

PATIENT AGREEMENT
Kathleen M. Curtis, M.D., P.C.

This is an Agreement entered into on _____, 20____, between Kathleen M. Curtis, M.D., P.C. and _____ (Patient or You).

Background

The PRACTICE is a Direct Pay primary care practice (DPC), which delivers primary care services at 3998 Fair Ridge Dr., Suite 280, Fairfax, VA 22033. In exchange for certain fees, the PRACTICE, agrees to provide You 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 the Provider shall provide care, and who have signed this agreement or are listed on the document attached as Appendix B, which is a part of this agreement.
- 2. Services.** In this Agreement, "Services", means the collection of services, offered to you by us in this Agreement. These Services are listed in Appendix A, which is attached and a part of this Agreement.

Agreement

3. NOTICE: THIS MEDICAL RETAINER AGREEMENT DOES NOT CONSTITUTE INSURANCE, IS NOT A MEDICAL PLAN THAT PROVIDES HEALTH INSURANCE COVERAGE FOR PURPOSES OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT AND COVERS ONLY LIMITED, ROUTINE HEALTH CARE SERVICES AS DESIGNATED IN THIS AGREEMENT.

_____ **(Initial)**

- 4. Term.** This Agreement will last for one year, starting on _____ and patient is responsible for all monthly payments during this time.
- 5. Renewal.** The Agreement will automatically renew each year on the anniversary date of the agreement unless Patient notifies Practice they wish to cancel on this date.
- 6. Payments – Amount and Methods.** In exchange for the Services (see Appendix A(1)), You agree to pay us, a monthly fee in the amount that appears in Appendix C, which is attached and is part of this Agreement.
 - a) This monthly fee is payable on a prorated basis when you sign the Agreement, and is due on the first business day of each month thereafter.
 - b) The Parties agree that the required method of monthly payment shall be by automatic payment, through a debit or credit card.

7. Non-Participation in Insurance. Your initials on this clause of the Agreement acknowledges the Patient's understanding that neither the PRACTICE, nor its Provider, participate in any health insurance or HMO plans or panels. We make no representations that any fees that you pay under this Agreement are covered by your health insurance or other third party payment plans. ____ **(Initial)**

8. This Is Not Health Insurance. Your initials on this clause of the Agreement acknowledges Your understanding that this agreement is not an insurance plan or a substitute for health insurance. You understand that this agreement does not replace any existing or future health insurance or health plan coverage that you may carry. The Agreement does not include hospital services, or any services not personally provided by the PRACTICE, or its employees. You acknowledge that the PRACTICE has advised You to obtain or keep in full force, health insurance that will cover You for healthcare not personally delivered by the PRACTICE, and for hospitalizations and catastrophic events. ____ **(Initial)**

9. Communications. The Patient acknowledges that although PRACTICE shall comply with HIPAA privacy requirements, communications with the Provider using e-mail, facsimile, video, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communications. As such, **Patient expressly waives the Provider's obligation to guarantee confidentiality with respect to the above means of communication.** Patient further acknowledges that all such communications may become a part of the medical record.

By providing an e-mail address on the attached Appendix B and/or during online enrollment, the Patient authorizes the PRACTICE, and its Providers to communicate with him/her by e-mail regarding the Patient's "protected health information" (PHI).¹ The Patient further acknowledges that:

- (a) E-mail is not necessarily a secure medium for sending or receiving PHI and, there is always a possibility that a third party may gain access;
- (b) Although the Provider will make all reasonable efforts to keep e-mail communications confidential and secure, neither the PRACTICE, nor the Provider can assure or guarantee the absolute confidentiality of e-mail communications;
- (c) At the discretion of the Provider, e-mail communications may be made a part of Patient's permanent medical record; and,
- (d) You understand and agree that e-mail is not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. **In an emergency, or a situation that You could reasonably expect to develop into an emergency, You understand and agree to call 911 or the nearest Emergency room, and follow the directions of emergency personnel.**
- (e) Email Usage. The Provider checks e-mail frequently on weekdays, during business hours. If You do not receive a response to an e-mail message by the next business day, You agree that you will contact the Provider by telephone or other means.
- (f) Technical Failure. Neither the PRACTICE, nor the Provider will be liable for any loss, injury, or expense arising from a delay in responding to Patient, when that delay is caused by technical failure. Examples of technical failures (i) failures caused by an

internet service

provider, (ii) power outages, (iii) failure of electronic messaging software, or e-mail provider (iv) failure of the PRACTICE's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third party which is unauthorized by the PRACTICE; or (v) Patient failure to comply with the guidelines for use of e-mail described in this Agreement.

10. Provider Absence. From time to time, due to vacations, illness, or personal emergency, the Provider may be temporarily unavailable to provide the services referred to above in this paragraph one.

11. Change of Law. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

12. Severability. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable, and the remainder of the contract will stay in force as originally written.

13. Reimbursement for Services Rendered. If this Agreement is held to be invalid for any reason, and the PRACTICE is required to refund fees paid by You, You agree to pay the PRACTICE an amount equal to the fair market value of the medical services You received during the time period for which the refunded fees were paid.

