EMPLOYER-SPONSORED PATIENT 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

_____ (Patient).

Background

The Clinic is a direct pay primary care practice (DPC), which delivers primary care services. In exchange for certain fees, the Clinic, agrees to provide You with the Services described in this Agreement and Appendices on the terms and conditions contained in this Agreement.

Definitions

1. Patient. In this Agreement, "Patient" or "Member" or "You" 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. This Agreement will last for one year, starting on _____.

5. **Renewal.** The Agreement will automatically renew each year on the anniversary date of the agreement.

6. Termination. Regardless of anything written above, either party reserves the right to cancel this agreement.

1. Patient or Clinic Termination: Either party can end this agreement at any time by giving the other party 30 days written notice per Section 27.
2. Employer Termination: if this Agreement, which is contingent on your Employer's Agreement with the Clinic, is terminated due to Employer action, your membership will end with the start of the next billing cycle unless we receive notice from you that you are electing to continue services with payment occurring as described in section 7.

7. Payments and Refunds – 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 You or your family members incur any incidental charges, balances are due at the time of service and as a backup will be paid via automatic payment on a monthly basis. In the event that your Employee Benefit ends with the Clinic, the following will hold true:

a. 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 card, credit card, or ACH bank transfer and is due on the first business day of each month.
    2. If this Agreement is cancelled by either party before the Agreement ends, We will review and settle your account as follows:
        i. We will refund to You the unused portion of your fees on a per diem basis; or
        ii. If 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.

_____ (Initial)

8. 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)**

9. WE CANNOT Accept Medicare or Medicare-Eligible 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 Patient, and the CLINIC will make every effort to provide the Patient with names and contacts for primary care alternatives. **_____ (Initial)**

10. 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)**

11. Communications. The CLINIC 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 e-mail, facsimile, video chat, cell phone, texting, and other electronic means can never be absolutely guaranteed to be secure or confidential methods of communications. By placing your initials at the end of this Clause, You understand and acknowledge the above and You agree that by initialing this clause, and 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**.** **_____ (Initial)**

12. Email and Text Usage. By providing an e-mail address on the attached Appendix B, the Patient authorizes the CLINIC and its staff to communicate with him/her by e-mail regarding the Patient's "protected health information" (PHI)[1]. By providing cell phone number on Appendix B and circling "YES" on the corresponding consent question, the Patient consents to text message communication containing PHI through the number provided. Patient further acknowledges that:

a. E-mail 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. Although the Practice and its staff shall make all reasonable efforts to keep e-mail and text communications confidential and secure, We cannot can assure or guarantee the absolute confidentiality of these communications;
c. E-mail and text communications will be made a part of the Patient's permanent medical record;
d. Patient is responsible for providing correct email and/or contact information and for updating such information in a timely manner;
e. You also understand and agree that e-mail and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information. **In an emergency, or a situation in which could reasonably be expected to develop into an emergency, You understand and agree to call 911 or go to the nearest emergency room**, and follow the directions of emergency personnel.
f. You agree that email and text messaging are not appropriate means of communication in situations requiring a quick response. You further agree that if you use these methods, and do not receive a timely response you will contact the Physician or other staff by telephone. You acknowledge that We have advised you that the only appropriate

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

means of communicating time-sensitive issues, or for disclosing sensitive information are either face to face or by telephone. You agree that if You do not receive a response to an e-mail message or other electronic communication, You shall contact the Clinic by telephone during regular business hours.

By placing your initials where indicated at the end of this clause, you verify that you understand this clause 12(a-f) and agree to its statements and terms. _____ **(Initial)**

13. Technical Failure. Neither the Clinic nor its staff 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.

14. Physician Absence. From time to time, due to vacations, medical conditions, or personal emergency, the Physician may be temporarily unavailable to provide the services referred to in this Agreement. 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. Treatments rendered by a non-Clinic substitute provider may not be covered under this contract.

