REED DIRECT PRIMARY CARE

DR. NATHAN D. REED

FAMILY MEDICINE PHYSICIAN

750 Twin Creeks Crossing Loop, Ste B
Central Point, OR 97502
541-665-8797
contact@reeddpc.com

DIRECT PRIMARY CARE PATIENT AGREEMENT

Thank you for choosing Reed Direct Primary Care for your healthcare needs. We regard the patient-physician relationship as of paramount importance. Good communication with your physician is at the center of our care, and this Agreement explains how we will work together.

This is an Agreement entered into between Reed Direct Primary Care ("Practice") and Dr. Nathan Reed, D.O. ("Physician") and You ("You" or "Patient"). The Practice offers primary care services in exchange for certain fees paid by You as described in this Agreement on the terms and conditions described below.

AGREEMENT

1. **Services.** As used in this Agreement, the term Services means primary care services and certain amenities (collectively "Services"), which are offered by Practice.
    a. Volume of Services. The number of in-person, virtual, and phone or message contacts / visits You may receive is not limited by this Agreement.
    b. Availability. Practice will make every effort to address Your medical needs in a timely manner, and strive to answer all questions and care needs as soon as possible, but we cannot guarantee availability, and we cannot guarantee that You will not need to ever seek treatment in an urgent care or emergency department setting.
    c. Included Services.
        i. Your membership includes primary care, including well and sick care, and basic gynecological services. Your physician will make an appropriate

determination about the scope of primary care services offered by Practice on a case-by-case basis.

ii. Some services available in our office, such as EKGs, are available at no additional cost to You.

iii. Some services, such as minor surgery or procedures, are available in our office, but will incur an additional fee ("Itemized Charges") for supplies and medication cost associated with that procedure.

d. Excluded Services. You may need the care of specialist consultations, emergency rooms, hospitalists, inpatient hospital services, urgent care centers, laboratory testing, radiologic testing, pathology studies, surgery and facilities that dispense medications that are outside of the scope of this Agreement. We highly recommend that you maintain health insurance, which may or may not cover the cost of these services. Practice will endeavor to place orders for Excluded Services in a manner that is most cost effective for You.

e. Controlled Substances. It is not the policy of Practice to prescribe chronic controlled substances. Decisions regarding prescriptions for chronic and regular use of controlled substances are made on a case-by-case basis and subject to our Controlled Substance Agreement.

2. **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 for treatment, 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 judgement of the attending physician or their assigned designees may be considered medically necessary or advisable.

3. **Scheduling.**

a. In order to best serve the needs of all our patients, we prefer that You schedule Your visit more than 24 hours in advance when possible.

b. Missed Appointments. We kindly request that You provide us with a minimum of 24 hours' notice, if at all possible, if You are unable to attend a scheduled appointment. Your advance notice helps us to provide the best possible experience and access for all of our patients.

4. **Fees.** In exchange for Services, You agree to pay the Practice a) the Monthly (or Annual) Fee; b) the Enrollment Fee; and c) any additional Itemized Charges (collectively "Fees"). In order to remain financially viable, Practice must, and does, reserve the right to change its fees at any time with ninety (90) days' notice to You.

a. Monthly Fee. Your Monthly / Annual Fee is identified in the chart below. This fee is for primary care provided by Practice in the month for which the fee was received. Your monthly fee is due on a revolving basis every month, at the end of the month of Service provision, and is payable by automatic debit from your bank or credit card account. Payment may be prorated for the first month of Service in order to have the Monthly Fee fall on the patient's day of the month of their choosing.

Patient type	Monthly Cost	Quarterly	Annually
Dependent 24yo or under	$50	$150	$600
Individual	$100	$300	$1200
Couple	$175	$525	$2100
Family Max [1-2 Adults and dependent children]	$250	$750	$3000

b. Enrollment Fee. Your Enrollment Fee is an additional fee that is equivalent to one times (1x) your applicable Monthly Fee. This fee covers the initial administrative cost of your membership and is not related to the provision of Services. Your enrollment fee is due at the time of Your enrollment with the practice and the mutual decision between You the Practice to initiate Services and is nonrefundable.

c. Itemized Charges. The fee for Itemized Charges changes is in response to our costs, and we endeavor to make these services as affordable as possible. You will be made aware of the fees for these services in advance of the services being performed. Payment for these services is due at the time services are rendered, or with your next scheduled Monthly Fee.

