Midwest Regional Health Services

YOUR HOME FOR BETTER HEALTH

DIRECT CARE AGREEMENT

THIS DIRECT PRIMARY CARE AGREEMENT (the "Agreement") is made and entered into on _____, 201___ (the "Effective Date"), by and between MIDWEST REGIONAL HEALTH SERVICES, LLC, a Nebraska professional limited liability company ("MRHS"), and _____ ("Patient").

PRELIMINARY STATEMENTS

WHEREAS, MRHS is a medical practice providing primary care in the areas of internal and family medicine through its employees and physicians (the "Business"). As part of the Business, MRHS provides direct primary care to those of its patients who enroll in MRHS' Direct Primary Care Plan ("DPC Plan") under a Direct Primary Care Agreement. MRHS operates the Business at 2727 S. 144th St., Suite 280, Omaha, Nebraska 68144, and 818 Village Square, Gretna, Nebraska 68028 (each a "Location" and collectively the "Locations").

WHEREAS, MRHS desires to provide direct primary care to the Patient, and Patient desires to receive direct primary care from MRHS under the DPC Plan, pursuant to the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and good and valuable consideration, MRHS and Patient hereby agree as follows:

1. **Plan Services.** As used in this Agreement, the term "Plan Services", shall mean the package of services, both medical and non-medical, offered by MRHS from the Locations under this Agreement, and set forth in Appendix A, attached to this Agreement and incorporated by this reference.

2. **Patient.** As used in this Agreement, "Patient" means the individual who has signed this Agreement and those other individuals who are identified on Appendix B, a copy of which is attached hereto and incorporated by this reference.

3. **Term; Renewal.** The initial term of this Agreement (the "Initial Term") shall be for one (1) year, commencing on the Effective Date and ending at 11:59 p.m. on the day immediately preceding the anniversary of the Effective Date. This Agreement will renew automatically for successive one (1) year terms (each a "Renewal Term"), unless at least thirty (30) days prior to the anniversary of the Effective Date or any subsequent anniversary thereof, either party will have given notice to the other party that the Agreement will terminate on the last day of the then current term. Notwithstanding anything herein to the contrary, this Agreement may be sooner terminated during the Initial Term or any Renewal Term as hereinafter provided.

4. **Termination.** Notwithstanding anything to the contrary in this Agreement, either party may terminate this Agreement at any time upon thirty (30) days written notice to the other party. In addition to the termination rights under this Section 4, MRHS shall have a right to terminate under Section 9, and Patient shall have a right to terminate under Section 17. In the event of termination, all rights, duties and obligations of the parties shall cease effective with the date of termination; provided, however, that Patient may be entitled to a refund through the date of termination pursuant to Section 6.

5. **Plan Fee.** In exchange for the Plan Services provided to Patient during the term of this Agreement, Patient agrees to timely pay MRHS the amount as set forth in Appendix A (the "Plan Fee"). As more fully laid out in Appendix A, the Plan Fee is payable in monthly installments over the Initial Term and any Renewal Term(s) of this Agreement, with the first monthly installment due upon the execution of this Agreement and each successive monthly installment being due no later than the fifth (5^{th}) business day of each month thereafter. Patient agrees that MRHS shall have the right to change the amount of the Plan Fee at MRHS' sole discretion by giving sixty (60) days notice of the change to Patient. If Patient does not agree with the amount of the changed Plan Fee, Patient shall have the right to terminate the Agreement pursuant to Section 4 of the Agreement.

6. **Refund.** If this Agreement is terminated by either party in accordance with this Agreement on a date other than the end of the current term, MRHS shall review and settle the Patient's account by refunding to Patient the unearned portion of the Plan Fee on a per diem basis calculated based on the remainder of the month in which the termination occurs and for which payment has been received. Any amount of repayment shall be made on before the later of (i) the date of termination, or (ii) thirty (30) days after the date on which the non-terminating party receives notice of the termination. Furthermore, if this Agreement is held to be invalid for any reason, and if MRHS is therefore required to refund all or any portion of the Plan Fee paid by Patient, Patient agrees to pay MRHS an amount equal to the reasonable value of the Plan Services actually rendered to Patient during the period of time for which the refunded Plan Fee was paid.

