PATIENT AGREEMENT
VIENNA PRIMARY AND PREVENTATIVE MEDICINE, PLLC

This is an Agreement entered into on_____, 20___, between Vienna Primary and Preventative Medicine, a Virginia Professional Limited Liability Company (Practice, Us or We), and_____(Patient or You).

Background

The PRACTICE is a Direct Pay primary care practice (DPC), which delivers primary care services through its physician, Dr. Micha Joffee (Physician), at 243 Church Street Northwest, Suite 100-C, Vienna, Virginia 22180. 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 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, which is attached and a part of this Agreement. Patient is responsible for all fees associated with any Services not listed in Appendix A.

Agreement

3. Term. This Agreement will last for one year, starting on_____.

4. Renewal. The Agreement will automatically renew each year on the anniversary date of the agreement, unless either party cancels the Agreement by giving 30 days written cancellation notice.

5. Termination. Regardless of anything written 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 and Refunds – Amount and Methods. In exchange for the Services You agree to pay Us, a fee in the amount that appears in Appendix C, which is attached and is part of this Agreement.

a) If you choose to pay monthly, this fee is payable on the effective date above, and on the 15th day of each month thereafter.

b) If you choose to pay annually, this fee is payable on the effective date above, and on the anniversary of this agreement each year thereafter.

c) The Parties agree that the required method of payment shall be by automatic payment through a debit or credit card, or automatic bank draft.

d) 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 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 PRACTICE 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 PRACTICE's usual and customary fee-for-service charges. A copy of these fees is available on request.

7. Non-Participation in Insurance. The Patient understands that neither the PRACTICE, nor its Physician, participate in any health insurance or HMO plans or panels and have opted out of Medicare. Neither make any representations that the fees paid under this Agreement are covered by the Patient's 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, HSA, or FSA and to submit any required billing.

_____ **(Initial)**

8. Medicare. The Patient understands that the Physician has opted out of Medicare, and as a result, Medicare cannot be billed for any services performed for the Patient by the Physician. The Patient agrees not to bill Medicare or attempt to obtain Medicare reimbursement for any such services. If the Patient is eligible for Medicare, or becomes eligible during the term of this Agreement, s/he will sign the Medicare Private Contract as Provided by the Practice and required by law.

9. This Is Not Health Insurance. The Patient understands that this agreement does not provide comprehensive health insurance coverage. It provides only the primary care services specifically described in this agreement. The Patient understands that this Agreement does not replace any existing or future health insurance or health plan coverage that Patient may carry, and standing alone, does not satisfy the requirements of the Patient Protection and Affordable Care Act. The Agreement does not include hospital services, or any services not personally

provided by the PRACTICE, or its employees. The Patient acknowledges that the PRACTICE has advised the Patient to obtain, or keep in full force, health insurance that will cover the Patient for healthcare not personally delivered by the PRACTICE, and for hospitalizations and catastrophic events.
_____ **(Initial)**

10. Communications. The Practice endeavors to provide Patients with the convenience of electronic communication options, and shall provide patient portal access as the main method of communication. However, there are times when communications by other modes, such as text messaging and email are more helpful or conducive to administrative notifications or patient care, so we offer these options as well. And although We are careful to comply with confidentiality requirements and take seriously, Our duty to protect patient privacy — communications by email, facsimile, text messaging, telehealth, patient portal and other electronic means, can never be guaranteed to be 100% secure or confidential. You understand and agree that by initialing this clause where indicated, and/or 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 any of the above means of communication is not a condition of membership in this Practice and that you have the option to decline any particular method of communication.
_____ **(Initial)**

11. Email and Text Usage. By providing an email address where requested in Appendix B, You authorize the Practice and its staff to communicate with You by email and patient portal in regard to the Patient's "protected health information" (PHI).[1] Likewise, in providing a cell phone number where indicated in Appendix B and checking the "YES" box on the corresponding consent question, You agree to participate in text message communication through the cell number provided. You further acknowledge that:

A. Email, and text messaging and other electronic means of communication are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access;

B. Email 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 which could reasonably be expected to develop into an emergency, the Patient understands and agrees to call 911 or go to the nearest emergency room and follow the directions of emergency personnel.

C. You agree that if You do not receive a response to a message sent

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

through the patient portal, e-mail, or text message within one business day, You agree that you will contact the Physician by telephone or other means.

12. Technical Failure. Neither the PRACTICE, 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 or cell phone 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's failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

13. Physician Absence. From time to time, due to circumstances such as conferences, patient emergencies, physician illness, and vacations, the physician may be temporarily unavailable. When the date/s of such absences are known in advance, the Practice shall notify the Patient so that they may schedule non-urgent care accordingly. In the event of unexpected physician absence, Patients with scheduled appointments shall be notified as soon as practicable, and appointments shall be rescheduled. If during a physician absence, the Patient should experience an acute medical issue requiring immediate attention, the Patient should proceed to an urgent care or other suitable facility for care. **When the physician is absent, if the Patient experiences an emergency, or any situation that the Patient could reasonably expect may develop into an emergency, the Patient agrees that in such situations, that the Patient shall call 911 or go immediately to the nearest emergency department/emergency room, and follow the directions of emergency medical personnel.** Charges from urgent care facilities or any other outside providers and facilities are not included under this Agreement and are the Patient's responsibility. The Patient may submit such charges to the Patient's insurance or request that the outside provider do the same. We cannot guarantee insurance reimbursement.

14. 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.

15. 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.

16. 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.

17. 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 14, above.

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

19. 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.

20. 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.

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

22. 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.

23. 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 Vienna, Virginia.

24. Notice. All written notices are deemed served if sent electronically, to the latest email address provided by the party, or by first class US Mail to the Practice, at the address first written above; and to the Patient at the address appearing in Appendix B.

