



**Concierge Pediatrics FL, LLC  
PATIENT AGREEMENT**

This Patient Agreement (Agreement) is between Concierge Pediatrics FL, LLC (the Practice, Us or We), and (Patient, Patient Representative, Member and You, Your).

**Background**

The Practice, located at 410 West 41<sup>st</sup> Street, Suite 406, Miami Beach, FL 33140, provides ongoing, pediatric, primary care services to its patients/members in a direct pay primary care practice model (DPC). In exchange for certain periodic fees (or Membership Fees), the Practice agrees to provide the Patient with the Services described in this Agreement under the terms and conditions contained within.

**Definitions**

1. Services. In this Agreement, "Services" means a collection of medical and non-medical services and identified in Appendix A (attached and made a part of this Agreement), which are provided to the Patient on an ongoing basis, in exchange for certain Membership Fees.
2. "Patient" or "Member" - means the person/s who are party to this Agreement, for whom the Practice shall provide care, and whose name/s appear in Appendix B, which is attached to this Agreement and incorporated by reference.
3. You, Your - Means the parent or legal guardian of the minor Patients named within, who is a signatory to, and bound by, this Agreement.
4. Term. This Agreement will last for one year, starting on the date which it is fully executed by the parties.
5. Renewal. The Agreement will automatically renew each year on the anniversary date of the Agreement unless either party terminates the Agreement by giving 30 days written notice of intent to terminate.
6. Termination. Either party can end this Agreement at any time by giving 30 days written notice to the other of intent to terminate.
7. Cancellation and Refund. If either party terminates this Agreement, We will refund you any unused portion of your Membership Fee on a per diem basis.
8. Payment Amount and Methods. In exchange for the Services identified in Appendix A, You agree to pay a Membership Fee in the amount described in Appendix C (attached and incorporated into this Agreement by reference). You further agree to the following terms:

B. The required payment method shall be automatic electronic payment through a bank draft or debit/credit card.



C. You are responsible for the costs associated with any laboratory testing, specimen analysis, product, or procedure which is not personally provided by the Practice and listed in Appendix A. The Practice shall inform You in advance if such additional costs may apply.

9. Non-Participation in Insurance. We do not participate with any private health insurance, HMO panels, government-sponsored health plans, or other third-party payors. Accordingly, We may not bill or otherwise attempt to obtain reimbursement from any of the above for the services We provide under this Agreement.

10. Medicare. The Practice staff is opted out of Medicare. You understand that this means that You may not submit charges to Medicare for any services received and included in this Agreement. You agree to advise the Practice if the Patient is, or becomes, a Medicare beneficiary or Medicare eligible. You further agree to refrain from billing or assisting others in billing Medicare for any services provided by the Practice, and to sign a Medicare private contract agreement as required by law.

11. Medicaid. Although We proudly welcome Medicaid Patients into Our Practice, we cannot bill or accept reimbursement from Medicaid for the services that we deliver under this Agreement. Accordingly, You understand that you, and not Medicaid, are responsible for the Patient's Monthly Membership Fee and any miscellaneous charges. However, You may continue to submit charges to, and be reimbursed by, Medicaid, for services that the Practice does not, itself, provide (for example, prescriptions, supplies, testing, and other services that the Practice orders, but which the Patient receives from an outside pharmacy, imaging center, or lab). Medicaid normally reimburses for services such as the above, when provided by an outside party, but You are always responsible for understanding your insurer's payment policies.

12. This Agreement Is Not Health Insurance. This Agreement is not an insurance plan or a substitute for health insurance. The Agreement does not, on its own, satisfy any government mandate to purchase health insurance and does not include hospital services or any services not specifically identified in Appendix A. You acknowledge that We have advised You to obtain or continue to maintain existing health insurance that will cover the Patient for healthcare services not specifically described in Appendix A, including but not limited to specialist care, hospitalizations, and catastrophic medical events.

13. Communications. The Practice endeavors to provide the convenience of a wide variety of electronic communication options. In our efforts to protect patient privacy, We provide a secure computer application through which You can access Your patient portal and communicate with the Practice via email, facsimile, video chat, cell phone, texting, and other electronic means. This is the preferred method of communication, especially when disclosing PHI or other sensitive information.

14. Confidentiality. We take Patient privacy seriously and take all reasonable efforts to ensure that Your information is safe and protected. Nevertheless, electronic communications can never be guaranteed to be 100% secure or confidential at all times. For reasons beyond the control of the Parties, computer systems can occasionally be hacked, and information can sometimes be intercepted by third parties. By participating in the above means of communication described above in paragraph 13, you expressly waive the guarantee of absolute confidentiality with respect to their use. You further understand that



participation in any of the above means of communication is not a condition of membership in this Practice and that you have the option to decline any specific means of communication.

