Client Enrollment Agreement

Kornweiss Medical LLC

This Client Enrollment Agreement (Agreement) is between Kornweiss Medical, a South Carolina Limited Liability Company (Practice, Us, Our, or We), and client, (Client, Patient, You, or Your) - collectively (the Parties). This Agreement includes Appendices A-C, Our Privacy Policy, and Our Authorization to Release Confidential Information all of which are attached.

Background

The Practice is a medical practice, which delivers medical services through its physician, Steven Kornweiss, MD (Physician). 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.

1. Definitions

1.1. Client

In this Agreement, “Client” means the person for whom the Physician shall provide care.

1.2. 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.

2. Agreement

2.1. Term

The Term of this Agreement is set out in Appendix C.

2.2. Termination

You have the right to terminate this Agreement at any time. You must submit notice of termination by email to the Practice and include a date of termination which cannot be earlier than the date on which the notice is sent.

Physician has the right to terminate this Agreement in accordance with medical ethics governing the Patient-Physician relationship.

According to the American Medical Association Code of Medical Ethics Opinion 1.1.5 referenced on December 6, 2021:

> *"Physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients. At the beginning of patient-physician relationship, the physician should alert the patient to any foreseeable impediments to continuity of care.*
>
> *When considering withdrawing from a case, physicians must:*
>
> *a. Notify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician.*
>
> *b. Facilitate transfer of care when appropriate."*

2.3. Payments and Refunds

In exchange for the Services (see Appendix A), You agree to pay Us according to the Fee Schedule indicated in Appendix C.

1. The Parties agree that the required method of payment shall be by automatic payment through a debit or credit card, or automatic bank draft.
2. If this Agreement is terminated by either Client or Physician before the end of the Term, We will review and settle Your account. The value of Services provided up until the termination will be calculated pro rata. We will charge your card or bank account on file for unpaid services. We will debit your card or bank account on file for fees paid in excess of the value of services rendered. You may request an itemized statement of this account settlement.

2.4. The Practice Does Not Accept Insurance

Neither the Practice, nor its Physician, participate in any health insurance or HMO plans or panels and cannot accept Medicare-eligible clients. We make no representations that any fees that Client pays under this Agreement are covered by Client's health insurance or other third-party payment plans. It is the Client's responsibility to determine whether reimbursement is available from a private, non-governmental insurance plan and to submit any required billing.

2.5. The Practice Cannot Accept Medicare Patients

Medicare Clients are not eligible to be treated by the Practice or its Physician, and Medicare cannot be billed for any Services performed by the same. Therefore, Client represents that Client is neither a Medicare beneficiary nor Medicare eligible. The Client agrees that if Client will become eligible for Medicare during the term of this Agreement, Client will notify the Practice within 60 days of becoming eligible and this Agreement will be terminated upon Medicare eligibility. The Practice will make reasonable efforts to provide the Client with names and contacts for alternative physicians.

2.6. This Is Not Health Insurance

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 provided by the Practice, or its employees. The Practice advises You to obtain or keep in full force, health insurance that will cover You for healthcare not delivered by the Practice, and for hospitalizations and catastrophic events.

2.7. This is Not Primary Care

This Agreement does not include primary care services (e.g. routine care, acute care, unscheduled care, annual physical exams, form completion, vaccination, etc.). It only includes the Services indicated in Appendix A. The Practice advises You to have a primary care physician.

2.8. This is Not Acute, Urgent, or Emergency Care

The Practice advises You to contact Your primary care physician or an appropriate acute care provider (e.g. urgent care, immediate care, emergency medical provider, or 911) for any acute medical problems or emergencies such as illnesses or injuries. The Practice advises You in the event of an emergency, or any situation that You could reasonably expect may develop into an emergency, that You should either call 911 or go to the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

2.9. Communications

The Client acknowledges that although Practice 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 guaranteed to be secure or confidential methods of communications. As such, Client expressly waives the Physician's obligation

to guarantee confidentiality with respect to the above means of communication. Client further acknowledges that all such communications may become a part of Client's medical record.

By providing an e-mail address or cell phone number, the Client authorizes the Practice, and its Physicians to communicate with him/her by e-mail or text message regarding the Client's "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations).

