EMPLOYEE MEMBER AGREEMENT
KANSAS CITY DIRECT PRIMARY CARE, LLC

This is an Agreement entered into on ________________________, 20_____, between Kansas City Direct Primary Care, a Kansas Limited Liability Company (Clinic, Us or We), and

____ (Member or You).

Background

The CLINIC is a Direct Pay primary care practice (DPC), which delivers primary care services through its physician, Dr. Allison Edwards or Dr. Hazen Short (Physician), and her associates at 2016 West 43rd Avenue, Suite A, Kansas City, Kansas 66103. In exchange for certain fees, the CLINIC, agrees to provide You with the Services described in this Agreement on the terms and conditions contained in this Agreement.

Definitions

1. **Member**. In this Agreement, “Member” means employees of ________________________ ____ (“Employer”) and their family members for whom the Physician 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(1), 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, Renewal**. This Agreement will last for one year, starting on ____________________________, and will automatically renew each year on the anniversary date.

5. **Termination.** Notwithstanding the above, You always have the right to cancel this agreement. Either party can end this agreement at any time by giving the other party 30 days written notice.

6. **Payments – Amount and Methods.** In exchange for the Services (see Appendix A(1)), Employer has agreed to remit your monthly membership fee, including any employee contribution, if required, on your behalf, in the amount outlined in Appendix C, which is attached and is Part of this Agreement. Should there be any incidental charges, you will be billed on a monthly basis. Balances for incidental charges are due at the time of service.

   a. In the event that you are no longer an Eligible Employee of your Employer and your

Employer ends your Employee benefit with the Physician, the following will hold true:

i. 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.
   1. The Parties agree that the required method of monthly payment shall be by automatic payment, through a debit or credit card.
   2. If this Agreement is cancelled by either party before the Agreement ends, We will review and settle your account as follows:
      a. We will refund to You the unused portion of your fees on a per diem basis; or
      b. If the Value of the Services you received over the term of the Agreement exceeds the amount You paid in membership fees, You shall reimburse the CLINIC in an amount equal to the difference between the value of the services received and the amount You paid in membership fees over the term of the Agreement. The Parties agree that the value of the services is equal to the CLINIC's usual and customary fee-for-service charges. A copy of these fees is available on request.

7. Non-Participation in Insurance. Your initials on this clause of the Agreement acknowledges the Patient's understanding that neither the CLINIC, nor its Physician, participate in any health insurance or HMO plans or panels and cannot accept Medicare eligible patients. 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. It is the Patient's responsibility to determine whether reimbursement is available from a *private, non-governmental* insurance plan and to submit any required billing. **_____ (Initial)**

8. WE CANNOT Accept Medicare Patients. Your initials on this clause of the Agreement acknowledges the Patient's understanding that at this time, Medicare Patients are not eligible to be treated by the CLINIC or its Physician, and Medicare cannot be billed for any services performed by the same. Therefore, Patient acknowledges that s/he is neither a Medicare beneficiary nor Medicare eligible. The Patient agrees that if s/he will become eligible during the term of this Agreement, s/he will notify the CLINIC within 60 days of becoming eligible and this agreement will be terminated upon Medicare eligibility. Any excess fees will be refunded to the Employer, and the CLINIC will make every effort to provide the Patient with names and contacts for primary care alternatives. **_____ (Initial)**

9. 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 CLINIC, or its employees. You acknowledge that the CLINIC has advised You to obtain or keep in full force, health insurance that will cover You for healthcare not personally delivered by the CLINIC, and for hospitalizations and catastrophic events. **_____ (Initial)**

10. Communications. The Member acknowledges that although CLINIC shall comply with HIPAA privacy requirements, communications with the Physician using e-mail, facsimile, video

chat, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communications. As such, **Member expressly waives the Physician's obligation to guarantee confidentiality with respect to the above means of communication.** Member 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, the Member authorizes the CLINIC, and its Physicians to communicate with him/her by e-mail regarding the Member's "protected health information" (PHI).[1] The Member 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 Physician will make all reasonable efforts to keep e-mail communications confidential and secure, neither the CLINIC, nor the Physician can assure or guarantee the absolute confidentiality of e-mail communications;
(c) At the discretion of the Physician, 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 Physician 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 Physician by telephone or other means.
(f) Technical Failure. Neither the CLINIC, nor the Physician 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 CLINIC'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 CLINIC; or (v) Patient failure to comply with the guidelines for use of e-mail described in this Agreement.

