Patient acknowledges that execution of this Services Agreement is an application to join Fiat Family Medicine, LLC ("Practice name") medical practice as a patient. Fiat Family Medicine, in its sole discretion, may accept or reject any Patient at any time for any reason. If Patient is accepted by Fiat Family Medicine, this Agreement shall govern the ensuing business relationship.

SERVICES AGREEMENT BETWEEN PATIENT AND PRACTICE

READ THIS CAREFULLY. THIS IS AN AGREEMENT BETWEEN **FIAT FAMILY MEDICINE**, A INDIANA LIMITED LIABILITY COMPANY ("**PRACTICE"**), AND YOU, ("**YOU**" OR "**PATIENT"**).

A patient is defined as those persons for whom the Practice shall provide Services, and who are signatories to, or otherwise listed in, this Agreement. Your decision to be a Patient of the Practice under this Agreement is voluntary. If you decide to cancel this Agreement, the Practice will make all efforts required by law to help you transfer your care to another physician or practice.

In exchange for certain fees paid by you as the Patient, Practice, through its physicians and staff, agrees to provide you with the Services described in this Agreement according to the terms and conditions herein.

1. Services. As used in the Agreement, "Services" shall mean those medical and non-medical services that the Practice's physicians and staff are permitted to perform and that are consistent with their training and experience, which are set forth in the Practice's "Schedule of Services," which is subject to change.

2. Fees. In exchange for the Services provided to Patient during the term of this Agreement, Patient agrees to pay Practice the amount set forth in the Schedule of Services as well as any corresponding price lists ("Fees").

a. You acknowledge that the Practice may not bill any other party for Services provided to You by the Practice. However, some of the Services provided may be partially or fully covered by your private health insurance or other third-party payment program ("Insurance"). You may, at your sole discretion and expense, seek reimbursement for such services unless otherwise prohibited. The Practice, at its sole discretion, may provide You with documentation related to the Services.
b. Payment of Fees is due at the time Services are rendered unless otherwise specified. If this Agreement is canceled by either party before the Agreement termination date, Practice shall refund, in accordance with this Agreement, the Patient's prorated share of any pre-paid Fees remaining after deducting charges for services rendered to Patient and any administrative fees up to and including date of termination.
c. All or part of the Fees may not be considered deductible for IRS or State tax purposes, nor reimbursable by private health insurance, Flexible Spending Accounts, Health Savings Accounts or Health Reimbursement Accounts. Insurance may not cover your Fees. You agree that the Practice has not made any guarantee as to what insurance will or will not cover or count toward any deductible.
d. You remain ultimately responsible for payment of all Fees. If part or all of your Fees are paid on your behalf by another party, such as an employer, You hereby agree that You shall remain responsible for any unpaid balance. Should such third party, for any reason, not pay a portion or all of your Fees, You shall be responsible for full payment during the Term of this Agreement. If You sponsor another patient, such as a dependent, You shall be responsible for payment of the sponsored patient's Fees, regardless of any contribution from a third party (such as an employer).

3. Insurance Processing for Services. Please note the Practice will submit any of the items below to your insurance provider for payment. Any copays, deductibles, and/or coinsurances will be billed to you. This will help us offset expenses incurred. By signing this agreement, I agree to allow Fiat

to submit these services to my insurance company on my behalf.

a. Vaccines/immunizations
b. Other services that may require high expense for Fiat, such as certain in-office procedures or other services based on the discretion of the provider.

4. Non-participation in Insurance Plans. You acknowledge the Practice (and/or its physicians) may not participate in private or public insurance programs. NO REPRESENTATIONS WHATSOEVER ARE MADE THAT ANY FEES PAID UNDER THIS AGREEMENT ARE COVERED AND/OR ELIGIBLE FOR REIMBURSEMENT BY PATIENT'S HEALTH INSURANCE AND/OR OTHER THIRD PARTY PAYERS. Patient shall retain sole responsibility for any such determination.

a. The Practice is not a participating provider in Medicaid or Medicare programs. If you have Medicaid or Medicare insurance ("Government Health Care"), or ever become eligible for such insurance, You acknowledge that the Practice will not submit bills to the Medicaid or Medicare programs. You hereby agree to the provisions of Attachment D to this Agreement as a condition of receiving Services from the Practice.
b. You agree to notify the Practice prior to receiving any further Services if You become a Government Health Care recipient. If You require a provider who participates in Medicare, Medicaid, or any other government-sponsored health care program, You may terminate this Agreement as provided herein, and the Practice will direct You to the appropriate resource for assistance in locating a provider who participates in Medicare or Medicaid and make commercially reasonable efforts to assist the transfer of Your care to another physician or practice.