15. Dispute Resolution. Each Party agrees not to make any inaccurate, untrue and/or 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 CLINIC, both the Member and the CLINIC 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:

1. Member shall first discuss any complaints concerns or issues with the clinic manager;
2. The clinic manager shall respond to each of Member's issues and complaints;
3. If, after such response, Member remains dissatisfied, the Parties shall enter into discussion and attempt to reach a mutually acceptable solution.

16. Fee Adjustments and Service Offerings. In the event that, prior to the termination of this Agreement the Practice finds it necessary to (a) increase/adjust monthly fees or (b) expand or eliminate certain Services contained in Appendix A, Practice shall give Patient 30 days written notice of any adjustment and 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, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to 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 will be amended to the extent necessary to be enforceable, and the remainder of the contract will stay in force as originally written.

19. 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.

20. 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 16 and 17, above.

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

22. 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.

23. 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.

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

25. **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.

26. 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.

27. Service and Notices. All written notices are deemed served if sent to 2016 W 43rd Ave, Ste A, Kansas City, KS 66103 or the patient address appearing in Appendix B by first class U.S. mail. Patients will be notified of any change in clinic address. Written notices are deemed served if sent by first class US Mail except for the notice of termination per paragraph number 6, which may be sent via email to address provided and is noted as served when acknowledged by the clinic.

(Continued from prior page.)

Printed Name of KCDPC Representative *For KANSAS CITY DIRECT PRIMARY CARE, LLC*	Signature	Date
Printed Name of Head of Household	Signature of Head of Household	Date
Printed Name of Spouse	Signature of Spouse	Date
Printed Name of Adult Child(ren) *(18+ yrs old)*	Signature of Adult Child(ren)	Date

KC DPC

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

**Patient is responsible for all costs associated with any procedure, laboratory testing, pathology fees, medications dispensed, radiology ordered, and specimen analysis.*

The Patient may also receive 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;
- 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

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

course of care and are **included in the monthly membership fee**:

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.

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 during regular business hours. **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 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. ***Appointment Availability*.** When an established Patient calls or e-mails the 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. New patients will be seen as soon as Clinic capacity allows.

e. ***Specialist Coordination.*** Clinic and Physician shall coordinate as best as possible given the constraints in interoperability in the current healthcare system 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 in Appendix C shall apply to the following Patient(s)*, who by signing this agreement certify that they have read, understand, and agree to the terms and conditions set forth in the KANSAS CITY DIRECT PRIMARY CARE Patient Agreement Form and have been offered a copy of the agreement. Unless requested and approved in writing, new members will be assigned to the KCDPC physician with the most availability.

_____ _____ _____
Head of Household - Print Name | Date of Birth (MM/DD/YYYY) | Age

_____ _____
Street Address | City, State, Zip

_____ _____
Home Phone | Cell Phone

_____
Preferred email

I consent to receiving communications from the clinic to the above email address and/or cell number [ ] YES or [ ] NO _____ **(Initial)**

Spouse to Whom this Agreement Applies *(i.e. enrolling for care)*

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

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

I consent to receiving communications from the clinic to the above email address and/or cell number [ ] YES or [ ] NO _____ **(Initial)**

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

KCDPC

APPENDIX B, CONTINUED

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

Name of Legal Guardian(s): ______________________ Relationship: ______________

I, the above named legal guardian of the child(ren) under the age of 18 whose names appear on this document, consent to receiving communications regarding such children, from the Clinic by text to the cell number(s) and/or email address(es) provided above [ ] YES or [ ] NO _____ **(Initial)**

Child's Name ______________________ Date of Birth (MM/DD/YYYY) ______________ Age ______

Child's Cell Phone ______________ Child's Preferred Email ______________________

If 18+ Years Old: I consent to receiving communications from the clinic to the above email address and/or cell number [ ] YES or [ ] NO _____ **(Initial)**

Child's Name ______________________ Date of Birth (MM/DD/YYYY) ______________ Age ______

Child's Cell Phone ______________ Child's Preferred Email ______________________

If 18+ Years Old: I consent to receiving communications from the clinic to the above email address and/or cell number [ ] YES or [ ] NO _____ **(Initial)**