14. Amendment. No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties. Except for amendments made in compliance with Section 12, above.

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

16. Legal Significance. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that You have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

17. Miscellaneous. This Agreement shall be construed without regard to any rules requiring that it be construed against the party who drafted the Agreement. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

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. No Waiver. In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce the other party's requirement or duty under this agreement (for example notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

20. Jurisdiction. This Agreement shall be governed and construed under the laws of the Commonwealth of Virginia. All disputes arising out of this Agreement shall be settled in the court

of proper venue and jurisdiction for the PRACTICE in Fairfax, Virginia.

21. Service. All written notices are deemed served if sent to the address of the party written above or appearing in Appendix B by first class U.S. mail.

The parties may have signed duplicate counterparts of this Agreement on the date first written above.

Kathleen M. Curtis, M.D., for Kathleen M. Curtis, M.D., P.C.

Printed Name of Patient

Signature of Patient

Date

APPENDIX A SERVICES

1. Medical Services. Medical Services under this agreement are those medical services that the Provider is permitted to perform under the laws of the Commonwealth of Virginia, are consistent with Provider's training and experience, are usual and customary for a family medicine provider to provide, and include the following:

- Acute and Non-acute Office Visits (minimum of 30 minutes)
- Chronic Disease Management
- Well-Woman Care
- Well-Baby Care
- Electrocardiogram (EKG)
- Blood Pressure Monitoring
- Diabetic Monitoring
- Breathing Treatments (nebulizer or inhaler with spacer)
- Urinalysis
- Rapid Test for Strep Throat and other in office testing
- Removal of benign skin lesions/warts
- Simple aspiration/injection of joint
- Removal of Cerumen (ear wax)
- Abscess Incision and Drainage
- Basic Vision Screening
- Vaccines

2. Non-Medical, Personalized Services. PRACTICE shall also provide Patient with the following non-medical services ("Non-Medical Services"), which are complementary to our members in the course of care:

- a. **After Hours Access.** Patient shall have direct telephone access to the Provider seven days per week. Patient shall be given a phone number where Patient may reach the Provider directly for guidance regarding concerns that arise unexpectedly after office hours. Video chat may be utilized when the Provider and Patient agree that it is appropriate.
- b. **E-Mail Access.** Patient shall be given the Provider's e-mail address to which non-urgent communications can be addressed. Such communications shall be dealt with by the Provider or staff member of PRACTICE in a timely manner. **Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that Patient could reasonably expect may develop into an emergency.** Patient agrees that in such situations, when a Patient cannot speak to Provider immediately in person or by telephone, that Patient shall call 911 or the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.
- c. **No Wait or Minimal Wait Appointments.** Reasonable effort shall be made to assure that Patient is seen by the Provider immediately upon arriving for a scheduled office visit or after only a minimal wait. If Provider foresees a minimal wait time, Patient shall be contacted and advised of the projected wait time.
- d. **Same Day/Next Day Appointments.** When Patient calls or e-mails the Provider prior to noon on a normal office day (Monday through Thursday) to schedule an appointment, every reasonable effort shall be made to schedule an appointment with the Provider on the same day. If Patient calls or e-mails the Provider after noon on a normal office day (Monday through

Thursday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with the Provider on the following normal office day. In any event, however, PRACTICE shall make every reasonable effort to schedule an appointment for the Patient on the same day that the request is made.

- e. **Visitors. Non-Medicare** family members temporarily visiting a Patient from out of town may, for a two-week period, take advantage of the services described in subparagraphs (a), (d), and (e) of this paragraph. Medical services rendered to Patient's visitors shall be charged on a fee-for-service basis.
- f. **Specialists Coordination.** PRACTICE and Provider 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 include and do not cover specialist's fees or fees due to any medical professional other than the PRACTICE Provider.**

APPENDIX C

Fee Itemization

Tier I – Services guaranteed to be provided by Dr. Curtis: \$80 a month single
\$100 a month family ____ **(Initial)**

Tier II – Services guaranteed to be provided by Nurse Practitioner: \$60 a month single
\$80 a month family ____ **(Initial)**

Please initial option to apply to this agreement.

Capital Family Practice

Kathleen M. Curtis, M.D., P.C.

Board Certified Family Practice

3998 Fair Ridge Drive #280

Fairfax, Virginia

(703) 352-0500 Fax (703) 352-0669

Please complete the information below:

I _____ authorize Kathleen M. Curtis, M.D., P.C. to charge my credit/debit card indicated below for amount agreed to in the contract on the first of each month for the duration of the contract.

CHECK CARD USED		
<input type="checkbox"/> MASTER CARD	<input type="checkbox"/> VISA	<input type="checkbox"/> DISCOVER

CARD NUMBER _____
Exp. Date _____

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

SIGNATURE _____

DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Kathleen M. Curtis, M.D., P.C. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Kathleen M. Curtis, M.D., P.C. may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$30.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Please return signed contract and auto payment agreement to Capital

Family Practice. You will be charged for the first month to reserve your membership. Your card will not be charged again until May 1, 2018.

Thank you,
Kathleen M. Curtis, M.D>