Signatures appear on the following page.

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

FOR: VIENNA PRIMARY AND PREVENTATIVE MEDICINE, PLLC

_____
By Micha Joffee, MD

_____
Date

PATIENT:

_____ _____

Patient Signature

_____
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 Commonwealth of Virginia, are consistent with Physician's training and experience, are usual and customary for a family medicine physician to provide, and include the following, as deemed appropriate and medically necessary by the Physician:

- 6 visits to include Acute and Non-acute Office Visits per year (In person or Virtual, with additional visits available at the discounted rate of $40 per visit)

THE FOLLOWING MAY BE INCLUDED IN ACUTE AND NON-ACUTE VISITS:

- Electrocardiogram (EKG)
- Blood Pressure Monitoring
- Diabetic Monitoring
- Breathing Treatments (nebulizer or inhaler with spacer)
- Rapid Test for Strep Throat
- Removal of benign skin lesions
- Removal of Cerumen (ear wax)
- Simple Wound Repair and Sutures (excluding face)
- Simple Abscess Incision and Drainage
- Basic Vision/Hearing 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 through select vendors.*

*Patient is responsible for all costs associated with any procedures, including supplies, laboratory testing, and specimen analysis.

As one of the 6 included visits the Patient is entitled to a personalized, annual in-depth "physical 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 assessment utilizing current screening guidelines;

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- Preventative health counseling, which may include: nutrition counseling, smoking cessation, behavior modification, etc.;
- Custom wellness plan to include recommendations for immunizations, additional screening tests/evaluations, fitness and dietary plans;
- Physical exam & form completion as needed.

2. Non-Medical, Personalized Services. PRACTICE shall also provide Patient with the following non-medical services ("Non-Medical Services"), which are complimentary 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 and cannot reasonably wait until the next business day. Video chat and text messaging may be utilized when the Physician and Patient agree that it is appropriate.

b. ***E-Mail Access*. Patient shall be given e-mail access to the Physician's through a patient portal** to which non-urgent communications can be addressed. Such communications shall be dealt with by the Physician or staff member of PRACTICE in a timely manner. **Patient understands and agrees that e-mail 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 go to 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 an extended wait time, Patient shall be contacted and advised of the projected wait time.

d. ***Same Day/Next Day Appointments*.** When Patient calls the Physician prior to noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule an appointment with the Physician on the same day. If Patient calls the Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with the Physician on the following normal office day. If Physician cannot see Patient on the same day, but believes a same day visit is necessary, Patient may be advised to visit urgent care

Initial _____

e. ***Specialists Coordination.*** PRACTICE 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 PRACTICE Physician.**

Initial _____

APPENDIX B

PATIENT ENROLLMENT FORM

CHECK YES WHERE INDICATED ONLY IF YOU AGREE TO TEXT MESSAGE COMMUNICATION. PROVIDE AN EMAIL ADDRESS ONLY IF YOU AGREE TO EMAIL COMMUNICATION. YOUR SIGNATURE INDICATES ACCEPTANCE OF THE TERMS OF THE PATIENT AGREEMENT.

The fees as set out in the attached Appendix C, shall apply to the following Patient(s), who by signing below (or as parent or legal guardian), certify that they have read, agree to, and are bound by the terms and conditions of the Agreement.

Patient 1

Print Patient Name_____ Date of Birth_____

Street Address_____

City, State, Zip_____

Home Phone_____ Cell Phone _____Email_____

Agree to Text Communication: (check one below)

- ☐ Yes
- ☐ No

Signature: _____

Patient 2

Patient Name_____ Date of Birth_____

Street Address_____

City, State, Zip_____

Home Phone_____ Cell Phone _____Email_____

Agree to Text Communication: (check one below)

- ☐ YES
- ☐ NO (check one)

Signature _____

Initial _____

MINORS TO WHOM THIS AGREEMENT APPLIES:

PRINT NAME _____

DATE OF BIRTH _____
MM DD YYYY

PRINT NAME _____

DATE OF BIRTH_____
MM DD YYYY

PRINT NAME _____

DATE OF BIRTH__ _____
MM DD YYYY

DO YOU AGREE TO TEXT MESSAGE COMMUNICATION REGARDING THE ABOVE-NAMED CHILDREN (INCLUDING PHI)?

(CHECK ONE BELOW))

☐ YES
☐ NO

PARENT/GUARDIAN SIGNATURE:

SIGNATURE: _____

PRINTED NAME: _____ DATE: _____

REALTIONSHIP TO MINOR/S): _____

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Preferred Payment Method*

□ Monthly (Credit/Debit Card/Bank Draft)

□ Annually (Credit/Debit Card/Bank Draft/Check)

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

Initial _____

APPENDIX C

Fee Itemization

6-24 years of age with a parent enrolled	$39 per month*
18-24 years of age without a parent enrolled	$104 per month
25-49 years of age	$104 per month
50+ years of age	$124 per month
Enrollment Fee	$99**

*Patients under 18 require the enrollment of at least one adult member.
**Non-refundable fee. Should your membership lapse or be terminated, the enrollment fee must be paid again for membership to become active.

Fees Due Upon Enrollment

Patient 1	$_____
Patient 2	_____
Patient 3	_____
Patient 4	_____
Additional Patients	_____
Enrollment Fee	_____
TOTAL FEE	$_____

Monthly Membership Fees

Patient 1	$_____
Patient 2	_____
Patient 3	_____
Patient 4	_____
Additional Patients	_____
TOTAL MONTHLY FEE	$_____

Annual Membership Fees

Patient 1	$_____
Patient 2	_____
Patient 3	_____
Patient 4	_____
Additional Patients	_____
TOTAL ANNUAL FEE	$_____

Initial _____