11. Physician Absence. From time to time, due to vacations, illness, or personal emergency, the Physician may be temporarily unavailable to provide the services referred to above in this paragraph one. In the event of the Physician's absence during usual clinic hours, Patients will be given the name and telephone number of an appropriate provider for the Patient to contact. Any treatment rendered by a non-CLINIC substitute provider is not covered under this contract, but may be submitted to Patient's health plan.

12. 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.

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

13. 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.

14. Reimbursement for Services Rendered. If this Agreement is held to be invalid for any reason, and the CLINIC is required to refund fees paid by You, You agree to pay the CLINIC 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.

15. 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.

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

17. 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.

18. 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.

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

20. 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.

21. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Kansas. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the CLINIC in Kansas City, Kansas.

22. 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.

The parties may have signed duplicate counterparts of this Agreement on the date noted below.

____ _______________

Allison Edwards, MD or Zach Brower
for KANSAS CITY DIRECT PRIMARY CARE, LLC

Date

______________________ ______________________ _______________

Printed Name of Member Patient

Signature of Member Patient

Date

APPENDIX A
SERVICES

1. **Medical Services.*** Medical Services under this agreement are those medical services that the Physician is permitted to perform under the laws of the State of Kansas, are consistent with Physician's training and experience, are usual and customary for a family medicine physician to provide, and include the following:[2]

- o Acute and Non-acute Office Visits
- o Chronic Disease Management
- o Well-Woman Care/ Pap Smear*
- o Well-Baby Care
- o Electrocardiogram (EKG)
- o Blood Pressure Monitoring
- o Diabetic Monitoring
- o Breathing Treatments (nebulizer or inhaler with spacer) **
- o IUD Removals
- o Urinalysis *
- o Rapid Test for Strep Throat *
- o Removal of benign skin lesions/warts *
- o Simple aspiration/injection of joint *
- o Removal of Cerumen (ear wax)
- o Wound Repair and Sutures *
- o Abscess Incision and Drainage *
- o Basic Vision Screening
- o At the Physician's discretion, additional services may be offered for an additional fee.
- o Drawing basic labs. Labs and testing that cannot be performed in-house will be offered at a discounted rate through select vendors.*
- o The convenience of access to many commonly prescribed prescription medications at greatly reduced prices, dispensed on premises.**

**Member is responsible for all costs associated with any procedure, laboratory testing, and specimen analysis.*
***Prescription medications dispensed by the CLINIC pharmacy are subject to an additional charge, for which the Member is responsible.*

The Member is also entitled to a personalized, annual in-depth "wellness examination and evaluation," which shall be performed by the Physician, and may include the following, as appropriate:

- ○ Detailed review of medical, family, and social history and update of medical record;
- ○ Personalized Health Risk Assessment utilizing current screening guidelines;
- ○ Preventative health counseling, which may include: weight management, smoking cessation, behavior modification, stress management, etc.;
- ○ Custom Wellness Plan to include recommendations for immunizations, additional screening tests/evaluations, fitness and dietary plans;

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[2] As deemed appropriate and medically necessary by the Physician.

- Complete physical exam & form completion as needed.