15. Email and Text Usage. By providing an email address where requested in Appendix B, You authorize the Practice and its staff to communicate with You by email regarding the Patient's protected health information (PHI)<sup>1</sup>. Likewise, in providing a cell phone number where indicated in Appendix B and checking the "YES" box on the corresponding consent question, You agree to participate in text message communication containing PHI through the cell number provided. You further acknowledge that:

A. Email and text message are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access;

B. Email and text messaging are not appropriate means of communication in an emergency, dealing with time-sensitive issues, or disclosing sensitive information. Furthermore, You understand and agree that in an emergency or a 1 s As the term is defined under HIPAA that could reasonably be expected to develop into an emergency, to call 911 or go to the nearest emergency medical care provider and follow the directions of emergency personnel.

16. Dispute Resolution. Each party agrees to refrain from making any inaccurate or untrue disparaging statements, oral, written, or electronic, about the other. We strive to deliver only the best of personalized patient care to every Member, but occasionally misunderstandings arise. We welcome sincere and open dialogue with our Members, especially if we fail to meet expectations, and We are committed to resolving all of Your concerns. Therefore, if You are ever dissatisfied with, or have concerns about, any staff member, service, treatment, or experience arising from Your child's membership in this Practice, both You and the Practice agree to refrain from making, posting, or causing to be posted on the internet or any social media, any untrue, inaccurate, disparaging comments about the other. Rather, the Parties agree to engage in the following process:

A. You shall first discuss any concerns with your physician;

B. Your physician shall respond to each issue;

C. If, after such response, You remain dissatisfied, the Parties shall enter into discussion and attempt to reach a mutually acceptable solution.

17. Physician Absence. Due to educational conferences, vacations, illness, or patient emergencies, your physician may be temporarily unavailable from time to time.

A. To allow for convenient scheduling of non-urgent care, the Practice will notify You of any planned physician absence appointments as soon as the dates of such absence are known.

B. In the event of unplanned absences, Patients with scheduled, non-urgent appointments shall be notified immediately and rescheduled for a date convenient for the Patient.



C. If the Patient should require urgent or emergent care during a physician absence, the Patient should obtain treatment at an emergency department, urgent care, or other substitute provider as appropriate to the circumstances.

D. You are responsible for the payment of all charges associated with such substitute providers' services but may submit them to Your insurance plan (if applicable) for reimbursement. Most health plans cover such charges, but You remain responsible for understanding Your health insurance payment policies, and We cannot guarantee reimbursement.

18. Subscription and Service Offerings Adjustments. In the event that the Practice finds it necessary to increase or adjust its Subscription and Service offerings at the beginning of the next annual subscription period of the Agreement, We shall give You 30 days' written notice of any adjustment. If You do not consent to the modification, You may choose not to renew the Agreement for the next annual subscription period.

19. Change of Law. If there is a change of any relevant federal, state, or local law or regulation which affects the validity of this Agreement, the parties agree to amend this Agreement as necessary to comply with such change.

20. Severability. If any part of this Agreement shall be considered legally invalid or unenforceable by a court of competent jurisdiction, that part shall be amended. But only to the extent necessary to be enforceable; the remainder of the Agreement shall stay in force as originally written.

21. Amendment. Except as provided within, no amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties.

22. Assignment. This Agreement, and any rights the parties have under it, may not be assigned, or transferred to any other party.

23. Legal Significance. You understand that this Agreement is a legal document and gives the parties certain rights and responsibilities. You acknowledge that You have had reasonable time to seek legal advice about 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.

24. Miscellaneous. This Agreement shall be interpreted without regard to any rule requiring that it be construed against the drafter. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

25. Entire Agreement. This Agreement contains the entire Agreement between the parties and replaces any earlier understandings and agreements, whether written or oral.

26. No Waiver. The failure of a party to insist upon adherence to any term of this Agreement on any occasion shall not be considered a waiver of such party's rights or deprive such party of the right to insist upon strict adherence to that term or any other term of this Agreement at any time in the future.



27. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Florida. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice in the corporate office located in St. Petersburg, Florida.

28. Notice. Written notice as required under the Agreement may be accomplished electronically by email sent to the latest address provided by the party to be noticed, or by first-class US mail: to the Practice, at the address written above and to Patient or representative, at the address appearing in Appendix B.

29. State Required Disclosure. This Agreement is not health insurance, and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by the agreement with the exception of third-party vendors associated with the Practice. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and 73 Affordable Care Act, 26 U.S.C. s. 5000A. This agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440. The Parties may have signed duplicate counterparts of this Agreement on the date first written above.

FOR PATIENT:

FOR CONCIERGE PEDIATRICS MIAMI BEACH, LLC

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient(s): \_\_\_\_\_

Title: \_\_\_\_\_



## Appendix A

### Services

1. Medical Services. The Patient is entitled to the Medical Services identified below, as deemed appropriate under the circumstances, at the sole discretion of the physician. Unless advised otherwise, You are responsible for all costs associated with any medications, laboratory testing, and specimen analysis related to these Services by third parties.