Child's Name ______________________ Date of Birth (MM/DD/YYYY) ______________ Age ______

Child's Cell Phone ______________ Child's Preferred Email ______________________

If 18+ Years Old: I consent to receiving communications from the clinic to the above email address and/or cell number [ ] YES or [ ] NO _____ **(Initial)**

Child's Name ______________________ Date of Birth (MM/DD/YYYY) ______________ Age ______

Child's Cell Phone ______________ Child's Preferred Email ______________________

If 18+ Years Old: I consent to receiving communications from the clinic to the above email address and/or cell number [ ] YES or [ ] NO _____ **(Initial)**

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

APPENDIX C
FEE ITEMIZATION

Prices may change; see paragraph 16.

Adult (Age 18+)	$75.00 per month
Child (Ages 0-17)	$35.00 per month
Family Rate	$220.00 per month
Two adults and children under 18 years old spanning two generations	
Enrollment Fee	$75 once per account***
Re-Enrollment Fee	$150 once per account***

**With the enrollment of at least one guardian member.*
***Also the price for those under 26 without an enrolled guardian member.*
****Non-refundable fee. Should your membership lapse or be terminated, the re-enrollment fee must be paid again for membership to become active.*

Ongoing Rates:

Patient 1 $_____

Patient 2 $_____

Patient 3 $_____

Patient 4 $_____

Additional $_____

TOTAL RATE $_____ per _____

One-time enrollment costs:

Enrollment Fee $_____

Prorate of Current Month $_____ paid _____

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 You elect to continue your membership after the termination of 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 6 of this agreement. **_____ (Initial)**

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To facilitate automated billing, complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Information can be later updated via secure link accessed through your electronic statement sent to your email. Your statement, which you will receive on the date of your payment/deductions, will include monthly fees and incidental charges.

Patient(s) Name(s): _____

_____

I authorize KANSAS CITY DIRECT PRIMARY CARE to automatically bill and charge the card listed below as specified on a MONTHLY basis:

Incidental charges (labs, medications, medical supplies, etc.) and $_____ for medical services.

Note: annual subscriptions available at a discount.

Start Date: _____/_____/_____ **End Date:** Upon cancellation

CREDIT/DEBIT CARD INFORMATION

Card Number: _____

Expires: _____/_____ CVC (Security Code): _____

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

_____

Customer's Signature: Date:

_____ _____

Is this credit card different than the one used to sign up online? [ ] YES or [ ] NO

Alternatively, you may pay using your bank account via monthly ACH withdrawal -- which helps us keep costs down! Please ask a KCDPC staff member for the appropriate form.

AUTOMATIC RECURRING ACH WITHDRAWAL AUTHORIZATION

To facilitate automated billing, complete the ACH Information section below and sign the form. All requested information is required. Information can be later updated via secure link accessed through your electronic statement sent to your email. Your statement will include monthly fees and incidental charges, which you will receive on the date of your payment/deductions.

Patient(s) Name(s): _____

_____

I authorize KANSAS CITY DIRECT PRIMARY CARE to automatically bill and charge the account listed below as specified on a monthly basis:

Incidental charges (labs, medications, medical supplies, etc.) and $_____ for medical services.

Note: annual subscriptions available at a discount.

Start Date: _____/_____/_____ **End Date:** Upon cancellation

ACH INFORMATION:

Bank Routing Number:

_____

Account Number:

_____

Account Holder's Signature: Date:

_____ _____

The ACH setup process is not complete until you have verified your account. Our software, Atlas.md, will verify ownership of this account by making two small deposits into your account within two business days of getting your account set up. The charge description should read VERIFICATION and the amount on each of these deposits will work as the verification key to confirm your ownership of the bank account. We will send you an email shortly with details about this process along with a link you may use to complete the verification process. If you have any trouble with this, please call us and we can manually enter the two small amounts! **NOTE: If you do not verify your account, we will charge the card on file that was used during your enrollment process for the above.**