2. **Non-Medical, Personalized Services**. CLINIC 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 Physician seven days per week. Patient shall be given a phone number where Patient may reach the Physician directly for guidance regarding concerns that arise unexpectedly after office hours. Video chat may be utilized when the Physician and Patient agree that it is appropriate.

b. ***E-Mail Access*. Patient shall be given the Physician's e-mail address** to which non-urgent communications can be addressed. Such communications shall be dealt with by the Physician or staff member of CLINIC 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 Physician 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 Physician immediately upon arriving for a scheduled office visit or after only a minimal wait. If Physician foresees a 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 Physician of Clinic on a normal office day, every reasonable effort shall be made to schedule an appointment with the Physician on the same day or on the following normal office day.

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.*** CLINIC and Physician 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 CLINIC Physician.**

APPENDIX B
PATIENT ENROLLMENT – MEDICAL AGREEMENT FORM

Fees as set out below shall apply to the following Member(s), who by signing below agree to the terms and conditions of the KANSAS CITY DIRECT PRIMARY CARE Medical Agreement Form.

Member's Printed Name (Head of Household) | Date of Birth (MM/DD/YYYY) | Age

Street Address | City, State, Zip

Home Phone | Cell Phone

Preferred email

Spouse/Child/Children to Whom this Agreement Applies *(i.e. those enrolling for care)*:

Spouse's Name | Date of Birth (MM/DD/YYYY) | Age

Spouse's Home Phone | Cell Phone | Spouse's Preferred Email

Child's Name | Date of Birth (MM/DD/YYYY) | Age

Child's Name | Date of Birth (MM/DD/YYYY) | Age

Child's Name | Date of Birth (MM/DD/YYYY) | Age

Child's Name | Date of Birth (MM/DD/YYYY) | Age

Preferred Payment Method*

Employer-sponsored plan:

☐ Yearly (Credit/Debit Card)

☐ Monthly (Credit/Debit Card)

*All patients must have a credit or debit card on file to cover the cost of membership & any incidentals not covered under the Agreement.

I certify that I have read, understand, and agree to the terms set forth in KANSAS CITY DIRECT PRIMARY CARE Medical Agreement Form. I further certify that I have received a copy of this form.

Signature: ______________________________ Date: ________________

APPENDIX C
FEE ITEMIZATION

Standard KCDPC Fee Itemization per Member:

0-18 years of age	$30 per month*
0-18 years of age	$65 per month**
19 - 25 years of age	$45 per month*
19 - 25 years of age	$65 per month**
26 - 64 years of age	$65 per month
65+ years of age	$90 per month***
Family Rate	$140 per month

Two adults and children 18 years old or younger spanning two generations

**With the enrollment of at least one parent member.*
***Without an enrolled parent member.*
****Medicare-eligible employees may not enroll per section 5, above.*

YOUR EMPLOYER WILL PAY KANSAS CITY DIRECT PRIMARY CARE FOR THIS MONTHLY FEE ON YOUR BEHALF. Your employer may or may not be covering all or part of this fee as an employee benefit; contact your employer directly for details.

If your Employer terminates their contract with KCDPC or if you are terminated from your position with your Employer, you will be charged the full amount of your monthly membership, as delineated above, to the payment form on file with us. You will be given notice prior to this occurring and may terminate your membership as detailed in paragraph 5 of this agreement.

______ (Initial)

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.

Patient(s) Name(s): ____

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PAYMENT INFORMATION
I authorize KANSAS CITY DIRECT PRIMARY CARE to automatically bill and charge the card listed below as specified:

Amount: $____________________ **Frequency:** Monthly

Authorization for incidental charges (labs, medications, medical supplies, etc.) to be automatically billed and charged on monthly invoice? YES or NO

Start Date:______/______/______ **End Date:** Upon member cancellation

CREDIT/DEBIT CARD INFORMATION:

Credit Card Number:

____

Credit Card Type: Expires: CVC (Security Code):

V MC AmEx Dis ________/_________ ________________________

Cardholder's Name (as it appears on the card):

____

Customer's Signature: Date:

____ ________________