

PATIENT AGREEMENT

THIS PATIENT AGREEMENT (the “Agreement”) is by and between **MD For Patients, LLC**, an Ohio limited liability company (the “Practice”) and you, the undersigned (the “Patient”).

BACKGROUND

In exchange for certain fees paid by you, the Practice agrees to provide you with the Services described in this Agreement on the terms and conditions set forth in this Agreement.

AGREEMENT

1. Patient. A Patient is defined as those persons for whom the Provider shall provide Services, and who are signatories to, or listed on the documents set forth on, the attached Appendix 2 to this Agreement. Practice may designate, from time to time, certain Terms of Usage for Patients as a supplement to this Agreement by providing written notice to patients of such terms. In the event Practice designates any Terms of Usage, such terms shall control over conflicting terms in this Agreement.

2. Provider. A Provider is defined as one or more physicians or other health care providers performing medical case reviews, consultations or other services for a Patient on behalf of the Practice. The Practice reserves the right to add or remove any Provider from service to Patients at any time without notice, but will endeavor to provide prior notice if a Provider is no longer available.

3. Services.

As used in this Agreement, the term “Services” shall mean the provision of second-opinion and consultative medical services and related services as requested by Patient and agreed to by the Practice, including without limitation, second-opinion consultations in medical specialties provided through telemedicine technology, which may consist of or include professional radiology interpretations provided through teleradiology technology.

It is understood that “Services” include all verbal and written consultations and communications, the independent interpretation of medical tests including but not limited to the Patient’s medical imaging examinations, laboratory and other medical test results, the review of relevant medical literature on behalf of Patients, Patient’s care and consultation, and all related correspondence, whether directly with Patients, or with Patients’ care providers if so directed by Patients.

If the Patient has one or more representatives who are designated to act as Durable Powers of Health Attorney (a “DPOHA”), then those DPOHA designees may engage the services of the Practice on behalf of those Patients for whom the DPOHA is so designated, and the Practice may then perform case reviews and consultations on behalf of Patients at the direction of such DPOHA designees so long as the DPOHA is acting on behalf of Patients. In such a case, the DPOHA agrees to inform the Practice in writing of their relationship to the Patient at the time that they engage the Services of the Practice, and in such cases signatures of the DPOHA and of an authorized representative of the Practice shall be required to initiate the engagement of Services by the

Practice. The Practice will also perform certain administrative functions such as acquiring copies of medical records, medical imaging examinations, and/or laboratory and other diagnostic test results, correspondence, and billing.

4. Acquisition of Medical Records. The Patient agrees that the Practice will use commercially reasonable efforts to acquire Patient's medical records, medical imaging exams, and laboratory and other medical test results as needed to conduct the consultation. The Patient further agrees that the Patient will assist the Practice in the process of acquiring these medical record documents and/or imaging examinations by completing the necessary forms and requests for records as required by the Patient's healthcare providers or as may be required by the Practice. In the event that one or more parts of the Patient's medical records cannot be successfully obtained by the Practice, the Patient will remain responsible for the time spent by the Practice in attempting to acquire the medical records.

5. Term. This Agreement will commence on the date first written above and shall continue until terminated. Both you and the Practice shall have the right to terminate the Agreement, without the showing of any cause for termination, by giving 30 days prior written notice to the other party.

6. Fees. In exchange for the services described herein, you agrees to pay the Practice the amounts set forth in Appendix 1, attached.

7. Non-Participation in Insurance. You acknowledge that neither the Practice, nor the Providers participate in any health insurance or HMO plans or panels and have opted out of Medicare. None of the above make any representations whatsoever that any fees paid under this Agreement are covered by your health insurance or other third party payment plans applicable to you. If you are eligible for Medicare, or during the term of this Agreement become eligible for Medicare, then you will sign the agreement attached as Appendix 3, and incorporated by reference. This Agreement acknowledges your understanding that the Practice and the Providers have opted out of Medicare, and as a result, Medicare cannot be billed for any services performed hereunder. You agree not to bill Medicare or attempt Medicare reimbursement for any such services. Each year you shall renew and sign the agreement in Appendix 3, or any successor agreement implemented by the Practice.

8. Insurance or Other Medical Coverage. Patient acknowledges and understands that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services, or any services not personally provided by the Practice or its Providers. You acknowledge that the Practice has advised you to obtain or keep in full force health insurance policies or plans that will cover you for general healthcare costs. You acknowledge that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that you may carry.

9. Communications. You acknowledge that communications with the Provider using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communication. As such, Patient expressly waives the Provider's obligations to guarantee confidentiality with respect to correspondence using such means of

communication. You acknowledge that all such communications may become a part of your medical records.

