DIRECT PEDIATRIC CARE AGREEMENT

Direct Pediatric Care. Direct Pediatrics, Inc. (DPC) is an innovative alternative payment model improving access to high functioning healthcare with a simple, flat, affordable membership fee. No wrestling with insurance denials or co-pays when you need care. In DPC there is a flexible and trusting relationship between you, your children and the pediatric care providers. Patients have extraordinary access to pediatric care for a monthly or annual fee. Our providers are accountable first and foremost to you so you can focus on keeping your child healthy, not on skyrocketing healthcare costs.

Services Provided. Practice provides general pediatric care for patients. Direct Pediatrics accepts new patients from 0-18 years of age. Patients still in college up to the age of 22 will continue to be seen based on the physician's discretion. A detailed list of services provided is attached to this Agreement. Additional fees may be required for specialty services, laboratory testing, or medications. Please ask the front desk for a list of services which may have an additional charge.

Volume of Services. We do not limit the number of visits your child may need on the attached service list. Additional services beyond those listed in the attached service schedule may require additional payment.

Fees. In exchange for Services, You agree to pay Practice a) the monthly fee billed on a quarterly basis; b) the Enrollment Fee of $150; and c) any additional Itemized Charges for laboratory services or medication/supplies (collectively "Fees"). Patients who leave the practice and return more than three (3) months later will be charged a re-enrollment fee of $250.

Payments will be made in advance on the 25th day of the preceding quarterly payment. Patients who pay annually in full will receive a 5 percent discount on the membership fee. Patients who elect to use a credit card for payment will be charged a credit card processing fee of 3%. The Fees are outlined as an attachment.

If it is necessary for you to pause your membership due to an absence for three or more months, please speak to the office manager right away to make appropriate arrangements.

Practice reserves the right to change the quarterly fee or the services covered by the annual fee at its discretion. Patients will be given ninety (90) days notice of any fee or service changes.

Practice is not an Insurance Company. The parties agree that the fees paid to Practice are payments for medical services and not contributions to a Health Savings Account (HSA) or premium payments to a health plan or health insurance company.

Cancellation and Refund Policy. You can cancel your membership at any time and the membership will be terminated at the end of the quarter (90 days).. There is no cancellation fee or charge. Your eligibility to Services begins the day you make Your first membership payment, unless we otherwise agree in writing, and continues monthly thereafter so long as you continue making timely payments when due. Refunds are made at the discretion of the practice and if made are only as a credit for future quarters (90 days) of service.

Non-Participation in Health Insurance. You acknowledge that neither Practice, nor the Provider(s) participate in any private health insurance or HMO plans, including Medicaid. Neither Practice nor its Provider(s) make any representations regarding third party insurance reimbursement of fees paid under this Agreement, and such reimbursement is not anticipated by this Agreement.

Non-Participation in Medicaid. You specifically acknowledge that pursuant to state law, Practice and its Provider(s) do not participate in the state's Medicaid program and have opted out of or are not covered by Medicare. Under state law, non-participating healthcare providers cannot provide medical services to Medicaid or Medicare recipients without permission being given by Medicaid or Medicare. This means that Medicaid and Medicare cannot be billed for any services performed under this Agreement unless your state has agreed to allow DPC payments. By signing this Agreement, you specifically acknowledge and agree that your child is not currently a Medicaid or Medicare recipient and that if the child becomes a Medicaid or Medicare recipient in the future, you will promptly notify Practice and discontinue your membership. In such a case, any unearned Monthly Fee will be refunded.

In some cases, Practice can provide care to a child who is covered under a federal or state disability waiver or who has a state Medicaid plan that allows for DPC care. Please notify the front desk if your child has a waiver of any kind or you want to see whether state Medicaid allows DPC care to your child.

Provider Access. Practice gives you multiple ways to contact your provider. We ask that the first visit be in-person where possible so we can get to know you and your child. A telehealth visit including video may fulfill this in-person requirement at the discretion of the provider. Later visits can include telehealth or phone call visits at the discretion of the provider and with patient consent.

Scheduling. Practice has scheduled office hours. In some cases, after hours or weekend visits may be available. Please check the Practice schedule on the social media platform and/or office website to determine any changes from standard office hours. If you need care after hours in a life threatening emergency, please contact 911 or your local hospital.

