ZIA Access Healthcare of New Mexico, P.C.

Patient Agreement

This is an agreement between ZIA Access Healthcare of New Mexico, P.C. and Gregory Koury, M.D.(physician), located at 10983 Highway 180 West, Silver City, NM and You _____.

Background

The Physician practices Family Medicine and delivers care on behalf of the Practice: ZIA Access Healthcare of New Mexico, P.C., in exchange for certain fees paid by You. The Practice, through its Physician, agrees to provide Patient with the Services described in this Agreement on the terms and conditions set forth in this Agreement.

Definitions/Sections

1. Patient: A patient is defined as those persons for whom the Physician shall provide Services, and who are signatories to, or listed on the documents attached as Appendix 1 and incorporated by reference, to this agreement.

2. Services: As used in this Agreement, the term Services shall mean a package of ongoing primary care services, both medical and non-medical, and certain amenities (collectively "Services") which are offered by the Practice and set forth in Appendix 1 and 2. The Patient will be provided methods to contact the Physician via phone, email, and other methods of electronic communication. The Physician will make every effort to address the needs of the Patient in a timely manner but cannot guarantee availability and cannot guarantee that the Patient will not seek treatment in the urgent care and/or emergency department setting.

3. Fees: In exchange for Services described herein, Patient agrees to pay Practice the amount as set forth in Appendix 1 and 2, attached. Applicable enrollment fees are payable upon execution of this agreement. If this agreement is terminated by either party before the end of an applicable monthly period, then the Practice shall seek only partial payment for the final month of Service based on the number of days of membership provided to the Patient and the itemized charges, set forth in Appendix 2, for Services rendered to Patient up to the date of termination.

4. Non-participation in Insurance: Patient acknowledges that neither Practice nor Physician will participate in any health insurance or HMO plans. Physician has opted out of Medicare. Patient acknowledges that federal regulations REQUIRE that Physician opt out of Medicare so that Medicare patients may be seen by the Practice pursuant to this private direct primary care contract. Neither the Practice nor Physician make any representations regarding third party insurance reimbursement of fees paid under this Agreement. The Patient shall retain full and complete responsibility for any such determination. If the Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient will sign the agreement attached as Appendix 3, and incorporated by reference. This agreement acknowledges your understanding that the Physician has opted out of Medicare, and as a result,

Medicare cannot be billed for any Services performed for you by the Physician. You agree not to bill Medicare or attempt Medicare reimbursement for any such Services.

5. Insurance or Other Medical Coverage: Patient acknowledges and understands that this Agreement is not an insurance plan and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services or any services not personally provided by Practice or its Physician. Patient acknowledges that Practice has advised that Patient obtain or keep in full force such health insurance policy(ies) or plans that will cover Patient for general healthcare costs. Patient acknowledges that THIS AGREEMENT IS NOT A CONTRACT THAT PROVIDES HEALTH INSURANCE and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that Patient may carry. This Agreement is for ongoing primary care and the Patient may need to visit the emergency room or urgent care from time to time. Physician will make every effort to be available at all times via phone, email or other methods such as "after hours" appointments when appropriate, but Physician cannot guarantee 24/7 availability.

6. Term: This Agreement will commence on the date it is signed by the Patient and Physician below and will extend monthly thereafter. Notwithstanding the above, both Patient and Practice shall have the absolute and unconditional right to terminate the Agreement without the showing of any cause for the termination. The Patient may terminate the Agreement with twenty-four hours prior notice but the Practice shall give thirty days prior written notice to the Patient and shall provide the Patient with a list of other practice in the community in a manner consistent with local patient abandonment laws. Unless previously terminated as set forth above, at the expiration of the initial one-month term (and each succeeding monthly term), the Agreement will automatically renew for successive monthly terms upon payment of the monthly fee at the end of the contract month. Examples of reasons the Practice may wish to terminate the Agreement with the Patient may include but are not limited to: (a) The Patient fails to pay applicable fees owed pursuant to Appendix 1 and 2 per this Agreement;
   (b) The Patient has performed an act that constitutes fraud;
   (c) The Patient repeatedly fails to adhere to the recommended treatment plan, especially regarding the use of controlled substances;
   (d) The Patient is abusive or presents an emotional or physical danger to the staff or other patients
   (e) Practice discontinues operation;
   (f) Practice has a right to determine whom to accept as a patient, just as a patient has the right to choose his or her physician. Practice may also terminate a Patient without cause as long as the termination is handled appropriately (without violating patient abandonment laws).

7. Privacy & Communications: Patient acknowledges that communications with the Physician using e-mail, fax, video chat, text or instant messaging and cell phone are not guaranteed to be secure or confidential methods of communications. The Practice will make every effort to secure all communications via passwords and other protective means. These will be discussed in an annually updated Health Insurance Portability and Accountability Act (HIPPA) "Risk Assessment" made available online (subject to change) at acchealth.com. The Practice will make an effort to

promote the utilization of the most secure methods of communication such as software platforms with data encryption, HIPPA familiarity and a willingness to sign HIPPA Business Associate Agreements. This may mean that conversations over certain communication platforms are highlighted as preferable based on higher levels of data encryption, but many communication platforms, including e-mail, may be made available to the Patient. If the Patient initiates a conversation in which the Patient discloses "Protected Health Information" (PHI) on one or more of these communication platforms then the Patient has authorized the Practice to communicate with the Patient regarding PHI in the same format.

