

**PATIENT AGREEMENT
NC MEDICAL WEIGHT LOSS & DIRECT PRIMARY CARE, PLLC**

This is an Agreement entered into on between NC Medical Weight Loss & Direct Primary Care Limited Liability Company (Clinic, Us or We), and Patient or You) for Medical Weight Loss Program or Direct Primary Care.

Background

Andy Phung, D.O. practices medical weight loss with family medicine and delivers care on behalf of NC Medical Weight Loss & Direct Primary Care, PLLC located at 1148 Executive Circle, Unit #3, Cary, NC 27511. In exchange for certain fees paid by You, Practice, through its Physician(s), agrees to provide You with the Services described in this Agreement on the terms and conditions contained in this Agreement. The practice website is www.drandyphung.com.

Definitions

1. Patient. In this Agreement, “Patient” means the persons for whom the Physician shall provide care, and who have signed this agreement or are listed on the document attached as Appendix B, which is a part of this agreement.

2. Services. In this Agreement, “Services”, means the collection of services, offered to you by Us in this Agreement. These Services are listed in Appendix A (1), which is attached and apart of this Agreement.

Agreement

3. NOTICE: THIS MEDICAL RETAINER AGREEMENT DOES NOT CONSTITUTE INSURANCE, IS NOT A MEDICAL PLAN THAT PROVIDES HEALTH INSURANCE COVERAGE FOR PURPOSES OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT AND COVERS ONLY LIMITED, ROUTINE HEALTH CARE SERVICES AS DESIGNATED IN THIS AGREEMENT.

_____ (Initial)

4. Term. This Agreement will commence at registration and will extend monthly thereafter. There is a mandatory enrollment period of two months at registration for Direct Primary Care.

5. Renewal. The Agreement will automatically renew each month, unless either party cancels the Agreement by giving 30 days written cancellation notice.

6. Termination. This Agreement will commence registration and will extend monthly thereafter. There is a mandatory enrollment period of two months. Both Patient and Practice shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving 30 days prior written notice to the other party. The Agreement shall terminate at the end of the 30-day notice.

7. Payments and Refunds – Amount and Methods. In exchange for the Services (see Appendix A(1)), You agree to pay Us, a monthly fee in the amount that appears in Appendix C, which is attached and is part of this Agreement.

a) This monthly fee is payable on a prorated basis when you sign the Agreement, and is due on the first business day of each month thereafter.

b) The Parties agree that the required method of monthly payment shall be by automatic payment, through a debit or credit card.

c) If this Agreement is cancelled by either party before the Agreement ends, We will review and settle your account as follows:

(i) We will refund to You the unused portion of your fees on a per diem basis; or

(ii) If Value of the Services you received over the term of the Agreement exceeds the amount You paid in membership fees, You shall reimburse the CLINIC in an amount equal to the difference between the value of the services received and the amount You paid in membership fees over the term of the Agreement. The Parties agree that the value of the services is equal to the fair market values of the services rendered.

8. Non-Participation in Insurance. Your initials on this clause of the Agreement acknowledges the Patient’s understanding that neither the CLINIC, nor its Physician, participate in any health insurance or HMO plans or panels and cannot accept Medicare eligible patients. We make no representations that any fees that You pay under this Agreement are covered by your health insurance or other third-party payment plans. 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. _____ **(Initial)**

9. WE CANNOT Accept Medicare Patients. Your initials on this clause of the Agreement acknowledges the Patient’s understanding that at this time, Medicare Patients are not eligible to be treated by the CLINIC or its Physician, and Medicare cannot be billed for any services performed by the same. Therefore, Patient acknowledges that s/he is neither a Medicare beneficiary nor Medicare eligible. The Patient agrees that if he/she will become eligible during the term of this Agreement, he/she will notify the CLINIC within 60 days of becoming eligible and this agreement will be terminated upon Medicare eligibility. Any excess fees will be refunded to Patient, and the CLINIC will make every effort to provide the Patient with names and contacts for primary care alternatives. _____ **(Initial)**

10. This Is Not Health Insurance. Your initials on this clause of the Agreement acknowledges Your understanding that this Agreement is not an insurance plan or a substitute for health insurance. You understand that this Agreement does not replace any existing or future health insurance or health plan coverage that You may carry. The Agreement does not include hospital services, or any services not personally provided by the CLINIC, or its employees. You acknowledge that the CLINIC has advised You to obtain or keep in full force, health insurance that will cover You for healthcare not personally delivered by the CLINIC, and for hospitalizations and catastrophic events. _____ **(Initial)**