7. **NOT A HEALTH INSURANCE SUBSTITUTE.** Patient understands that this Agreement and the benefits described herein IS NOT health insurance or a substitute for health insurance. Patient recognizes that this Agreement does not replace any existing or future health insurance or health plan coverage that Patient may carry. The Agreement does not include hospital services, or any services not personally provided by MRHS and described as a Plan Service in Appendix A. Patient acknowledges that MRHS has advised the patient to obtain or keep in full force, health insurance that will cover the Patient for healthcare not personally delivered by MRHS under this Agreement, and for hospitalizations and catastrophic events.

8. **Nonparticipation in Insurance.** Patient understands that MRHS will not bill insurance carriers, Medicare, or Medicaid for the Plan Services rendered under this Agreement. MRHS makes no representation that the Plan Fee paid under this Agreement is covered by the Patient's health insurance or other third party payment plans. Patient may submit bills for the Plan Fee to Patient's health insurance provider. It is the Patient's responsibility to determine whether reimbursement is available from a private, non-governmental insurance plan and to submit any required billing. MRHS makes not guarantee that Patient will be reimbursed for the Plan Fee by any other entity.

Patient shall be financially responsible for any medical services received by Patient, which are not covered by this Agreement, and are not otherwise covered by the patient's health insurance or third party payment plan.

9. **Not Medicare or Medicaid Eligible.** Patient understands that MRHS is prohibited by current federal and state law from entering into this Agreement with beneficiaries of Medicare and Medicaid. Patient hereby certifies that Patient is not eligible for or covered by Medicare or Medicaid, and that Patient will immediately notify MRHS if Patient becomes eligible for, or covered by, Medicare or Medicaid. MRHS shall terminate this Agreement upon receiving notice of the Patient's eligibility for Medicare or Medicaid by providing thirty (30) days notice to the Patient.

10. **Communications.** Patient acknowledges that although MRHS shall comply with all HIPAA (defined below) privacy requirements, communications with MRHS, and its employees, using email, facsimile, video chat, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communications. As such, Patient expressly waive MRHS' obligation to guarantee confidentiality with respect to the above means of communication. Patient further acknowledges that all such communications may become a part of the medical record.

By Providing Patient's e-mail address on the attached Appendix B, Patient authorizes MRHS and its employees to communicate with Patient by e-mail regarding Patient's "protected health information" ("PHI"), as the term is defined in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"). Patient further 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 MRHS and its employees will make all reasonable efforts to keep e-mail communications confidential and secure, neither MRHS nor its employees can assure or guarantee the absolute confidentiality of e-mail communications;

c. At the discretion of MRHS and its employees, e-mail communications may be made a part of the Patient's permanent medical record;

d. E-mail is not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. In the event of an emergency, or a situation that Patient could reasonable expect to develop into an emergency, Patient shall call 911 or the nearest Emergency room, and follow the directions of emergency personnel;

e. If the Patient does not receive a response to an e-mail message within twenty-four (24) hours, Patient agrees to contact MRHS by telephone or other means; and

f. Neither MRHS nor its employees will be liable for any loss, injury, or expense arising from a delay in responding to Patient, when that delay is caused by technical failure. Examples of technical failures include, but are in no way limited to, (i) failures caused by an internet service provider, (ii) power outages, (iii) failure of electronic messaging software, or e-mail provider, (iv) failure of MRHS' computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third party which is unauthorized by MRHS, or (v) Patient's failure to comply with the guidelines for use of e-mail described in this Agreement.

11. **No Third Party Beneficiaries.** This Agreement is intended to be for the exclusive benefit of the parties hereto and shall not be construed to create any rights or benefits, whether expressed, implied, or incidental, in or for the benefit of any other person or entity.

12. **Assignment.** This Agreement and any rights hereunder may not be assigned or transferred by either party without the written consent of the other. Any attempted assignment or transfer by either party in violation of this provision shall be void and have no binding effect.