Consent to Treat. Your signature on this document authorizes Practice to use and/or disclose health information which specifically identifies your child, or which can reasonably be used to identify your child, to carry out treatment, payment, and healthcare operations. Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the administration and use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable for treatment, including but not limited to diagnostic procedures, the taking and utilization of cultures, and of

other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable. You have the right to ask what treatment entails in advance and to seek care elsewhere if you disagree with your Provider's recommendations.

No Guarantee of Outcome. Your child's good health is our goal. We work hard to help your child get well and stay well. Healthcare is based on a number of factors and we cannot guarantee any particular outcome.

Referrals. In some cases your child will need care that is outside our scope. In those cases we will provide you with a referral to a specialist or hospital. You are responsible for paying for any care provided by a specialist or hospital.

Outside care. In some cases you may decide to take your child elsewhere for care. You are responsible for all charges associated with care rendered by outside providers.

Prescriptions. Our Practice may be able to provide you medication for some common childhood illnesses. Where those are available you will receive a prescription that we may be able to fill directly. Pricing for medications we can provide is available from the Office Manager. Other prescriptions can be filled at a pharmacy of your choice. Outside pharmacy charges are your responsibility.

Controlled substances. Some medications your child may need are considered controlled substances. Our providers have DEA licenses to prescribe those medications where appropriate. There may be required lab testing or pill counts for patients who receive controlled substances. Our providers reserve the right to determine whether a controlled substance is appropriate to your child's care.

Term and termination. This Agreement continues on a quarterly basis until it is canceled by either party, or the minor child reaches the age of 22 or is approved by the Physician.

Termination of this agreement can be made by patient/guardian or practice providing ninty (90) days written notice prior to the end of each quarter to the other party. 90 days after receipt of written notice of termination, Practice will cease billing you. You are responsible for monthly payments with due dates of less than 90 days after your written notice of termination.

This Agreement will be terminated immediately for nonpayment of premium. No notice is required before a nonpayment cancellation.

Not an insurance company. Practice is not an insurance company. The fees you pay for Direct Pediatric Care each month are not insurance premiums. We encourage you to maintain insurance that will cover care by specialists or hospitals outside the Direct Pediatric Care agreement.

Anti-Referral Laws. Nothing in this Agreement, nor any other written or oral agreement, nor any consideration in connection with this Agreement, contemplates or requires or is intended to induce or influence the admission or referral of any patient to or the generation of any business between Practice and any other person or entity. This Agreement is not intended to influence any provider's professional judgment in choosing the appropriate care and treatment of patients.

Assignment. This Agreement, and any rights you may have under it, are not assignable or transferable. This Agreement applies only to you and your child.

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.

Choice of law and jurisdiction. This Agreement is governed by Kentucky law regardless of choice of law provisions. Jurisdiction for any action related to this Agreement is in the Commonwealth of Kentucky unless otherwise required by the Medical or Nursing Board in the patient's state of residence.

Non-Discrimination. Under no circumstances will Practice discriminate against you or your child, or terminate this Agreement, on the basis of sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status, or any other protected status. Practice reserves the right to accept or decline patients based upon our capability to appropriately manage the pediatric care needs of our patients.

Notices. Any notices or payments required or permitted to be given under this Agreement shall be deemed given when in writing, by electronic transmission, hand delivered, or with proof of deposit in the United States mail. All notices shall be deemed delivered on the date of actual delivery.

Effective Date. This Agreement is effective on the date you sign it. You can begin receiving services immediately after signature.

PATIENT ACKNOWLEDGEMENTS

Please read each line carefully and initial to indicate your agreement with the statement.

____ I acknowledge that Practice has advised me to maintain health insurance for coverage of certain services not specifically provided for in this Agreement.

____ I acknowledge that this agreement is not a contract that provides health insurance.

____ I do not expect Practice to file or issue any third party insurance claims for care rendered on my child's behalf.

____ My child is not a Medicaid or Medicare recipient or my state's Medicaid allows care of my child by the Practice.

____ I understand that this Agreement does not fulfill the Affordable Care Act's requirements for insurance coverage.

____ I understand that if I fail to make timely quarterly payments, this Agreement will be

terminated on the due date of such nonpayment.