5. NOT Insurance. You understand that the Practice is not health insurance, a health benefit plan or a health insurance provider. The Practice is not responsible for making any health care available to you other than the Services. The Practice is not intended as and is not a substitute for emergency medical services. In the event of a medical emergency, you should call 911. The Practice encourages You to maintain adequate Insurance coverage at all times.

6. No Guarantee of Cure. You understand that no guarantees have been made to You as to the results of examinations or treatments provided to You at the Practice.

7. Annual Office Visits Required for Telemedicine. In order to receive any Services through telemedicine, a face-to-face visit at the Practice is required at least annually. It is Your responsibility to comply with this requirement.

8. Communications. You hereby consent to Practice's use of your designated email address to convey written notices under this Agreement.

a. **Personal Health Information:** You expressly consent to the Practice, AND/OR ITS PHYSICIANS, STAFF, EMPLOYEES, AGENTS AND REPRESENTATIVES, SHARING YOUR CONFIDENTIAL PERSONAL HEALTH INFORMATION, AS NECESSARY, WITH OTHER TREATING PHYSICIANS, HOSPITALS, HEALTHCARE FACILITIES, AND LICENSED HEALTHCARE PRACTITIONERS.
b. **Consent to Electronic Communications:** You acknowledge that You have been informed of how patient-physician email and other methods of electronic communication may be used by the Practice in connection with the Services, described in detail in the Patient-Physician Email Disclosure & Consent, included as Attachment A to this Agreement. By entering into this Agreement, You hereby agree to accept the terms and risks of such use of electronic communications as described therein.
c. **Communications with Employer:** If You participate in the Practice through enrollment with an employer or similar group, You hereby agree to the terms of the "Employer/Group Authorization", included as Attachment B to this Agreement, authorizing the Practice to use and share information about You as indicated therein.
d. **Communications with Caregivers:** If you designate a Caregiver, the Practice may communicate regarding Your personal health information with the individual(s) whom You designate as a Caregiver on the Caregiver Designation & Authorization form, included, if

applicable, as Attachment C to this Agreement. Such communications may include information about the Services that have or may be provided to You by the Practice, general Patient health status, and any particular Patient health conditions or concerns, as outlined therein.

9. Term; Termination. This Agreement will commence on the Effective Date and continue for a term of twelve (12) months, provided Patient fully complies with the terms and conditions of this Agreement upon commencement, including without limitation, the timely payment of all fees.

a. Renewal. Unless terminated as set forth herein, at the expiration of the initial Term (and each succeeding Term), the Agreement will automatically renew for successive twelve-month Terms.
b. Termination by Practice. Practice shall have the absolute and unconditional right to terminate the Agreement at any time, with or without cause. Any unused portion of any Fees already paid to Practice prior to date of termination shall be refunded to Patient, in accordance with this Agreement.
    i. Practice shall have the absolute and unconditional right to apply a late fee of $35 as a late payment penalty. After repeated late payment penalties by a Patient, the Practice reserves the to terminate the Agreement.
c. Termination by Patient.
    i. Patient shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving ninety (90) days' prior written notice to the Practice. Termination shall be effective upon the last day of the month during which such notice period expires ("Effective Date of Termination").
    ii. Termination shall not relieve Patient of any obligations, including without limitation, Fees, owed to Practice up to and including the Effective Date of Termination.

10. Severability. If for any reason any provision of this Agreement shall be deemed, by a court or legal proceeding of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of 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 in its modified form that provision shall then be enforceable.

11. Amendment. This Agreement may be amended to the extent required by federal, state, or local law or regulation ("Applicable Law"), and/or at Practice's sole discretion, by providing notice to Patient within thirty (30) days of such amendment. Any such changes shall be incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by Practice. Patients shall have the option to terminate this Agreement within thirty (30) days following receipt of such notice if any such amendment materially affects Patient's contractual rights under this Agreement. 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 a part of this Agreement as though they had been expressly set forth in this Agreement.

12. Relationship of Parties. The parties intend and agree that Practice (including its physicians and staff), in performing Services under this Agreement, shall be an independent contractor as defined by the guidelines promulgated by the United States Internal Revenue Service and/or the United States Department of Labor, and shall have exclusive control of all work and the manner in which it is performed.

13. Legal Significance. Patient acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Patient also acknowledges having 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.