5. **Disclaimer of Non-Insurance. Fees paid are not health insurance.** You acknowledge and understand that this Agreement is not a health insurance plan, and not a substitute for health insurance or other health plan coverage, such as participation in a Health Management Organization ("HMO"). This agreement in isolation 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 solely for primary care services provided directly to You by the Practice.** This Agreement does not cover hospital, specialist, or any services not directly provided by Practice or its Physicians. It is highly recommended that You maintain health insurance for care You may need that is not part of our Services.

6. **Non-Participation in Health Insurance.** Patient acknowledges that neither Practice, nor the Physicians participate in any health insurance or HMO plans. Physicians have 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 private direct primary care contract. Neither the Practice nor Physicians 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 the Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient will sign the agreement attached as Appendix 1, and incorporated by reference. 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 the Physician. **You agree not to bill Medicare or attempt Medicare reimbursement for any services directly provided by the practice.**

7. **Non-Participation in Medicaid.** You specifically acknowledge that pursuant to state law, Practice and its Physician(s) do not participate in Oregon's Medicaid Program. Further, You agree not to bill Medicaid or attempt Medicaid reimbursement for any such services. By signing this agreement, You specifically acknowledge and agree that You are not currently a Medicaid recipient and if You become a Medicaid recipient in the future, You will promptly notify Practice so that it can be determined if the Practice will still be able to provide Services to You in a manner consistent with normal primary care services. The rules and laws governing this are subject to frequent change and need to be evaluated on a case by case basis.
8. **Term.** This agreement will commence on the date it is signed by the parties and shall have an initial term of one (1) month. Upon the expiration of the initial term this Agreement shall automatically renew for successive monthly terms upon the payment of the Monthly Fee, until the Agreement is terminated pursuant to the terms of section 9.
9. **Termination.** Both You and the Practice shall have the absolute and unconditional right to terminate the Agreement, without cause.
    a. While we highly value Your membership, You are under no obligation to continue receiving Services and You may terminate this Agreement, in writing, upon 24-hours written notice to practice.
    b. In the event of termination, Your final bill will be prorated based upon the number of days membership was provided to You, plus any additional Itemized Charges Incurred. If such proration indicates that a portion of Your Fees is due back to you, this amount will be reimbursed within 14 days of final day of membership. As the Practice bills in arrears, this should only occur if Patient has elected to pay their Fee annually.
    c. Notwithstanding any other provision of this Agreement, if your decision to terminate is based on a grievance with the Practice, we request that You give us an opportunity to address such a grievance, prior to issuing Your written notice of termination or taking other action.
    d. If Practice elects to terminate this Agreement, Practice will provide You with a minimum of thirty (30) days' advance written notice. Upon termination, the

Practice shall comply with all rules and regulations of the State of Oregon Medical Board regarding the provision of emergent care for 30 days after termination and cooperate in the transfer of Patient's medical records to the Patient's new primary care physician, upon the Patient's written request and direction.

e. Practice has a right to determine whom to accept as a patient, just as You have the right to choose Your physician. There are certain circumstances in which we may choose to terminate this Agreement. Such circumstances may include, but are not limited to the following:

    i. You fail to pay fees and charges when they are due.

    ii. You have performed an act that constitutes fraud.

    iii. You fail to adhere to the recommended treatment plan, especially regarding the use of controlled substances.

    iv. You are disruptive, abusive, or present an emotional or physical danger to the staff or other patients of Practice.

    v. Practice discontinues operation.

10. **Re-Enrollment.** If You choose to discontinue Your membership and You later wish to re-enroll, Practice reserves the right (at its sole discretion) to decline re-enrollment or require You to pay a re-enrollment fee that is equivalent to three times (3x) your applicable Monthly Fee. Like the initial Enrollment Fee, any Re-Enrollment Fee is non-refundable.

11. **Privacy & Communications.**

    a. Limited Disclosure. Practice will not disclose your Protected Health Information ("PHI") for reasons unrelated to the delivery of Services, or the provision of other health care services on Your behalf.

    b. Your Privacy Rights. Practice will adhere to its obligations regarding your privacy rights as identified in Practice's Patient Notice of Privacy Practices.

    c. Methods of Communication. You acknowledge that Practice communications may include email, facsimile, video chat, instant messaging, and cell phone usage, and such communications by their nature cannot be guaranteed to be secure or confidential. If You initiate a conversation in which You disclose PHI on any of these communication platforms, then You authorize Practice to communicate with You regarding all PHI in the same format.

