GNQNC.INC
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Myneuro.care

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CONCIERGE NEUROLOGICAL CARE PATIENT AGREEMENT

This Concierge Neurological Care Agreement (the "Agreement") between you, the undersigned member ("You" or "Patient"), and GNQNC, INC. ("Company"), specifies the terms and conditions under which You may participate in Company's concierge neurological care services (the "Concierge Neurological Care"). This Agreement becomes effective on the date that You sign this Agreement or Company receives payment for the Concierge Neurological Care, whichever is later (the "Effective Date").

WHEREAS, the Patient identified below desires the unique services and benefits to be provided by Physician that are not covered or otherwise not reimbursable under a private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, in which Patient may be enrolled;

WHEREAS, the Company, through Galina Nikolskaya, M.D. ("Physician"), desires to provide such unique services and benefits to Patient for which neither Physician nor Company can, nor will, seek reimbursement under a private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, in which Patient is enrolled;

NOW, THEREFORE, by signing this Agreement, Patient and Physician hereby agree, as of the Effective Date, for valuable consideration, to enter into a contractual relationship for the provision of specified services and benefits under the following terms and conditions.

Arbitration: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this Agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Patient: A "Patient" is defined as those persons for whom Company shall provide services.

Concierge Neurological Care: The Concierge Neurological Care includes the following services ("Concierge Neurological Care Services"): Same or next day non-urgent appointments with a neurologist, with an option of being seen in Patient's own home; extended appointments; direct access to a neurologist via cell, text, portal, and email; botulinum toxin injections, occipital nerve blocks; electroencephalography interpretation; detailed educational services, including education on the latest advancements in neurology and in-depth explanation of brain and spine imaging, EMG/NCS interpretation, and lab work results **[NOTE TO CLIENT:** the Concierge Neurological Care Services you list must **only** be items and services that are **not covered by Medicare**. If Medicare covers botox, nerve blocks, EEG, etc., delete those items from your description of services.**]**

Concierge Neurological Care Fee: Patient will pay an annual fee ("Concierge Neurological Care Fee") of $ 3000 to Company as valuable consideration for the Concierge Neurological Care. Company may change the Concierge Neurological Fee from time to time in its sole discretion, by 30 days' advance written notice to Patient.

Billing: The initial Concierge Neurological Care Fee processed at the time of enrollment. Subsequent payments are billed quarterly, semi-annually or annually, as elected by the Patient and approved Company. Upon execution of this Agreement, Patient will have 3 business days to rescind this agreement. After 3 days, Patient shall be responsible for the full extent of the Concierge Neurological Care Fee. If Patient cancels participation after the 3 days for any reason whatsoever, Patient will receive no refund.

Payment Security: To the extent that the Patient provides Company with credit card(s) information for payment on Patient's account, Company shall be authorized to charge Patient's credit card(s) for any charges on the dates such amounts become due, without separate authorization in order to do so. Patient will not make any chargebacks to Company's account or cancel or change the credit card that is provided as security without Company's prior written consent. Patient is responsible for any fees associated with recouping payment on chargebacks and any collection fees associated therewith.

Patient Acknowledgement and Conditions of Participation: Patient acknowledges that Company does not participate in health insurance plans. Fees paid under this Agreement are not covered by your health insurance or other third party payment plans applicable to the Patient. The Patient shall retain full and complete

responsibility for any such determination. The Concierge Neurological Care Services are not covered or otherwise reimbursable under any private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, in which Patient is enrolled. Accordingly, Patient understands and acknowledges that the Concierge Neurological Care Services convey value and benefits that Patient does not already receive under any private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, in which Patient is enrolled. To the extent any one or more of the Concierge Neurological Care Services are considered covered and reimbursable benefits, the Concierge Neurological Care Fee is consideration for the remaining items of Concierge Neurological Care Services.

The list of Concierge Neurological Care Services may be amended or modified to the extent necessary to reflect any change in interpretation or terms of coverage and benefits of any private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, in which Patient is enrolled. In such case, Company will provide you with written notice of the changes.

For Concierge Neurological Care Services provided hereunder, Patient and/or Physician and/or Company cannot and will not bill or seek reimbursement from any private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, in which Patient is enrolled.

Company and Physician may also provide services to Patient that are covered or reimbursable from a private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, in which Patient is enrolled, under the terms and conditions of Patient's enrollment with such payor(s). Physician may also seek reimbursement from Patient as permitted under Patient's enrollment agreement with such payor(s) (*e.g.*, deductibles, coinsurance, or copayments). Patient understands and acknowledges that any covered and reimbursable services are separate and distinct from and independent of the Concierge Neurological Care Services provided herein.