11. Communications. The Patient acknowledges that although CLINIC shall comply with HIPAA privacy requirements, communications with the Physician using e-mail, 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 waives the Physician’s 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 an e-mail address on the attached Appendix B and/or during online enrollment, the Patient authorizes the CLINIC, and its Physicians to communicate with him/her by e-mail regarding the Patient’s “protected health information” (PHI). The Patient 1 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 the Physician will make all reasonable efforts to keep e-mail communications confidential and secure, neither the CLINIC, nor the Physician can assure or guarantee the absolute confidentiality of e-mail communications;

(c) At the discretion of the Physician, 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 in an emergency, for time-sensitive problems, or for disclosing sensitive information. **In an emergency, or a situation that You could reasonably expect to develop into an emergency, You understand and agree to call 911 or the nearest Emergency room, and follow the directions of emergency personnel.**

(e) Email Usage. The Physician checks e-mail frequently on weekdays, during business hours. If You do not receive a response to an e-mail message by the next business day, You agree that you will contact the Physician by telephone or other means.

(f) Technical Failure. Neither the CLINIC, nor the Physician 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 (i) failures caused by an internet service provider, (ii) power outages, (iii) failure of electronic messaging software, or e-mail provider (iv) failure of the CLINIC’s 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 the CLINIC; or (v) Patient failure to comply with the guidelines for use of e-mail described in this Agreement.

12. Physician Absence. From time to time, due to vacations, sick days, and other similar situations, not be available to provide the services referred to above in this Appendix A. During such times, Patient’s calls to the Physician, or to the Physician’s office, will be directed to a physician who is “covering” for the Physician during his absence. The practice will make every effort to arrange for coverage but cannot guarantee such coverage

13. Change of Law. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

14. Severability. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable, and the remainder of the contract will stay in force as originally written.

¹ as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations.

15. Reimbursement for Services Rendered. If this Agreement is held to be invalid for any reason, and the CLINIC is required to refund fees paid by You, You agree to pay the CLINIC an amount equal to the fair market value of the medical services You received during the time period for which the refunded fees were paid.

16. Amendment. No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties. Except for amendments made in compliance with Section 13, above.

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

18. Legal Significance. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that You have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

19. Miscellaneous. This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

20. Entire Agreement. This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

21. No Waiver. In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce the other party's requirement or duty under this agreement (for example notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

22. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of North Carolina. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the CLINIC in Cary, North Carolina.

23. Service. All written notices are deemed served if sent to the address of the party written above or appearing in Appendix B by first class U.S. mail.

24. Insurance & Billing. Patients are billed directly for this program. The monthly fees you pay are a retainer for services and we will work with you either by providing you super-bills & receipts or by working with you to submit a claim insurance for reimbursement. Each health insurance is different, please contact your insurance provider directly to inquire about your “Out of Network” deductible and co-payments. Our billable services for this program include several physician visits, as well as chronic care management. If you have any questions, please call our office.

25. State Licensure. Dr. Andy Phung is licensed to practice Medicine in state of North Carolina where he can order lab work, make diagnoses, and adjust & prescribe medications. If you are located outside of North Carolina, Dr. Andy Phung cannot prescribe or adjust medications. The guidance provided to you is considered educational purposes and health coaching.

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

Andy Phung, DO, for NC MEDICAL WEIGHT LOSS & DIRECT PRIMARY CARE, PLLC

Print Name of Patient

Signature of Patient

Date

Appendix A: Service Agreement

Medical Services. As used in this Agreement, the term Medical Services shall mean those medical services that the Physician, himself is permitted to perform under the laws of the State of North Carolina, and that are consistent with his training and experience as a family medicine physician, as the case may be.