The Client further acknowledges that:

1. E-mail and text message are not necessarily secure means of sending or receiving PHI, and there is always a possibility that a third-party may gain access;
2. Although the Physician will make reasonable efforts to keep email and text communications confidential and secure, neither the Practice nor the Physician can assure or guarantee the absolute confidentiality of these communications;
3. At the discretion of the Physician, e-mail and/or text communications may be made a part of Client's permanent medical record; and
4. Client understands and agrees that e-mail and text messaging are not appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. In an emergency, or a situation that Client could reasonably expect to develop into an emergency, The Practice advises Client to call 911 or go to the nearest emergency room, and follow the directions of emergency personnel.
5. *Technical Failure*. Neither the Practice, nor the Physician will be liable for any loss, injury, or expense arising from a delay in responding to Client, when that delay is caused by technical failure. Examples of technical failures include but are not limited to: (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 email communications by a third-party which is unauthorized by the Practice; or (v) Client's failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

2.10. Physician Absence

From time to time, due to vacations, illness, or personal emergency, the Physician may be temporarily unavailable to provide the Services indicated in Appendix A.

2.11. 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.

2.12. Severability

If any part of this Agreement is ruled 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 Agreement will stay in force as originally written.

2.13. Amendment

No amendment of this Agreement shall be binding on a Party unless it is in writing and signed by all the Parties.

2.14. Assignment

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

2.15. 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 are satisfied with the terms and conditions of the Agreement.

2.16. Miscellaneous

The terms of this Agreement shall not be construed against any Party on the basis that the Party drafted this Agreement. The headings and titles in this Agreement are only for convenience and have no legal meaning.

2.17. Entire Agreement

This Agreement including its appendices contains the entire agreement between the Parties and replaces any earlier understandings and agreements whether written or oral.

2.18. 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 a reasonable time.

2.19. Jurisdiction

This Agreement shall be governed and construed under the laws of the State of South Carolina. All disputes arising out of this Agreement shall be submitted in a court of proper venue and jurisdiction in the state where the Practice is

located.

2.20. Notice

All written notices under this Agreement shall be delivered by email.

Signatures

If not provided on this form, a legally binding signature is also indicated by checking the agreement box on the web-based client enrollment form.

Client (Patient) Signature

Physician Signature

Appendix A - Services

Kornweiss Medical LLC

Medical Services

Services are only the following:

Services

Examples of Services Not Provided

- Primary care services (e.g. routine care, acute care, unscheduled care, annual physical exams, form completion, vaccination, etc.)
- In-person Care

Third-Party Services

Additional labs, radiology, and testing will be offered through select vendors.

Additional Costs

The Client is responsible for additional costs associated with third-party services such as but not limited to laboratory testing, imaging, medications, supplements, and medical devices.

Access to Physician

Client shall have direct access to Physician by email Monday-Friday from 9am-5pm.

Client Signature

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Appendix B - Client Information

Kornweiss Medical LLC

Fees, as set out in Appendix C, shall apply to the following Client(s):

If not provided on this form, this information may also be provided by filling out the client enrollment form on the Practice's website.

Name

Date of Birth

Phone Number

Email Address

Address

Client Signature

Appendix C - Term & Fee Schedule

Kornweiss Medical LLC

Term

Start Date

End Date - if not specified, Agreement will continue until terminated by one of the Parties

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Fees

Fee Schedule

- 25% due upon signing this Agreement
- The remainder is due in equal installments on the 1st of each month for the duration of the Term such that the final payment will occur on the 1st of the final month of the Term.
- The Client may pause the agreement for up to six months. The Fee Schedule will be shifted accordingly.

Client Signature

Sample Fee Schedule

- Agreement signed: 1/1/21
- Term: 2/1/21–4/30/21
- Total Fees: $4000

DATE	EVENT	PAYMENT
1/1/21	Agreement signed	$4000*0.25 = $1000
2/1/21	month 1 of 3	$3000/3=$1000
3/1/21	month 2 of 3	$3000/3=$1000
4/1/21	month 3 of 3	$3000/3=$1000
		Total = $4000

Notice of Privacy Practices

Kornweiss Medical LLC

This notice describes how medical information about You may be used and disclosed and how You can get access to this information. Please review it carefully. If You have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose Your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

It also describes Your rights to access and control Your protected health information. “Protected health information” (hereafter referred to as “PHI”) is information about You, including demographic information, that may identify You and that relates to Your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time and the new notice will be effective for all PHI that we maintain at that time. The most current Notice of Privacy Practices can be found on our website as well as in our office.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by Physician, our office staff, and others outside of our office involved in Your care and treatment for the purpose of providing health care services to You. Your PHI may also be used and disclosed to pay Your health care bills and to support the operation of the Practice. We will share Your PHI with third-party “business associates” that perform various activities (for example, billing or transcription services) for our Practice. We may use or disclose Your PHI, as necessary, to provide You with information

about treatment alternatives or other health related benefits and services that may be of interest to You. You may contact our Privacy Officer to request that these materials not be sent to You.

