HENDERSON
INTERNAL MEDICINE

Membership Contract

Dear Patient: Henderson Internal Medicine ("HIM") is committed to delivering high quality healthcare services to each and every patient. HIM treats far fewer patients per full- time doctor than the average primary care practice. This low patient to doctor ratio is a benefit not available with traditional health insurance reimbursement, and it allows us to be more responsive to your healthcare needs both during and between office visits. HIM appreciates that patients may desire to purchase service amenities above and beyond what is covered by health insurance and managed care programs. In response to this need we are pleased to provide you with these amenities to complement your insurance-covered healthcare services. If you would like to join our HIM practice please review our Program Agreement ("Agreement") outlined below and provide your signature in the space provided.

Sincerely,
Paige Hixson, MD

Patient Name:_____

Date:_____

I am requesting services by Henderson Internal Medicine and agree to the following terms and conditions:

Henderson Internal Medicine Patient Program-
The Program's Annual Fee includes these enhanced service amenities:
• Unhurried office visits 15-90min depending on the patient's care needs
• Telehealth visits
• In-house pharmacy non-controlled substance medications only
• Direct physician text/phone contact (office hours)
• Same day or next day appointments[1]
• Family care conference availability
• FMLA/ disability paperwork/ other medical related paperwork

1 Staffing limitations may occasionally make this appointment time frame be longer

These amenities are not intended to encourage additional medical utilization or increased medical billing for the patient, but rather are intended to provide the patient a broader array of health and wellness options, education, and support. Our intention is to decrease the need for medical care or plan utilization.

Should you require hospital admission, hospital care will be delivered by a designated hospital medicine specialist, with involvement and help with transition care coordination by Dr. Hixson.

Provider coverage will be provided during times Dr. Hixson is not available due to scheduled leave/ time off.

I understand and agree to pay the Fee selected below for the above-described amenities with Henderson Internal Medicine

INDIVIDUAL PLAN

- Initial signup fee: $180 (one time fee/person)

- Individual Membership: (Select one)
  ____$80 per month per individual
  ____$240 per quarter per individual (Quarterly Plan)
  ____$480 biannually per individual (Biannual Plan)
  ____$960 per year per individual (Yearly Plan)

FAMILY PLAN

- Initial signup fee: $180 (one time fee/person)

- Family Membership: # Family members ___ (max 4) (Select one)
  ____$70 per month per individual
  ____$210 per quarter per individual (Quarterly Plan)
  ____$420 biannually per individual (Biannual Plan)
  ____$840 per year per individual (Yearly Plan)

Renewals and Termination:

The Agreement shall auto-renew until canceled by the member. In the instance that the behavior agreement is violated the termination of membership is immediate. I understand that failure to make timely payment of my membership fees may result in termination of my membership in Henderson Internal Medicine. Accounts >30days in arrears will be frozen and then deactivated after a 45days.[2,3]

2 If terminating your plan you must sign a HIPAA compliant request to transfer records to your new physician. One copy of your records will be provided to your new physician at no charge. Additional copies of your records will be charged at the current rates.

3 Failure to renew or to make payment in a timely fashion will be taken as your decision to immediately establish yourself with a new physician. Your physician will provide emergency care only for 30 days at which time you will be terminated from the program. After this time Dr. Hixson will no longer be responsible for any aspect of your medical care and you should see your new physician for all medical issues. You and/or your insurance company as the case may be, will be responsible for any charges incurred for emergency care provided during this time

Cancellation Policy

_____ (Initial) I understand that cancellations are permanent

_____ (Initial) I understand that when I cancel I will call or email **before my autopay date**

_____ (Initial) I understand that after canceling, no more services will be provided such as consultation, medications and procedures

_____ (Initial) I understand that upon cancellation my account will be inactivated and will no longer be billed monthly

_____ (Initial) I understand I can request a copy of my medical records

_____ (Initial) I agree to use one of these forms of communication to cancel my membership: **email, phone call**

I understand that I, or my insurance company, are responsible for all healthcare services that are traditionally covered by a health insurance program. These services exclude the services that are provided under my Membership Fee. Regardless of health coverage, I understand that all co-payment, co-insurance and/or deductibles will apply as defined by my insurance policy. In the event that the services are not covered by my Payor, I understand that I am responsible for payment.

Entire Agreement:

This Agreement constitutes the entire understanding of the parties with respect to the subject matter outlined in this Agreement. The undersigned agrees to the terms and conditions of this agreement and acknowledges there are no promises or representations except as specifically listed in this Agreement.

Governing Law:

This Agreement shall be governed by and constructed in accordance with the laws of the State of Nevada

This Membership Contract is entered into as of the _____ day of _____, and is effective as of the _____ day of _____ between you, the undersigned Patient ("You"), and Henderson Internal Medicine ("HIM"). By voluntarily entering into this Agreement and remitting the Membership Fee (as set forth above), you may participate in the HIM's Personalized Primary Care beginning on the Effective Date.

I, _____, agree to the terms and conditions herein.
Patient Printed Name

I, further, acknowledge I understand the "Program," is not an insurance product, and that I have been advised I will need to continue my own health insurance. I have read and agree to the terms of the HIM's payment policies.

_____ _____
Patient Signature Date

_____ _____
Paige Hixson, MD Date

Terms and Exclusions:

I understand that the Membership Fee payable to HIM strictly covers healthcare, amenities and service that are not reimbursed or covered through the Medicare, Medicaid and third-party payers (health insurance) programs. As such, HIM will not seek reimbursement for services provided as part of your Membership Fees with your medical insurance. I understand that I am solely financially responsible for payment of my Membership Fees and that this fee is not reimbursable by my private insurance carrier, Medicare or Medicaid. However, some of the fees for my membership fee may be submitted to my health savings account (HSA), medical savings account (MSA) or flexible benefits account (FBA) for reimbursement but please consult a tax expert or your tax preparer for guidance in this regard.