PATIENT SERVICES AGREEMENT

(Disability Benefits Questionnaire Evaluation)

This patient services agreement is between TP-HEALTH, INCORPORATED, TP-HEALTH CA PC AND TP-HEALTH TX PC, ("**Company**"), and_____ __ _____ __ ___ __ _____, an individual ("**Veteran**").

Veteran desires to obtain from Company certain services supporting Veteran's own effort to obtain reevaluation of his or her disability rating, and Company agrees to provide services to Veteran, according to the terms of this agreement. Accordingly, Veteran remains solely responsible for making all of his or her own decisions and filings regarding veteran claims matters.

The parties agree as follows:

1. **Medical Review Services.** In consideration of the fee set forth in this agreement, Company agrees to provide Veteran certain services ("**Services**") including access to medical providers independent of the VA in order to complete their DBQ's. Company does not file claims on behalf of clients nor assist with the presentation, production, or prosecution of claims. [[d|1]]

2. **Medical Review Fee.** Veteran agrees to pay Company $400 for a psychiatric DBQ. Additionally, Veteran agrees to pay company $450 for medical DBQ's. The medical DBQ fee includes up to 3 DBQ's. Additional DBQ's (four or more) will be charged at $100 per additional Disability Rating questionnaire (the "**Evaluation Fee**). Opinion letters will be charged at $75 p e r opinion. Please note, mental and medical services are treated as two separate services as it requires two separate providers, a psychiatric and an internal medicine/family medicine provider respectively. Veteran shall pay Company before scheduling an appointment. The Evaluation Fee is not contingent upon the result of the Claims Process. As a courtesy to others and the providers, Company requires a 24-hour cancellation notice if Veteran is unable to attend the scheduled appointment. Veteran must notify Company of any cancellation at least 24 hours in advance. Failure to give such advanced notice will result in paying an additional Evaluation Fee for any new evaluation appointment and no fee will be refunded. With such advanced notice, Veteran may reschedule such appointment at the mutual agreement between Company and Veteran. The Evaluation Fee is nonrefundable.

3. **Relationship of the Parties.** Company does not represent Veteran and has no authority for or over Veteran in any capacity, including with respect to the VA, the Claims Process, or any related benefit. Company is not in any way responsible for finalizing, approving, or filing Veteran's VA claim or any paperwork associated therewith, or for communicating in any fashion with the VA on Veteran's behalf. The Services are not and may not be construed as assistance with or representation as to the filing of Veteran's VA claim, Disability Rating, or any benefit entitlement. Veteran understands and acknowledges that Company's knowledge is comprised of publicly available information, which may be equally available to Veteran.

4. **General Provisions.**

4.1 **No Waiver.** A waiver by either party of any of the terms and conditions of this agreement in any instances shall not be deemed or construed to be a waiver of such term or condition for the future, or of any subsequent breach thereof, or of any other term and condition of the agreement.

4.2 **Notice.** Any notice, request, demand or other communication permitted to be given hereunder shall be in writing and shall be deemed to be duly given when personally delivered to said person, if party is an individual, or if an entity, an executive officer of the notified party, as the case may be, or when deposited in the United States mails, by certified or registered mail, return receipt requested, postage prepaid, at the respective addresses of each party as described below. A party may change, by written notice transmitted in the manner prescribed above, the address to which notices are to be sent.

Company:
110 S Gordon St Alvin, TX
77511-2333

Veteran:

_____

_____

_____

4.3 **Indemnification.** Each party shall defend, indemnify and hold harmless the other party, including affiliates and each of their respective officers, directors, shareholders, employees, representatives, agents, successors and assigns from and against all claims of third parties, and all associated losses, to the extent arising out of (a) a party's gross negligence or willful misconduct in performing any of its obligations under this agreement, or (b) a material breach by a party of any of its representations, warranties, covenants or agreements under this agreement.

4.4 **Mediation.** If a dispute arises from or relates to this agreement or the breach thereof, and if the dispute cannot be settled through direct discussions, the parties agree to endeavor first to settle the dispute by mediation.

4.5 **Governing Law.** This agreement shall be construed, interpreted, and enforced in accordance with the laws of the state of Texas.