12. **Miscellaneous.**

    a. Amendment. No amendment or variation of the terms of this Agreement shall be valid unless in writing and signed by both Parties.

b. Anti-Referral Laws. Nothing in this Agreement, nor any other written or oral agreement, nor any consideration in connection with this Agreement, contemplates or requires or is intended to induce or influence the admission or referral of any patient to or the generation of any business between Practice and any other person or entity. This Agreement is not intended to influence any Physician's professional judgement in choosing the appropriate care and treatment of patients.

c. Assignment. This Agreement, and any rights You may have under it, are not assignable or transferable by You.

d. Authorization for Agreement. The execution and performance of this Agreement by Practice and You have been duly authorized by all necessary laws, resolutions, and corporate or partnership action, and this Agreement constitutes the valid and enforceable obligations of the parties in accordance with its terms.

e. Captions and Headings. The captions and headings for each provision of this Agreement are included for convenience of reference only and are not to be considered a part hereof, and shall not be deemed to modify, restrict or enlarge any of the terms or provisions of this Agreement.

f. Entire Agreement. This Agreement constitutes the entire agreement between the Parties with respect to the subject matter hereof, and supersedes any and all other agreements, understandings, negotiations, or representation, oral or written, between them.

g. Governing Law. This Agreement shall be subject to and governed by the laws of Oregon, without regard to any conflicts of law provisions therein contained. All disputes arising out of this Agreement shall be settled by binding arbitration. The provider of arbitrations services shall be made solely at the Practice's discretion and costs of arbitrations shall be borne equally by the parties.

h. No Waiver. No waiver of a breach of any provision of this Agreement will be construed to be a waiver of this Agreement, whether of a similar or different nature, and no delay in acting with regard to a breach shall be construed as a waiver of that breach.

i. Non-Discrimination. Under no circumstances will Practice discriminate against You, or terminate this Agreement, on the basis of sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status or any other protected status. However, Practice reserves the right to accept or decline patients based upon our capability to appropriately manage the primary care needs of our patients.

j. Notices. Any notices or payments required or permitted to be given under this Agreement shall be deemed given when in writing, by electronic transmission,

hand delivered, or with proof of deposit in the United States mail. All notices shall be deemed delivered on the date of actual delivery, as evidence by the return receipt or courier record, or by verified digital date stamp in the case of electronic transmission.

k. Severability. If 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 the offending 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.

   If this Agreement is held to be invalid or unenforceable for any reason, and if Practice is therefore required to refund all or any portion of the Monthly Fees paid by You, You agree to pay Practice an amount equal to the fair market value of the Services actually rendered to You during the period of time for which the refunded fees were paid commensurate with prevailing rates in the Practice area.

l. Survival. Any provisions of this Agreement creating obligations extending beyond the term of this Agreement shall survive the expiration of termination of this Agreement, regardless of the reason for such termination.

[THE REST OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the Parties hereto or their duly authorized representatives have executed this Agreement as of the Effective Date first written below.

Printed name / Signature of Patient/Parent/Guardian/Authorized Representative Date

---

Printed name / Signature of Patient/Parent/Guardian/Authorized Representative Date

Printed Names of Enrolled Members	Date of Birth

PATIENT ACKNOWLEDGEMENTS

Please read each line carefully and initial to indicate your agreement with the statement.

_____ This Agreement is for ongoing primary care and is NOT a medical insurance agreement.
_____ I do NOT have an emergent medical problem at this time.
_____ In the event of a medical emergency, I agree to call 911 first.
_____ I do NOT expect the practice to file any third party insurance claims on my behalf.
_____ I do NOT expect the practice to prescribe chronic controlled substances on my behalf.
(These include commonly abused opioid medications, benzodiazepines, and stimulants.)
_____ In the event I have a complaint about the Practice I will first notify the Practice directly.
_____ This Agreement does not meet the insurance requirements of the Affordable Care Act.
_____ I am enrolling (myself and my family if applicable) in the practice voluntarily.
_____ I may receive a copy of this document upon request.
_____ This Agreement is non-transferable.

Physician Name _____

Physician Signature _____(date)

Appendix 1 Reed Direct Primary Care Medicare Patient Understandings

This agreement is between Reed Direct Primary Care, and

Medicare Beneficiary: _____
Who resides at: _____
With Medicare ID #: _____

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 his/her legal representative that Physicians at the Practice have opted out of the Medicare program. The Physicians in the Practice have not been excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial each:
_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.
_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.
_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.
_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the 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 his/her legal representative enters into this contract with the knowledge that he/she has 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 his/her 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 his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.
_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

By: _____(date)
Medicare Beneficiary or his/her legal representative

And: _____(date)
On behalf of Reed Direct Primary Care