- 4 house calls within the first 2 months of life for newborn home visit package
- House calls as deemed appropriate by physician and at physician's sole discretion for an additional fee
- All routine well-child visits as per the American Academy of Pediatrics
- Medical form completion, including School, Camp, and Sports Physicals
- Acute and Non-acute Office Visits
- Health Risk Assessment
- Psycho-social Screening
- Anxiety/Depression Screening and Management
- ADHD Evaluation and Treatment
- Medication Management\*\*
- Developmental Screening
- Sleep Health Assessment
- Paternal and Maternal Postpartum Depression Screening
- Nutritional/Lifestyle assessment
- Custom Wellness Plan to include Exercise and Dietary Plan
- Blood Pressure Testing
- Capillary Lead Screening
- Capillary Anemia Testing
- Acute single dose medications dispensed include: Nebulized Albuterol Breathing Treatments, Nebulized Ipratropium Bromide Treatments, Prednisolone, Dexamethasone, Ondansetron
- Urinalysis
- Urine Pregnancy testing
- Rapid test for Acute Streptococcal Tonsillitis
- Rapid test for influenza virus
- Silver Nitrate Cauterization of Umbilical Granulomas
- Removal of Cerumen (ear wax) and Lavage
- Minor Laceration Repair (Suture/Staple/Dermabond)
- Staple/Suture Removal
- Abscess Incision and Drainage\*
- Basic Vision/Hearing Screening
- Ingrown toenail removal



\*\* Requests for prescription refills should be made during regular office hours and may take up to 48 hours to complete. State regulations require that Patient's on controlled drugs must be seen by the physician in the office at least once every three months in order to obtain continuing refills.

2. Non-Medical, Personalized Services. The Practice shall also provide the Patient with the following non-medical services ("Non-Medical Services"), which are complementary to our members in the course of care:

- Direct Access. You shall be given direct telephone access to your physician for guidance regarding urgent concerns that arise unexpectedly after office hours. Video chat and text messaging may be available when the Physician and Patient agree that it is appropriate.
- Email Access. You shall be given access to a secure patient portal through which non-urgent communications can be addressed and which shall be responded to by Your physician or a staff member as appropriate. You understand and agree that email and the internet should never be used to access medical care in the event of an emergency or any situation that could reasonably be expected to develop into an emergency. You agree that in such situations, You will call 911 or go to the nearest emergency medical facility and follow the directions of emergency medical personnel.
- No Wait or Minimal Wait Appointments. Reasonable effort shall be made to assure that the Patient is seen by the physician immediately upon arriving for a scheduled office visit or after only a minimal wait. In the unusual event that the physician foresees more than a minimal wait time, the Patient shall be advised and given the option to come at the later time or reschedule the appointment at Patient's convenience.
- Same Day/Next Day Appointments. Every reasonable effort shall be made to accommodate urgent same or next day appointments when necessary and requested.
- Specialist Coordination. The physician shall coordinate with the Patient's medical specialists and clinicians and shall assist the Patient in obtaining specialty care as needed. The Patient understands that fees paid under this Agreement do not include and do not cover specialist's fees or fees due to any medical professional other than the Practice physician.



**Appendix B**

**PATIENT ENROLLMENT FORM**

THE FEES AS SET OUT IN THE ATTACHED APPENDIX C, SHALL APPLY TO THE FOLLOWING PATIENT(S). THE PARENT OR GUARDIAN, BY SIGNING THIS APPENDIX B, CERTIFIES THAT THEY HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT.

CHILD/CHILDREN TO WHOM THIS AGREEMENT APPLIES: Patient

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Patient

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Patient

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Patient

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Patient

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Patient

PARENT OR GUARDIAN: (Provide email address only if you agree to Email communication) Street

Address \_\_\_\_\_ City, State,

Zip \_\_\_\_\_ Preferred Contact

Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Check YES/NO where indicated only if you agree to text message communication. Your signature indicates acceptance of the terms of the Patient Agreement

DO YOU AGREE TO TEXT AND EMAIL MESSAGE COMMUNICATION REGARDING THE HEALTH CARE CONCERNS OF THE ABOVE-NAMED CHILDREN? (CHECK ONE)  YES  NO

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient(s): \_\_\_\_\_





## Appendix C

### MEMBERSHIP ITEMIZATION

#### Annual Membership Fee

\$5950 for children under 2 years old

\$4950 for children over 2 years old

This includes all services listed in Appendix A as well as in-house labs and unlimited office visits, text messaging, video conferences and phone calls with 24/7 access to the providers.

#### Discounts

10% Discount for a second child

Discount is applied to the cost of the additional child, not the entire membership fee.

#### House Calls

House calls are included in the membership fee (4 total) for newborns – 2 months of age.

For any child over 2 months of age, house calls will be made available upon request for a \$400 additional fee.

Monthly Membership Auto Deduction via ACH, Debit/Credit Card Option is available.

Payment of first month's membership amount as well as completion of Authorization of Automatic Billing and Medical Records Release is strongly encouraged to be completed within ONE WEEK of signing this agreement to confirm your enrollment without any potential delays in access to the office.

Signature \_\_\_\_\_

Signature Date \_\_\_\_\_

Full Name Relationship to patient \_\_\_\_\_