Not Insurance: You understand that this Agreement is not an insurance plan, not a contract for health insurance, and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). This Agreement will not cover hospital services, or any services not included in the Concierge Neurological Care Services. In the event of an emergency, Patient should call 911 or the nearest emergency room, and follow the directions of emergency personnel.

Renewals and Termination: The Concierge Neurological Care Fee covers a period of **one (1) year** (the "Term"). Unless otherwise terminated, this Agreement will automatically renew for additional one (1) year periods upon the expiration of each Term. Patient or Company may terminate this agreement at any time effective upon 30 days written notice to the other. If Patient or Company terminates this Agreement for any reason prior to the end of the Term, Patient will be entitled to a prorated refund of the Concierge Neurological Care Fee. The proration is calculated based on the effective date of termination, and there are no financial penalties to You. In the event that Patient is in arrears of payment or otherwise in default of this Agreement, all payments due hereunder shall be immediately due and payable. Company shall be allowed to immediately collect all sums from Patient and may terminate providing further services to Patient.

Communications. You acknowledge electronic communications with the Physician are not secure or confidential methods of communications. As such, you expressly waive the Physician's obligation 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 email address, Patient authorizes the Company and Physician to communicate with Patient by email regarding Patient's protected health information ("PHI") (as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations) Patient acknowledges that:

(a) Email is not a secure medium for sending or receiving PHI and a third party will have access;
(b) Although the Physician will make all reasonable efforts to keep email communications confidential and secure, neither Company nor the Physician can assure or guarantee confidentiality of email communications;
(c) In the discretion of the Physician, email communications may be made a part of Patient's permanent medical record; and
(d) Patient understands and agrees that email is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. In the event of an emergency, or a situation in which the Patient could reasonably expect to develop into an emergency, Patient shall call 911 or the nearest emergency room, and follow the directions of emergency personnel. If Patient does not receive a response to an e-mail message, Patient agrees to use another means of communication to contact the Physician. Neither Company nor the Physician will be liable to Patient

for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient.

Change of Law: If there is a change of any law, regulation or rule, federal, state or local, which affects 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. If the parties are unable to reach an agreement concerning the modification of the Agreement within thirty days after of date of the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party.

Severability: In the event that any provision of this Agreement, or the application thereof, becomes or is declared by a court of competent jurisdiction to be illegal, void or unenforceable, the remainder of this Agreement shall continue in full force and effect and the application of such provision to other persons or circumstances shall be interpreted so as reasonably to effect the intent of the Parties. This Section shall survive termination or expiration of this Agreement.

Entire Agreement; Amendment: The undersigned agrees to the terms of this Agreement, all of which are expressed herein. There are no promises or representations except as set forth in the Agreement. No amendment of this Agreement shall be binding on a party unless made in writing and signed by all parties. Notwithstanding the foregoing, Company may unilaterally amend this Agreement to the extent required by law or regulation by sending Patient advance written notice of any such change; any such changes are incorporated into this Agreement by reference without the need for signature by the parties and are effective as of the date established by Company.

Telehealth: Patient acknowledges that Company and Physician may provide certain Concierge Neurological Care Services via telemedicine/telehealth. Patient shall execute Company's Informed Consent for Telehealth Services, attached hereto as Exhibit A and incorporated herein by this reference.

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

Miscellaneous; 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.

Disclaimer of Guarantee: Although Company aims to enhance overall health and wellness which can lead to good outcomes, neither Company nor Physician makes any guarantee or warranty that the Concierge Neurological Care will meet Patient's expectations or that Patient will achieve the desired results, or any particular result (including, for example, cure of a particular disease).

Clear understanding: You acknowledge that the terms of this Agreement are clear and that no undue pressure has been exerted on You to sign this Agreement.

Governing Law: This Agreement shall be governed by and construed in accordance with laws of the State of California without regard to California's choice of law provisions.