13. **Binding Effect.** This Agreement shall be binding upon and inure to the benefit of all the parties hereto, their heirs, administrators, personal representatives, successors and assigns, subject to the restrictions on assignment in Section 12.

14. **Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

15. **Entire Agreement.** This Agreement constitutes the entire agreement and understanding between MRHS and Patient with respect to the subject matter of this Agreement, and supersedes all prior agreements and understandings, whether written, oral or implied, between the parties with respect to the subject matter of this Agreement.

16. **Amendment.** No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties. Notwithstanding the foregoing, MRHS may unilaterally amend this Agreement to the extent required by state or federal law, regulation, rule, or administrative policy ("Applicable Law") as set forth in Section 17. 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 MRHS, except that Patient shall initial or sign any such change at MRHS' 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 as a part of this Agreement as though they had been expressly set forth in this Agreement.

17. **Change of Law.** In the event that MRHS determines, in good faith, or receives general or specific notice from any other governmental agency that all or any provision of this Agreement: (i) violates or fails to comply with any Applicable Law; or (ii) exposes MRHS or any person employed by or affiliated with MRHS to any other sanctions imposed by any governmental agency, then MRHS shall be entitled to modify or terminate this Agreement by providing thirty
(30) days' notice to the Patient. Modifications to the Agreement made pursuant to this Section are limited to those modifications reasonably determined by MRHS to be necessary to comply with a change of law or other event described in this Section. If Patient does not agree with such modifications, Patient shall have the right to terminate the Agreement upon thirty (30) days' written notice to MRHS.

18. **Governing Law.** This Agreement shall be governed by, and construed in accordance with, the laws of the State of Nebraska, except to the extent preempted by federal law.

19. **Construction.** The rule that a contract is construed against the party drafting the contract is hereby waived, and shall have no applicability in construing this Agreement or the terms hereof. The paragraph headings in this Agreement are for convenience only. Where appropriate, words used in this Agreement in a singular include the plural and words used in any gender include all genders.

20. **Notices.** Service of all notices under this Agreement shall be sufficient if given in person or in writing by U.S. first class mail postage prepaid, to MRHS at the address set forth above, or to Patient at the address set forth in Appendix B, or to such other address as either party may from time to time designate in writing. Any notice sent by mail shall be deemed to be given on the date it is deposited in a United States Postal depository

21. **Severability.** The invalidity or unenforceability of any covenant, agreement, term or condition of this Agreement or the application thereof to any person or circumstance shall not affect the validity, enforceability or applicability of any other provision in this Agreement.

22. **Waiver.** The failure of either party at any time or times to demand strict performance by the other of any of the terms, covenants or conditions of this Agreement shall not be construed as a continuing waiver or relinquishment of any rights under this Agreement.

23. **Legal Significance.** Patient acknowledges that this Agreement is a legal document and gives the parties certain rights and responsibilities. Patient further acknowledges that Patient has 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.

24. **Disclaimer.** MRHS makes no representations on the tax or legal implications this Agreement shall have on the Patient, including, but not limited to, the Patient's continued eligibility for his or her health insurance or third-party payment plan. If Patient is concerned about the effect of this Agreement, Patient should contact his or her tax or legal advisor.

NOTICE: This Agreement does not constitute insurance and is not a medical plan that provides health insurance coverage for purposes of any federal mandates. This Agreement only provides for the primary care services described in Appendix A. It is recommended that insurance be obtained to cover medical services not provided for under this Agreement. You are always personally responsible for the payment of any additional medical expenses you may incur.

IN WITNESS WHEREOF, Patient and MRHS have executed this Agreement as of the date first set forth above.