By providing Patient's e-mail address on the attached Appendix 2, you authorize the Practice, its staff, and its Providers to communicate with you by e-mail regarding your "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations). By inserting Patient's e-mail address in Appendix 2, Patient 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 Practice and the Providers will make all reasonable efforts to keep e-mail communications confidential and secure, neither the Practice nor the Providers can assure or guarantee the absolute confidentiality of e-mail communications; (c) in the discretion of the Provider, 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 regarding urgent or emergency situations, time-sensitive issues, or for inquiries regarding sensitive information. **In the event of an emergency, or a situation in which you could reasonably expect to develop into an emergency, you shall call 911 or the nearest Emergency room, and follow the directions of emergency personnel.**

Neither the Practice nor the Provider will be liable to you for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to you as a result of technical failures, including, but not limited to, (i) technical failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages, (iii) 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; or (v) your failure to comply with the guidelines regarding use of e-mail communications set forth in this Agreement.

10. Change of Law. If there is a change of any law, regulation or rule, federal, state or local, which affects this Agreement or the terms set forth on the attached appendices, which are incorporated by reference in this Agreement, or the activities of either party under the Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights, obligations or operations associated with the Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of the Agreement, including the terms set forth in the appendices attached hereto. If the parties are unable to reach an agreement concerning the modification of the Agreement within fifteen days after the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party.

11. Severability. If for any reason 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 that 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.

12. Amendment. Except as otherwise provided herein, no amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties hereto. Notwithstanding the foregoing, the Practice may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation (“Applicable Law”) by sending Patient 30 days advance written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by the Practice, except that you shall initial any such change at Practice request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

13. Miscellaneous. This Agreement, and any rights you may have under it, may not be assigned or transferred by you. This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted. Captions in this Agreement are used for convenience only and shall not limit, broaden, or qualify the text. This Agreement contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement. This Agreement shall be governed and construed under the laws of the State of Ohio and all disputes arising out of this Agreement shall be exclusively settled in the court of proper venue and jurisdiction for the Practice’s address in Cincinnati, Ohio. EACH OF THE PARTIES HERETO WAIVES ANY OBJECTION THAT IT MAY HAVE TO THE LOCATION OF THE COURT CONSIDERING THE DISPUTE. Patient acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Patient also acknowledges having had a reasonable time to seek legal advice regarding the Agreement and has either chosen not to do so or has done so and is satisfied with the terms and conditions of the Agreement.

14. Limits of Liability. With respect to each party’s obligations under this Agreement, neither party shall be liable to the other for consequential, incidental, indirect, punitive or special damages (including loss of profits, data, business or goodwill), regardless of the legal theory advanced or of any notice given as to the likelihood of such damages, and the Practice’s total aggregate liability to Patient shall not exceed the total fees paid by Patient hereunder.

15. Authenticity. Patient represents and warrants that (i) all information provided to the Practice is and will be accurate to the best of his or her knowledge, (ii) that all records submitted to the Practice for review relate to, and are the legal property of, the Patient, and (iii) that the care sought hereunder, and all information provided by Patient to the Practice, do not relate to any past, present, or contemplated litigation or adversary proceeding of any kind, unless otherwise noted in writing to Practice at the time the related information is provided to Practice.

[SIGNATURE PAGE FOLLOWS]

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

PRACTICE:

MD For Patients, LLC

Name: Mark Halsted, M.D.
Title: President

PATIENT:

Name:

Date:

DURABLE POWER OF HEALTH ATTORNEY
ACTING ON BEHALF OF PATIENT:

Name:

Date:

Appendix 1
Payment Terms

1. **Hourly Rate.** The fee for all time the Practice's physicians spend providing Services will be compensated at a rate of \$199 per quarter hour. The fee for all time the Practice's nurses spend providing Services will be compensated at a rate of \$49 per quarter hour. Any administrative time will be billed at \$39 per quarter hour.
2. **Document Retrieval / Copying Costs:** All direct costs charged by healthcare institutions to produce, reproduce, copy, send, ship, or otherwise share the Patient's health records will be paid by the Patient. Additionally, if Patient does not provide all necessary medical records to the Practice, and the Practice is required to acquire the same on Patient's behalf, the Practice shall charge a flat fee of \$199 for acquisition of medical records.
3. **Initial Payment; Credit Card On File.** The Practice will charge Patient's credit card an initial payment of \$500.00, against which the Practice will charge its fees hereunder. The initial payment is refundable if not spent. Unless Patient makes other arrangements with the Practice, Patient agrees to provide the Practice with a valid credit card to be kept on file, and hereby irrevocably authorizes the Practice to charge Patient's credit card on file for all the charges due hereunder.
4. **Monthly Billing Reports.** A billing summary is provided to the Patient once per month.
5. **Final Invoice.** At the conclusion of the Services, an invoice is provided to the Patient explaining the invoiced charges.
6. **Subpoenas; Expert Witness Work.** Any time required of Provider in connection with or arising out of the Services, whether pursuant to subpoenas, discovery, court proceedings, investigators, or otherwise, shall be billed at Provider's regular rates, plus an administrative fee.

Appendix 2

Fees as set out below shall apply to the following Patient, who by signing below agrees to the terms and conditions of the Patient Agreement, and represents and warrants that (i) they are the person described below, or the guardian of the same, (ii) the information contained herein is accurate to the best of his or her knowledge, and (iii) that all records submitted to the practice for review relate to and are the legal property of the following Patient.