____ I understand that if my payment by check or automatic debit is not honored, this Agreement will be canceled on that date.

____ I agree to pay all costs for specialty, lab or medication charges that are not covered within the scope of service listed on the fee schedule attached to this Agreement.

Name(s) of Minor Children:

_____

_____ _____

Parent or Guardian Date

_____ _____

Practice Representative Date

Attachment: Fees

Our fee is $165 per month per child with a family monthly max of $500.

One-time Registration Fee: $150 per family

Monthly Membership paid on an annual basis in advance of the year with 5% annual discount: $1881

Re-enrollment Fee: $250 (if Membership is terminated)

Itemized Fees: (anything purchased through the Practice and not covered by the Membership Fee.)

Attachment: Services

These services are included in the monthly fee paid for direct pediatric care:
- Access (eg, 24-7 via phone with the Physician)

- Home visits for newborns (living within 5 miles of the office) for first two months of life

- All well visits (check-ups are in-person)

- Unlimited sick visits (in-person or virtual)

- In-office testing for strep throat, flu, RSV, and COVID

- Administration of all routine vaccinations

- School/camp/sports physical forms

- Management of minor trauma, injuries, and lacerations (splinting, glue, wound management)

- Developmental and behavioral screenings

- Counseling and guidance (nutrition, development, sleep, toileting, behavior, parenting, and more)

- Management of chronic conditions such as asthma

- Care coordination for diagnostic testing, specialty care, emergency care and hospital care as is common for a general pediatrician

ADVANCE BENEFICIARY NOTICE

PATIENT NAME:_____

PARENT/GUARDIAN NAME:_____

COVERAGE: Practice is a direct patient care Practice. We do not take insurance for our services and we are not in network with any insurance payors or plans

You might have health insurance that may cover some or all of your costs for treatment for some of the services offered by Practice if you went to a provider who is in network with your health insurance company.

Practice has explained to you that it does not bill any insurance companies as "in network". No co-pays or deductibles will be reported to your health insurance by Practice.

You have asked Practice not to bill your insurance company and you agree that Practice's services will not be paid by your insurance. Practice has explained its services to you.

Parent/guardian affirms by signature hereon that the patient/child is not covered by Kentucky Medicaid as a primary payor.

SERVICES AND CPT CODES: The services to be offered are general pediatric care. A list of the services to be rendered to your child are available from the front desk.

ESTIMATED COST: The cost of care is included in the monthly Direct Pediatric Care payment. Lab services, certain medications and specialty care may require an additional charge. A list of those charges is available from the front desk.

WHAT YOU NEED TO DO NOW:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- If you have questions on this notice or the billing policy of your insurance company, please call the number on the back of your insurance card.

- SIGNING MEANS THAT YOU HAVE RECEIVED AND UNDERSTAND THIS NOTICE AND AGREE TO PAY FOR THE SERVICES RENDERED

_____

Print Name Date

_____

Signature

Direct Pediatrics

Telehealth consent to Treat

What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner. You can talk to your provider from any place, including your home. You don't have to take your child to the Practice for care.

You have the right to decline telehealth visits and ask if you can be seen in the office. Your provider has the right to tell you that an in-office visit is necessary for your care.

In some circumstances you and the provider will decide that a telehealth visit is the best for the patient. You can stop using telehealth any time, even during a telehealth visit, if it is not working for you/the patient. You can request an office visit if you do not want to use telehealth for care. The cost of a telehealth visit is included in your Direct Pediatric Care payment.

Practice will not record visits with your provider. Your provider will tell you if someone else from their office can hear or see you. Practice uses telehealth technology that is designed to protect your privacy.

Your provider will discuss telehealth and your consent with you at your first visit.

Signing this consent form means that you agree that: You understand what telehealth is and want to be able to use telehealth for your care or the care of your child. You recognize that you will discuss telehealth with your provider or Practice staff and that those individuals can answer any questions you have. Your signature shows that you want to use telehealth for visits where appropriate.

Your name (please print) Date

Name of Minor Date

Guardian Signature Date

Privacy Notice

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll

provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice 10/1/2023

Questions about this Notice should be directed to the front desk, who will refer you to the responsible management individual.