PATIENT

Signature: _____

Name (Printed): _____

MIDWEST REGIONAL HEALTH SERVICES, LLC, a Nebraska professional limited liability company

By: _____

Title: _____

APPENDIX A SERVICE AND PAYMENT TERMS

1. **Plan Services.** Pursuant to Section 1 of this Agreement, the term "Plan Services" shall mean the package of services, both medical and non-medical, offered by MRHS and covered under this Agreement, as set forth below:

a. Unlimited Office Visits;
b. Unlimited Virtual and Telemedicine Visits; and
c. Secure Messaging and Portal Access

The services listed above shall constitute all of the Plan Services covered by this Agreement. Patient understands that any additional services, whether medical or non-medical, which are not found in the above list, are not covered by this Agreement or the Plan Fee described in Section 3 of this Appendix A. MRHS shall provide the Plan Services at the following two locations at 2727 S. 144th St., Suite 280, Omaha, Nebraska 68144, and 818 Village Square, Gretna, Nebraska 68028.

2. **Services Not Covered.** Any medical or non-medical services not covered under this Agreement, may be provided by MRHS, its employees and affiliates, at an additional cost not covered by the Plan Fee (the "Uncovered Services"). The Uncovered Services include, but are not limited to, all laboratory, medications, immunizations, preventative care and procedures provided by MRHS, its employees, and affiliates. Patient acknowledges that the prices for the Uncovered Services are constantly changing due to the actions of third party payers, providers and suppliers. In the event Patient wishes to know the price of an Uncovered Service, Patient may contact MRHS on or before such Uncovered Service is provided and MRHS shall provide Patient with the then current price of the Uncovered Service.

MRHS will bill Patient's insurance provider for the costs of the Uncovered Services, but makes no representation that Patient's insurance provider will cover the Uncovered Services. To the extent Patient's insurance provider does not cover the Uncovered Services, Patient shall be responsible for all remaining costs associated with the Uncovered Services.

3. **Payment Terms.** Pursuant to Section 5 of the Agreement, Patient agrees to pay MRHS, in exchange for the Plan Services, the Plan Fee equal to the total monthly fees charged by MRHS for each individual covered by this Agreement ("Covered Individuals"). Each Covered Individual shall be assigned to one of the following three patient classes based upon their age and the other Covered Individuals under the Agreement ("Patient Classes"):

Patient Classes	Age Range	Monthly Fee
Adult Patient	19 years of age and older	$75 per month
First Child Patient	18 years of age and younger	$60 per month
Each Additional Child Patient	18 years of age and younger	$50 per month

MRHS shall charge Patient for each Covered Individual the monthly fee listed above in conjunction with the Covered Individual's assigned Patient Class. Pursuant to Section 5 of the Agreement, MRHS shall have the right to change the amount of the monthly fees listed above by giving sixty (60) days' notice of the change to Patient. If Patient does not agree with the changed monthly fees, Patient shall have the right to terminate the Agreement pursuant to Section 4 of the Agreement.

The Plan Fee charged by MRHS shall be paid by Patient in monthly installments over the Initial Term and any Renewal Term(s) of the Agreement by automatic withdrawal from Patient's checking account or automatic charge against Patient's debit or credit card. Patient must have a checking account, credit card or debit card on file to cover the Plan Fee of this Agreement and any incidental costs not covered under the Agreement, and must complete the Automatic Billing Authorization Form attached as Appendix C to the Agreement and incorporated by this reference.

APPENDIX B PATIENT APPLICATION FORM

1. **Covered Individuals.** The Plan Fee as set out in Appendix A shall apply to the following Patient and Covered Individuals (defined below), who by signing below agree(s) to the terms and conditions of the Agreement and Appendix A.

a. Adult Patient Information:

Last Name:	First Name:	Middle Initial:
DOB (MM/DD/YYYY):	SSN:	Gender
Home Phone:	Cell Phone:	Work Phone:
Home Address, City, State, Zip:		
Email:		

b. Child Patient #1 Information:

Last Name:	First Name:	Middle Initial:
DOB (MM/DD/YYYY):	SSN:	Gender:

c. Child Patient #2 Information:

Last Name:	First Name:	Middle Initial:
DOB (MM/DD/YYYY):	SSN:	Gender:

d. Child Patient #3 Information:

Last Name:	First Name:	Middle Initial:
DOB (MM/DD/YYYY):	SSN:	Gender:

e. Child Patient #4 Information:

Last Name:	First Name:	Middle Initial:
DOB (MM/DD/YYYY):	SSN:	Gender:

2. **Election of Direct Primary Care Coverage.** The number of individuals covered by this Agreement and listed above in Section 1 of this Appendix B ("Covered Individuals"), that fall within each of the three (3) Patient Classes described in Appendix A, is as follows:

Number of Covered Individuals	Patient Classes
_____	Adult Patient (19 years of age or older) ($75 / Month)
_____	First Child Patient (18 years of age or younger) ($60 / Month)
_____	Additional Child Patients ($50 each / Month)

3. **Total Monthly Plan Fee**: Based on the number of Covered Individuals and their respective assigned Patient Classes, the total monthly Plan Fee payable by Patient under this Agreement is: $ _____

4. **Payment Method.** Patient must complete the Automatic Billing Authorization Form provided in Appendix C and have a checking account, credit card or debit card on file to cover the Plan Fee and any incidental costs not covered under the Agreement or under Patient's health insurance or third party payment plan.

Patient shall be financially responsible for any medical services received by a Covered Individual, which are not covered by this Agreement, and are not otherwise covered by the Patient or Covered Individual's health insurance or third party payment plan.

6. **Insurance Information.** Does Patient or any of the Covered Individuals have health insurance coverage or health care Flexible Spending Account coverage that has a balance available as of the Effective Date of this Agreement?

Yes: ____ No: ____

If yes, provide:

Company Name:	Policy Number:	Group Number:
Name(s) of Insured (first, middle initial, last):		

7. **Medicare or Medicaid Coverage.** Pursuant to Section 9 of this Agreement, MRHS is prohibited from providing the Plan Services under the Agreement to Covered Individuals who are eligible for or covered by Medicare or Medicaid. Is Patient, or any of the Covered Individuals, eligible for, or covered by Medicare or Medicaid?

Yes: ____ No: ____

NOTICE: This Agreement does not constitute insurance and is not a medical plan that provides health insurance coverage for purposes of any federal mandates. This Agreement only provides for the primary care services described as Plan Services in Appendix A. It is recommended that insurance be obtained to cover medical services not provided for under this Agreement. Patient is always personally responsible for the payment of any additional medical expenses that Patient or Covered Individuals may incur.

I certify that I have read, understand, and agree to the terms set forth in the Agreement, Appendix A, and Appendix B. I further certify that I have received a copy of the Agreement, Appendix A, and Appendix B. In addition, to the best of my knowledge, all statements and answers in this Appendix B to the Agreement are complete and true.

Signature: _____ Date: _____, 201__

APPENDIX C AUTOMATIC BILLING AUTHORIZATION FORM

I, _____, authorize Midwest Regional Health Services, LLC, a Nebraska professional limited liability company ("MRHS"), to automatically bill the account or credit care indicated below as specified:

Amount: $_____ **Frequency**: Monthly, billed on the first (1st) business day of each month.

Start Date: _____, 201__ **End Date**: Upon account or card holder cancellation

Account or Card Holder Information:

Last Name:	First Name:	Middle Initial:
Home Phone:	Cell Phone:	Work Phone:
Home Address, City, State, Zip:		
Email:		

Account or Credit Card Information:

Name on Account:	Type of Account (Savings/Checking):
Bank Name:	Bank City, State:
ACH Routing Number:	Account Number:

Or

Name of Cardholder:

C-1

Credit Card Number:	Credit Card Type:
Expiration Date: (MM/YYYY)	CVC: (Security Code)

I understand that this authorization shall remain in effect for a period of twelve (12) months from the date of the first payment and will automatically renew for consecutive periods of twelve (12) months, unless and until I cancel it in writing. I agree to notify MRHS in writing of any changes in my account information or termination of this authorization at least thirty (30) days prior to the next billing date. In the case of an ACH transaction being rejected for Non-Sufficient Funds (NSF) I understand that MRHS may at its discretion attempt to process the charge again within thirty (30) days, and agree to an additional $10.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. las. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this form. I further acknowledge that this authorization is for a period of twelve (12) months, which renews automatically unless terminated in writing.

Signature: _____ Date: _____, 201__