Uses and disclosures of Protected Health Information based upon Your written authorization:

Other uses and disclosures of Your PHI will be made only with Your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time.

If You revoke Your authorization, we will no longer use or disclose Your PHI for the reasons covered by Your written authorization. Please understand that we are unable to take back any disclosures already made with Your authorization.

Uses and disclosures of Protected Health Information that may be made without Your authorization or opportunity to agree or object:

We may use or disclose Your PHI in the following situations without Your authorization or providing You the opportunity to agree or object.

These situations include: when required by law, for reasons related to public health, when someone may be exposed to a communicable disease, for health oversight purposes (such as audits, investigations, and inspections), reporting cases of abuse or neglect, to the Food and Drug Administration, for legal proceedings, to law enforcement, to coroners, to funeral directors, for organ donation

purposes, for research, reporting criminal activity, military activity and national security, to Workers' Compensation programs, and to a correctional facility if You are an inmate.

Finally, we may use or disclose Your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in Your health care.

Uses and Disclosures that require providing You the opportunity to agree or object:

Unless You object, we may disclose to a member of Your family, a relative, a close friend or any other person You identify, Your PHI that

directly relates to that person's involvement in Your health care. If You are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in Your best interest based on our professional judgment.

We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for Your care of Your location, general condition or death.

2. Your Rights

Following is a statement of Your rights with respect to Your PHI and a brief description of how You may exercise these rights.

You have the right to inspect and copy Your PHI.

This means You may inspect and obtain a copy of PHI about You for so long as we maintain the PHI. You may obtain Your medical record that contains medical and billing records and any other records that Physician and the Practice use for making decisions about You. As permitted by federal or state law, we may charge You a reasonable copy fee for a copy of Your records.

Under federal law, however, You may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable.

In some circumstances, You may have a right to have this decision reviewed. Please contact our Privacy Officer if You have questions about access to Your medical record.

You have the right to request a restriction of Your PHI.

This means You may ask us not to use or disclose any part of Your PHI for the purposes of treatment, payment or health care operations. You may also request that any

part of Your PHI not be disclosed to family members or friends who may be involved in Your care or for notification

purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom You want the restriction to apply. Physician is not required to agree to a restriction that You may request. If Physician does agree to the requested restriction, we may not use or disclose Your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction You wish to request with Physician. You may request a restriction by sending written, specific instructions to

our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

We will accommodate reasonable requests. We may also condition this accommodation by asking You for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from You as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have Physician amend Your PHI.

This means You may request an amendment of PHI about You in a designated record set for so long as we maintain this information. In certain cases, we may deny Your request for an amendment. If we deny Your request for amendment, You have the right to file a statement of disagreement with us and we may prepare a rebuttal to Your statement and will provide You with a copy of any such rebuttal. Please contact our Privacy Officer if You have questions about amending Your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of Your PHI.

This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to You if You authorized us to make the disclosure, to family members or friends involved in Your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if You believe Your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of Your complaint. We will not retaliate against You for filing a complaint. You may contact our Privacy Officer for further information about the complaint process.

Privacy Officer Contact Information

Steven Kornweiss, MD

privacy@kornweissmedical.com

Kornweiss Medical, LLC
1140 Woodruff Road Ste. 106
Greenville, SC 29607

Client Signature

Authorization for Release of Confidential Information
Kornweiss Medical LLC

Patient Information

- *Last Name* ___
- *First Name* ___
- *Date of Birth* ___

Please Send All Records

- Physician and Nursing documentation
- Lab Results
- Radiology Reports and Images
- Operative Reports
- Electrocardiographs

Send Records To

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Steven Kornweiss, MD | Kornweiss Medical LLC
Fax: 587-200-3716 | Phone: 864-206-5225
records@kornweissmedical.com

1140 Woodruff Rd. Ste 106
Greenville, SC 29607
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Authorization
I hereby authorize Kornweiss Medical LLC to receive information from the above named patient's medical records including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment. I understand that this authorization may be revoked at any time in writing. I further understand that continued treatment of the above named patient is not contingent upon receipt of this information. Also, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA privacy rule.

Patient Signature