Patient Printed Name	Date of Birth (MM/DD/YYYY)	Age
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Street Address	City	State, Zip
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Home Phone	Work Phone	Cell Phone
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Preferred email _____

Spouse's Name	Date of Birth (MM/DD/YYYY)	Age
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Home Phone	Work Phone	Cell Phone
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Child/Children to Whom this Agreement Applies:

Patient Printed Name	Date of Birth (MM/DD/YYYY)	Age
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Patient Printed Name	Date of Birth (MM/DD/YYYY)	Age
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Patient Printed Name	Date of Birth (MM/DD/YYYY)	Age
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I certify that I have read, understand, and agree to the terms set forth in the Patient Agreement. I further certify that I have received a copy of this form.

Signature: _____ Date: _____

Printed Name: _____

- ☐ Signing as Patient
- ☐ Signing on behalf of Patient as Patient's representative (please provide documentation of designation as Durable Power of Health Attorney)

Appendix 3 Medicare Opt-Out Agreement

This agreement (“Agreement”) is entered into by and between **MD For Patients, LLC**, a medical practice owned and operated by Dr. Mark J. Halsted, M.D. (the “**Physician**”), and the undersigned, a beneficiary enrolled in Medicare Part B (“Beneficiary”).

Introduction

The Balanced Budget Act of 1997 allows physicians to “opt out” of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, physicians are required to file an affidavit with each Medicare carrier that has jurisdiction over claims that they have filed (or that would have jurisdiction over claims had the physicians not opted out of Medicare). In essence, the physician must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years.

This Agreement between Beneficiary and Physician is intended to be the contract physicians are required to have with Medicare beneficiaries when physicians opt-out of Medicare. This agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

Physician Responsibilities

- (1) Physician agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.
- (2) Physician agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.
- (3) Physician agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.
- (4) Physician agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Physician also agrees to retain a copy of this document for the duration of the opt-out period.
- (5) Physician agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS) upon the request of CMS.

Beneficiary Responsibilities

- (1) Beneficiary agrees to pay for all items or services furnished by Physician and understands that no reimbursement will be provided under the Medicare program for such items or services.
- (2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Physician for such items or services.

(3) Beneficiary agrees not to submit a claim to Medicare and not to ask Physician to submit a claim to Medicare.

(4) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Physician that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

(5) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other physicians or practitioners who have not opted out of Medicare.

(6) Beneficiary understands that Medicare plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare.

(7) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

Medicare Exclusion Status of Physician

Beneficiary understands that Physician has not been excluded from participation under the Medicare program under section 1128, 1156, 1892, or any other sections of the Social Security Act.

Duration of the Contract

This contract becomes effective on _____, _____, and will continue in effect until _____. Either party may terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

Successors and Assigns

The parties agree that this agreement will be fully binding on their heirs, successors, and Assigns. Physician and Beneficiary intend to be legally bound by signing this agreement on the date set forth below.

Name of Beneficiary (printed): _____

Address of Beneficiary: _____

Signature of Beneficiary: _____

Date Signed: _____

Name of Physician (printed): _____

Signature of Physician: _____

Date Signed: _____

Appendix 4 Informed Consent

I understand that I am engaging MD For Patients, LLC (“MD For Patients”) not to serve as a primary caregiver, but instead to provide a second opinion regarding care for which the patient’s existing treating healthcare team has had, and will continue to have throughout the duration of this consultation, primary responsibility.

I have in so doing asked the specific questions that I want addressed by MD For Patients, and MD For Patients’ involvement in my care is expressly limited to providing answers to the questions that I have posed.

It is to be understood that the opinions rendered by MD For Patients, and the obligations of MD For Patients, will under this consulting engagement therefore be different from those that physicians are typically asked to provide in the usual course of providing first-line clinical care. I acknowledge and agree that there is no expectation that, unless expressly agreed, MD For Patients’ physicians will perform a complete review of any part of my medical records, including any diagnostic test(s) or imaging exams. Further, I agree and understand that a limited review contains inherent limitations and will not provide the same comprehensive assessment that a more fulsome review would.

For example, if the scope of my request of MD For Patients is to help me understand a term that was used in the original report of my diagnostic test, and I request a consultation from MD For Patients to perform this specific task and no other function, then MD For Patients is obligated only to address my specific question, and beyond this specific task, there is no other obligation or requirement that MD For Patients should review, examine, or render any opinion about the actual findings on that diagnostic test, nor should it provide a formal written report regarding those findings or their significance.

Similarly, if for example I ask MD For Patients to perform a focused, limited evaluation of only one or more specific parts of a diagnostic test, then in so doing I expressly release MD For Patients from any obligation to review the other elements of that test, and acknowledge that review of other elements of that test may have revealed the presence of other information, including significant and otherwise undisclosed risks to my health and wellbeing.

I, the undersigned, being informed of the risks of a limited review, and having read and having understood the information provided above, and having had the opportunity to discuss the same with my medical professional, do hereby give my informed consent for the provision of such limited review(s) as I may request in my medical care from MD For Patients.

Name:

Date: