Start Date

I authorize Tailored Pediatric Medicine, PC to charge the one-time enrollment fees listed in Appendix B upon execution of this Appendix C. I authorize Tailored Pediatric Medicine, PC to charge the recurring monthly fee listed in Appendix B, on the 1st or 15th of the month using my credit or debit card on file.

Signature : _____ Date: _____

(**Patient** if 18yo or older; Patient Guardian/Guarantor)