Arbitration: In the event that any dispute arises between the parties arising out of or related to the validity, interpretation, enforcement, or performance of this Agreement, or otherwise arising out of the relationship between the parties or the termination of that relationship, and a party wishes to pursue the dispute, such party shall submit the dispute to binding arbitration in accordance with the Commercial Rules of the American Arbitration Association ("AAA"). The Arbitration shall be held in Los Angeles County, California. The arbitrator(s) shall apply California substantive law, or federal substantive law where state law is preempted. Civil discovery for use in such arbitration shall be conducted in accordance with the provisions of California law that would apply if the matter were being litigated in a Superior Court of the State of California. The arbitrator selected shall have the power to enforce the rights, remedies, duties, liabilities and obligations of discovery by the imposition of the same terms, conditions and penalties as can be imposed in like circumstances in a civil action by a court of competent jurisdiction of the State of California. The provisions of California law governing discovery in a civil action filed in Superior Court of the State of California (including without limitation depositions) are incorporated herein by reference and made applicable to this Agreement. The arbitrator shall have the power to grant all legal and equitable remedies provided by California law and award compensatory damages provided by California law, except that punitive damages shall not be awarded. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based. The arbitrator shall not have

the power to commit errors of law or legal reasoning. Any judicial review of the arbitrator(s) decision shall be governed by California Code of Civil Procedure, Sections 1285 et seq., except that the parties expressly grant the Superior Court the authority to correct errors of law, and modify the arbitrator's ruling to avoid errors of law. EACH PARTY HAS READ AND UNDERSTANDS THIS SECTION, WHICH DISCUSSES MEDIATION AND ARBITRATION. EACH PARTY UNDERSTANDS THAT BY SIGNING THIS AGREEMENT, THE PARTY AGREES TO SUBMIT ANY CLAIMS ARISING OUT OF, RELATING TO, OR IN CONNECTION WITH THIS AGREEMENT, OR THE INTERPRETATION, VALIDITY, CONSTRUCTION, PERFORMANCE, BREACH, OR TERMINATION THEREOF TO MEDIATION AND ARBITRATION, AND THAT THE DISPUTE RESOLUTION PROVISIONS SET FORTH IN THIS SECTION CONSTITUTE A WAIVER OF THE PARTY'S RIGHT TO A JURY TRIAL.

Patient may rescind his/her agreement to arbitrate within 30 days of Patient's execution of this Agreement.

(Signature page follows)

NOTICE: BY SIGNING THIS AGREEMENT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

By signing below, Patient and Company represent that they fully understand and freely covenant to accept their rights and obligations under this Agreement.

_____
Print Patient name

_____
Signature

_____
Date
Patient address:

_____
_____
_____

GNQNC, INC.

_____
By: Galina Nikolskaya, MD
Its: President
Date: _____

EXHIBIT A
Informed Consent for Telehealth Services

GNQNC, INC. (the "Company") offers certain medical services through telehealth technologies. Telehealth is a mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of health care, while patients and their health care providers are in different sites. Telehealth involves the use of technology to enable remote communications between and among health care providers and patients.

While telehealth may improve access to care and lead to more efficient diagnosis, treatment, and care management, there are potential risks associated with telehealth, as there are with any medical treatment or procedure. The potential risks associated with telehealth include, but are not limited to, insufficient transmission of information that does not allow for appropriate decision-making and diagnosis by the health care provider; delays in diagnosis, consultation, and/or communication due to deficiencies or failures of equipment or systems; failure of security protocols, resulting in a breach of privacy of personal health information; or adverse results or reactions due to lack of access to complete medical records.

By signing this informed consent, I understand the following:

1. I understand that the details of my telehealth interaction, which may include oral, visual, and electronic communications between me and my health care provider, will become part of my medical records, as such details would for any other type of face-to-face interaction with a health care provider.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to treatment or care in the future.
3. I understand that it is my duty to inform my health care provider of my medical history and details regarding my condition in order for Company's health care providers to provide the best care possible.
4. I understand that I may expect certain anticipated benefits of the use of telehealth by my health care providers, but that no outcomes or results are guaranteed.
5. I understand that telehealth-based services may not be as complete or appropriate as face-to-face interactions under certain circumstances, and my health care provider may refer me to another health care provider for follow-up or additional care.
6. I understand that nothing within this consent precludes me from seeking or receiving in-person care if I choose, even after consenting to receive services via telehealth.

I have read and understand the information provided above regarding telehealth, including the potential risks. I have had the opportunity to discuss the use of telehealth with my Company health care provider and to ask questions regarding the use of telehealth, and all of my questions have been answered to my satisfaction.

By signing below, I hereby provide my consent to engage in telehealth with Company's health care providers and authorize Company's health care providers to use telehealth in the course of my diagnosis and treatment.

_____
Print Patient Name: _____
Date:_____

The undersigned health care provider initiated the use of telehealth with the patient, informed the patient of the risks of telehealth interactions, answered all questions from the patient, and obtained verbal or written consent from the patient for the use of telehealth.

_____
Print Provider Name: _____
Date:_____