14. Miscellaneous. This Agreement, and any rights the Patient may have under it, may not be assigned or transferred by Patient. The Practice may change its location with thirty (30) days' written notice to you. This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted. Captions in this Agreement are

used for convenience only and shall not limit, broaden, or qualify the text. This Agreement contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement. This Agreement shall be governed and construed under the laws of the State of Minnesota. You and the Practice each agree to use good faith negotiation to resolve any dispute, claim, or controversy that may arise under or relate to this Agreement or to a breach of the Agreement. In the event that You and the Practice are not able to resolve any dispute, claim, or controversy by negotiation, any such dispute, claim, or controversy shall be settled by binding arbitration which shall be conducted in the county and state where the Practice is located. All written notices are deemed served if sent to the address of the party by certified U.S. mail unless otherwise specified herein.

I, THE PATIENT, HEREBY PERMIT AND AUTHORIZE THE PRACTICE AND ITS MANAGERIAL PARTNER FREEDOM HEALTHWORKS LLC, TO USE MY WRITTEN OR VERBALLY EXPRESSED WORDS, VIDEO AND/OR AUDIO RECORDINGS AND/OR OTHER LIKENESSES OF MYSELF FOR PUBLICITY, MARKETING AND PROMOTIONAL PURPOSES, WITHOUT COMPENSATION TO ME.

I AUTHORIZE FIAT FAMILY MEDICINE, AND/OR ITS SERVICE PROVIDERS TO BILL THE CARD PROVIDED TO PAY ALL FEES UNDER THIS AGREEMENT.

I, THE UNDERSIGNED, OF THE FOLLOWING ADDRESS CERTIFY THAT I HAVE READ THIS AGREEMENT, UNDERSTAND ITS CONTENTS AND SIGNIFICANCE, AND AM COMPETENT TO EXECUTE IT.

By Patient(s) and/or Legal Representative(s)

Patient Name:

_____

Attachment A

PHYSICIAN-PATIENT EMAIL DISCLOSURE AND CONSENT

Use of Electronic Communications: You and the Practice may use patient-physician e-mail and other methods of electronic communication in connection with the Services. You have the option to receive Services, to the extent medically appropriate as determined by the Practice, through the use of Internet or cellular video, audio and audio-video services, and cellular text and cell phones ("E-communications"). Applicable law may require information exchanged through certain E-communications such as e-mail must be maintained in hard copy as part of your medical records.

However, E-communications are not an appropriate means of communicating regarding emergency or other time-sensitive issues. **In the event of an emergency, or a situation in which You could reasonably expect to develop into an emergency, You should call 911, and follow the directions of emergency personnel.** The Practice may provide after-office-hours phone consultation to help you decide if You have an emergency. If You do not receive a response to an email or cellular messaging system communication within two business days, You agree to use another means of communication to contact the Practice, including via telephone. The Practice will not be liable to You, your successors or assigns, for any damages caused by a delay in responding to You as a result of technical failures.

Privacy Risks: You acknowledge that E-communications with the Practice are not guaranteed by the Practice to be secure or confidential methods of communication. There is some risk that information transferred through E-communications may be misdirected, intercepted or improperly disclosed. As such, **You expressly waive the Practice's obligation to ensure confidentiality with respect to those means of communication and agree to hold harmless the Practice for any losses, damages, or causes of action resulting from or arising in connection with any information lost, misdirected, intercepted, or disclosed due to technical failures.**

Security Safeguards: The Practice will make commercially reasonable efforts to limit information sent via E-communications to the minimum necessary and to keep Internet and cellular communications confidential and secure. The Practice will not disclose your personal health information to a third party without express authorization from You or as required by law. In making any authorized or required disclosure to a third party, the Practice will take commercially reasonable precautions to ensure that the receiving party is who they claim to be and has a legitimate need for the patient-identifiable information requested.

Cancellation: You are not required to authorize the use of unencrypted email and cellular communications and a decision to not consent to the use of unencrypted email and cellular communications will not affect the care You receive from the Practice. You may cancel the Practice's use of email and cellular communications in writing at any time. It is understood that the revocation will not apply to information that has already been released based on this authorization.

Non-Compliance: If You fail to comply with the terms under which E-communications may be used as outlined above, the Practice may terminate the use of such E-communications as determined in the Practice's sole discretion.

Authorization: You authorize the Practice to communicate with You regarding prescription refills, appointment scheduling, patient education, and any other matters related to Services or your participation in the Practice, which may include Your Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA")), using the e-mail address and/or cellular phone number You provide below. By indicating that You consent to receive cellular and/or e-mail messaging and providing an email address or cellular phone number below, You authorize the Practice to use the indicated means of communication even though the confidentiality of Your information transmitted through such means cannot be guaranteed.