<ul style="list-style-type: none"> Chronic Metabolic Disease Management 	<ul style="list-style-type: none"> Spirometry
<ul style="list-style-type: none"> Nutritional Medical Weight Loss Program* 	<ul style="list-style-type: none"> Skin tag removal
<ul style="list-style-type: none"> Wellness visit for children/adults. 	<ul style="list-style-type: none"> Simple laceration repair (\$50 supply fee)
<ul style="list-style-type: none"> Vision and Hearing Screening 	<ul style="list-style-type: none"> Skin biopsy (pathology fee extra; if stitches required, \$50 supply fee)
<ul style="list-style-type: none"> Sick visits 	<ul style="list-style-type: none"> Simple aspiration/injection of joint (\$50 supply fee)
<ul style="list-style-type: none"> Body Fat Analysis 	<ul style="list-style-type: none"> Pap smear (pathology fee extra)
<ul style="list-style-type: none"> In-house labs (strep, UA, Blood Ketone) 	<ul style="list-style-type: none"> IUD Removals (\$50 supply fee)
<ul style="list-style-type: none"> EKG 	<ul style="list-style-type: none"> Nexplanon insertion/removal (\$100)

*16-week Intensive Lifestyle-Nutrition program which is separate from Direct Primary Care.

Ongoing Primary Care and In-Office procedures – there are no additional fee “copays” for office visits. Some procedures have a nominal fee to cover the cost of supplies. These are detailed above and subject to change.

Laboratory studies (blood work or urine testing) – will be charge according to the practice negotiated direct prices.

Pathology (Pap smear or skin biopsy) – studies will be ordered in the most economical manner possible. Patient will (or patient’s insurer) will be responsible for the pathology charges.

After-Hour visits – There is no guarantee of after-hours availability. This agreement is for ongoing primary care, not emergency or urgent care. Your physician will make reasonable efforts to see you as needed after hours if your physician is available.

Medical Services that are NOT included.

Vaccinations are NOT offered in the office at this time. Practice will make an effort to help Patient obtain needed vaccinations at a low cost.

Surgery and Specialist Consults. However, Practice will attempt to recommend specialty services in the most cost-effective manner possible for Patient. Hospital Services and Obstetric Services are NOT a part of our membership. Physician does not maintain admitting privileges at any hospital.

APPENDIX B

PATIENT ENROLLMENT – MEDICAL AGREEMENT FORM

Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the NC Medical Weight Loss & Direct Primary Care, LLC Medical Agreement Form.

_____	_____	_____
Print Patient Name	Date of Birth (MM/DD/YYYY)	Age
_____	_____	
Street Address	City, State, Zip Code	
_____	_____	
Home Phone	Cell Phone	

Preferred Email		

Spouse/Child/Children to Whom this Agreement Applies (i.e. those enrolling for care):

_____	_____	_____
Spouse's Name	Date of Birth (MM/DD/YYYY)	Age
_____	_____	
Spouse's Home Phone	Cell Phone	Spouse's preferred Email
_____	_____	_____
Child's Name	Date of Birth (MM/DD/YYYY)	Age
_____	_____	_____
Child's Name	Date of Birth (MM/DD/YYYY)	Age
_____	_____	_____
Child's Name	Date of Birth (MM/DD/YYYY)	Age

Preferred Payment Method*

Monthly (Credit/Debit Card)

*All patients must have a credit or debit card on file to cover the cost of membership & any incidentals not covered under the Agreement.

I certify that I have read, understand, and agree to the terms set forth in NC Medical Weight Loss & Direct Primary Care, LLC Medical Agreement Form. I further certify that I have received a copy of this form.

Signature: _____ Date: _____

**APPENDIX C
FEE ITEMIZATION**

16 – Week Intensive Lifestyle-Nutritional Medical Weight Loss Program	
1. Without real-time monitoring	\$300/month
2. Without intensive Follow-Up	
1. With real-time monitoring	\$400/month
2. With Intensive Follow-Up	

Direct Primary Care	Monthly #	Yearly *	Enrollment **	Re-enrollment***
Individual	\$99/month	10% off	\$100	\$200
Family of 2	\$150/month	10% off	\$200	\$400
Family of 3-4	\$175/month	10% off	\$200	\$400

Patients on the monthly plan sign up for a minimum of 2 months and then continue month-to-month, renewing automatically thereafter.

* Patients on yearly plan sign up gets 10% discount on membership fee.

** Enrollment fee – 1 time charged enrollment fee when patient enrolls with the practice and is nonrefundable.

*** Re-Enrollment fee – Doubling the enrollment fee, if patient discontinues membership and later wishes to re-enroll with the practice. Practice reserves the right to decline a re-enrollment.

Ongoing Rates Plans:

Patient 1 \$ _____

Patient 2 \$ _____

Patient 3 \$ _____

Patient 4 \$ _____

Additional \$ _____

TOTAL RATE \$ _____ per _____

One-time enrollment costs:

Enrollment Fee \$ _____

Prorate of Current Month \$ _____ paid _____