4.6 **Venue.** The parties agree that all disputes related to this agreement shall be resolved exclusively in Texas in Harris County.

4.7 **Copies and Counterparts.** This agreement may be executed in multiple originals or counterparts, each of which shall be deemed to be an original but all of which shall constitute one and the same document. If any signature is delivered by facsimile transmission or by e-mail delivery of a ".pdf" format data file, such signature shall create a valid and binding obligation on the party executing the same (or on whose behalf such signature is executed) with the same force and effect as if such facsimile or ".pdf" signature page were an original thereof.

4.8 **Entire Agreement.** This agreement embodies the entire agreement of the parties relating to the subject matter hereof.

4.9 **Effective Date.** This agreement will become effective when all parties have signed it. The date of this agreement will be the date this agreement is signed by the last party to sign it (as indicated by the date associated with that party's signature).
Each party is signing this agreement on the date stated adjacent to that party's signature

Company:

TP-HEALTH, INCORPORATED/TP HEALTH CA PC/TP HEALTH TX PC

By:_____
Name:_____
Title:_____
Date:_____

Veteran:

_____
_____

AUTHORIZATION FOR RELEASE OR USE OF PROTECTED HEALTH

INFORMATION TO VETERAN BENEFITS CENTER **(the "Consultant")**

Name of Patient:	
Date of Birth:	
Social Security Number:	
Phone Number:	
Email Address:	
Street Address:	
City, State, Zip	
ITF EXPIRATION	

1. Authorization for Use and /or Disclosure. By my signature below I authorize the TP-Health, Incorporated and its officers, directors and employees (the "**Provider**") to receive, use and disclose my protected health information ("**PHI**") to Consultant and the employees and independent contractors of Consultant for the purpose of performing services on my behalf.

2. Information to be Used and/or Disclosed. I authorize the use and disclosure of any and all PHI I provide directly to Provider or which Provider obtains under a separate authorization for release of PHI that I may sign in the future, to allow Consultant to obtain PHI about me from any source other than me. Such PHI includes any and all medical records, including every page thereof, including but not limited to office notes, face sheets, history and physical, consultation notes, inpatient records, outpatient records, emergency room records, all clinical charts, order sheets, progress notes, nurses notes, doctors' orders, treatment plans, admission records, discharge summaries, requests for and reports of consultations, correspondence, test results, statements, questionnaires and histories, photographs, imagining including CT scans, MRIs, X-rays, sonograms, videotapes, telephone messages, billing records, pharmacy/prescription records, etc.

3. Consent to Release and Use of Specially Protected PHI. I understand that my express consent is required to authorize the use or disclosure of certain records, including information related to testing, diagnosis and/or treatment for HIV (the AIDS virus), sexually transmitted diseases, psychiatric, psychological or mental health disorders or treatment, or drug and/or alcohol use and treatment. I understand that the information to be used or disclosed pursuant to this authorization may include such information. By my separate signature affixed here, I confirm that this authorization is effective as to such records and PHI and I authorize the use and disclosure of this type of information.

4. Term of Authorization and Right to Revoke. This authorization shall be valid until the following time until there is a final determination of my Disability Rating and benefits by the VA or until revoked. I understand, in addition, that I have the right to revoke this authorization at any time by a notice delivered to Consultant and Provider in writing, except to the extent that PHI has already been released in reliance upon this authorization.

5. Acknowledgment of Possibility of Re-disclosure. I understand that once the information released pursuant to this authorization is received by the recipient, whether Consultant or a third party, it may be re-disclosed and no longer protected under Privacy Laws. I agree to hold Provider its directors, officers and employees harmless from any claim for damages that may occur thereby.

6. Copies As Effective as Original. Any facsimile, copy or photocopy of this authorization shall be as effective and enforceable as the original.

7. Authorization Not A Requirement of Services. I sign this Authorization voluntarily and I understand that signing this authorization is not required.

8. Consent: I give my consent to TP-Health and affiliates to contact me via text message and email.

AUTHORIZATION AND AGREEMENTCONFIRMED BY SIGNATURE BELOW:

_____ _____

Signature of Client/Patient or Legally Authorized Representative Date

If signed by Legal Representative:_____

Print Name of Legally Authorized Representative of Representative

Relationship to Patient or Legal Authority