Cellular Messaging

You hereby Consent to receive cellular messaging services from the Practice regarding Your care, with the understanding that it may not be a secure transmission

E-mail Messaging

You hereby Consent to receive email messages from the Practice regarding Your care, with the understanding that it may not be a secure transmission.

Attachment B

EMPLOYER/GROUP AUTHORIZATION

If the undersigned, a patient at the Practice ("You"), participates in the Practice through a group plan (such as that provided by an employer), and/or such employer/group pays all or part of your Fees, then You authorize the release of summary health information about You as follows:

Requests for Summary Information about You: As part of making certain Services available to you at the Practice, the employer/group under which You are enrolled may request from the Practice information about the results of any biometric screening examinations and/or health risk assessments that You have completed. In addition, the employer/group may request summary reports concerning the utilization of Services among its enrollees who participate in the Practice. You acknowledge that such summary information will be prepared using information from the medical records maintained by the Practice about You.

Authorization to Release: You authorize the Practice to use health information about You that is maintained by the Practice to prepare the summary information described in this Employer Authorization and disclose such information in reports to the employer/group under which You are enrolled.

Term of Authorization: This authorization will be effective for as long as You are participating in the Practice through an employer/group.

Attachment C

CAREGIVER DESIGNATION & AUTHORIZATION

The undersigned, a patient at the Practice ("You"), designate one or more Caregivers and authorize such Caregiver(s) to engage with the Practice on Your behalf as follows:

Caregiver Designation: You desire to designate the individual(s) listed below as Your Caregiver(s) for purposes of assisting with and facilitating the Services You receive from the Practice:

1. _____ Relationship to You: _____
   Caregiver Name (Print) Phone Number: _____
   E-mail Address: _____

2. _____ Relationship to You: _____
   Caregiver Name (Print) Phone Number: _____
   E-mail Address: _____

3. _____ Relationship to You: _____
   Caregiver Name (Print) Phone Number: _____
   E-mail Address: _____

Scope of Caregiver Authority: You authorize the Caregiver(s) to assist with, participate in, and facilitate all aspects of Your participation as a patient in the Practice, including, but not limited to, the following activities:

1. Scheduling appointments for You.
2. Attending consultations.
3. Communicating with the Practice through E-communications, including cellular messaging and/or e-mail messaging, as authorized by the Physician-Patient EMail Disclosure & Consent.
4. Accessing, amending, and updating information in Your medical records maintained by the Practice.
5. Assisting with or making payments on behalf of You.

Authorization to Disclose PHI: You authorize the Practice to disclose Your Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), to the Caregiver(s) You have designated herein for the purposes outlined in this Caregiver Designation & Authorization form.

Right to Modify or Rescind: You are not required to designate any Caregiver(s) in order to participate in the Practice. You may rescind or modify this Caregiver Designation & Authorization form at any time by providing written notice to the Practice.

Patient ("You")

Printed Name: _____ Date: _____

Signature: _____

If signed by a Legal Representative of a minor patient, complete the following:

1. Print Name: _____
2. Legal authority: □ Parent □ Legal guardian

Attachment D

MEDICARE OPT-OUT NOTICE & PRIVATE AGREEMENT

The undersigned ("You"), agrees as follows if: (1) You are a Medicare beneficiary, or, (2) You ever become eligible to be a Medicare beneficiary:

Notice of Opt-Out: The Practice is not a participating provider in the Medicare program ("Medicare"), and the physician providing Services on behalf of the Practice ("Practice Physician") does not participate in Medicare. The Practice and Practice Physician have never been excluded from Medicare; however, the Practice Physician has opted-out of the Medicare program.

Responsibility for Payment: You agree to accept full financial responsibility for payment of the Participation Fee and any other charges incurred for Services under the Practice Services Agreement (the "Agreement"). Medicare pricing and charge limits do not apply to the Participation Fee or any other charges for Services furnished by the Practice. Once you enter into this Private Agreement, Medicare may not pay for any items or services furnished by the Practice, even items that otherwise would have been covered by Medicare. In addition, Medigap plans may not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

No Claims to Medicare: You agree not to submit any claims to Medicare and will not ask the Practice to submit any claims to Medicare for any Services furnished to you by the Practice.

Voluntary Agreement: You enter in this Private Agreement with the knowledge that You have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare. You are not required to enter into any private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out of Medicare.