8. 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 a jurisdiction to which it applies, the validity for 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 its modified form, and that provision shall then be enforceable.

9. Reimbursement for Services if Agreement is Invalidated: If this Agreement is held to be invalid for any reason, and if Practice is therefore required to refund all or any portion of the monthly fees paid by Patient, Patient agrees to pay Practice an amount equal to the fair market value of the Services actually rendered to Patient during the period of time for which the refunded fees were paid.

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

11. Jurisdiction: This Agreement shall be governed and construed under the laws of the State of New Mexico and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice address in Silver City, New Mexico.

APPENDIX 1

PERIODIC & ENROLLMENT FEES

This Agreement is for ongoing primary care. This Agreement is NOT HEALTH INSURANCE and is NOT A HEALTH MAINTENANCE ORGANIZATION. The Patient may need to use the care of specialists, emergency rooms, and urgent care centers that are outside the scope of this Agreement. The Physician will make an appropriate determination about the scope of primary care services offered by the Practice. Examples of common conditions we treat, procedures we perform, and medications we prescribe are listed on our website: www.ziaccesshc.com and are subject to change.

FEE SCHEDULE

ENROLLMENT FEE-This is charged when the Patient enrolls with the Practice and is nonrefundable. This fee is subject to change. If the Patient discontinues membership and wishes to re-enroll in the Practice, we reserve the right to decline re-enrollment or to require that the re-enrollment fee reflect the amount equivalent to the months of absent payments when dis-enrolled from the Practice.

YOUR ENROLLMENT FEE is $49.00

YOUR MONTHLY FEE is $49.00 per month (due on the first of the next calendar month after the ongoing primary care has been provided). The Patient is entitled to leave the Practice at any time and be assigned a pro-rated final bill based upon the date of withdrawal from the Practice.

MONTHLY FEE- (billed the first of each Service month)- is for ongoing primary care Services. Each scheduled in-person visit will be charged $25.00 per visit. Your number of virtual visits (e-mail, electronic & phone) are not capped but may be charged at a rate equivalent to an in-person Service. We prefer you schedule visits more than 24 hours in advance when possible. Many services performed in our office during an in-person visit-basic lab tests, EKG, urinalysis, strep test, urine pregnancy test-are available at no additional cost to you. Please see our website for other Services performed at in-person visits that can be provided 'at cost' (based on our actual acquisition costs of supplies). Examples of these ancillary Services include Kenalog injection, laceration repair (sutures) and joint injection. The full price list can be found on our website at www.ziaccesshc.com

NO SHOW APPOINTMENTS or CANCELED APPOINTMENTS WITHIN 24 HOURS

You agree will incur a fee of $25.00

AFTER-HOURS VISITS

There is no guarantee of after-hours availability. This Agreement is for ongoing primary care, not emergency or urgent care. The Physician will make reasonable efforts to see you as needed after hours.

ACCEPTANCE OF PATIENTS

We reserve the right to accept or decline patients based upon our capability to appropriately handle the Patient's primary care needs. We may decline new patients because the Physician's panel is full (capped at 1,200 patients or fewer) or because the patient requires medical care outside the Physician's scope of Services.

APPENDIX 2

Itemized Fees

Ongoing primary care is included with the Monthly Fee described in Appendix 1. Please see a list of some of the chronic conditions we routinely treat on the Practice website @ www.ziaccesshc.com (subject to change without notice).

Hospital services are NOT covered by our membership plan.

Appendix 3

Medicare Beneficiaries Understandings

This Agreement is between Zia Access Healthcare, P.C. and Medicare Beneficiary_____

Who resides at:_____

Medicare ID#_____

Patient is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balances Budget Act of 1997. The Practice has informed the Patient or his/her legal representative that the Physician has opted out of the Medicare program. The Physician has not been excluded from participating in Medicare Part B under [1128] 1128, {1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial

____ Beneficiary or his/her legal representative accepts full responsibility for payment of the Physician's charge for all services furnished by the Physician.

____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the Physician may charge for items or services furnished by the Physician.

____Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to request the Physician to submit a claim to Medicare.

____Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the Physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

____Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who not opted out.

____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

____Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him/her.

____This Agreement is for ongoing primary care and is NOT a medical insurance agreement.

____I do NOT have an emergent medical problem at this time.

____In the event of a medical emergency, I agree to call 911 first.

____I do NOT expect the Practice to file or fight any third party insurance claims on my behalf.

____In the event I have a complaint about the Practice, I will first notify the Practice directly.

This Agreement is non-transferable. I am enrolling (myself and my family, if applicable) in the Practice voluntarily. I may receive a copy of this document upon request.

Executed on (date) _____

By: _____

Medicare Beneficiary/Patient or his/her legal representative

And: _____

On behalf of Zia Access Healthcare of New Mexico, P.C.