PATIENT AGREEMENT
TERMS OF SERVICE

This Patient Agreement is between **ALL IN HEALTH**

(the Practice), and _____ (Patient, Member, or You).

Background

The Practice, located at **541 WEST LAMAR ALEXANDER PARKWAY MARYVILLE, TN 37801** provides ongoing primary care medicine to its Members in a direct pay, membership model (DPC). In exchange for certain periodic fees, the Practice agrees to provide You with the Services described in this Agreement under the terms and conditions contained within.

Definitions

1. **Services**. In this Agreement, "Services" means the collection of services, medical and non-medical, which are described in Appendix A (attached and incorporated by reference), which We agree to provide to You under the terms and conditions of this Agreement.

2. **Patient.** In this Agreement, "Patient," "Member," "You" or "Yours" means the persons for whom the Practice shall provide care, who have signed this Agreement, and/or whose names appear in appendix B (attached and incorporated by reference).

Agreement

3. **Term**. This Agreement will last for one year, starting on the date it is fully executed by the parties.

4. **Renewal.** The Agreement will automatically renew each year on the anniversary date of the Agreement unless either party cancels the Agreement by giving 30 days written notice.

5. **Termination.** Either party can cancel this Agreement at any time by giving 30 days' written notice to the other of intent to terminate.

6. **Payments and Refunds – Amounts and Methods.**

   A. In exchange for the Services described in Appendix A, You agree to a monthly payment (or Membership Fee) in the amount which appears in Appendix C, which is attached and incorporated by reference;

   B. Thereafter, the Membership Fee shall be due on the first business day of every month. Amount will be prorated for members who sign up during the month.

   C. The Parties agree that the required method of payment shall be by automatic payment through a debit or credit card or automatic bank draft.

7. **Early Termination.** If You cancel this Agreement before its term ends, We will refund any unused portion of your membership fee on a per diem basis.

8. **Non-Participation in Insurance.** The Practice does NOT participate with any health plans, HMO panels, or any other third-party payor. As such, we may not submit bills or seek reimbursement from any third-party payors for the Services provided under this Agreement.

9. **Medicare.** The Patient understands that the Practice and staff have opted out of Medicare. As a result, both the Patient and the Practice shall be prohibited by law from seeking reimbursement from Medicare for any Services provided under this Agreement. Accordingly, the Patient agrees not to submit bills or seek reimbursement from Medicare for any such services. Furthermore, if the Patient is eligible or becomes eligible for Medicare during the term of this Agreement, the Patient agrees to immediately inform the Practice and sign the Medicare private contract as provided and required by law.

10. **This Agreement Is Not Health Insurance**. The Patient has been advised and understands that this Agreement is not an insurance plan. It does not replace any health coverage that the Patient may have, and it does not fulfill the requirements of any federal health coverage mandate. This Agreement does not include hospital services, emergency room treatment, or any services not personally provided by the Practice or its staff. This Agreement includes only those Services identified in Exhibit A. If a Service is not specifically listed in Appendix A, it is expressly excluded from this Agreement. The Patient acknowledges that We have advised them to obtain health insurance that will cover catastrophic care and other services not included in this Agreement. Patients are always personally responsible for the payment of any medical expenses incurred for services not included under this Agreement.

11. **Communications**. The Practice endeavors to provide Patients with the convenience of a wide variety of electronic communication options. Although We are careful to comply with patient confidentiality requirements and make every attempt to protect Your privacy, communications by email, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed secure or confidential methods of communications. By placing Your initials at the end of this agreement, You acknowledge the above and indicate that You understand and agree that by initiating or participating in the above means of communication, you expressly waive any guarantee of absolute confidentiality with respect to their use. You further understand that participation in the above means of communication is not a condition of membership in this Practice; that you are not required to initial this clause; and that you have the option to decline any particular means of communication.

12. **Email and Text Usage.** By providing an email address on the attached Appendix B, the Patient authorizes the Practice and its staff to communicate with him/her by email regarding the Patient's "protected health information" (PHI).[1] By providing a cell phone number in Appendix B and checking the "YES" box on the corresponding consent question, the Patient consents to text message communication containing PHI through the number provided. The Patient further understands and acknowledges 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, for dealing with time-sensitive issues, or for disclosing sensitive information. Therefore, in an emergency or a situation that could reasonably be expected to develop into an emergency, the Patient agrees to call 911 or go to the nearest emergency care facility and follow the directions of personnel.

13. **Technical Failure.** Neither the Practice nor its staff will be liable for any loss, injury, or expense arising from a delay in responding to the Patient when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service outages; (ii) power outages; (iii) failure of electronic messaging software, or email outages of physician; (iv) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission; (iv) any

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

interception of email communications by a third party which is unauthorized by the Practice; or (v) Patient's failure to comply with the guidelines for use of email or text messaging, as described in this Agreement.

14. **Physician Absence.** From time to time, due to such things as vacations, illness, or personal emergency, the physician may be temporarily unavailable. When the date/s of such absences are known in advance, the Practice shall give notice to Patients so that they may schedule non-urgent care accordingly. During unexpected absences, Patients with scheduled appointments shall be notified as soon as practicable, and appointments shall be rescheduled at the Patient's convenience. If during physician's absence, the Patient experiences an acute medical issue requiring immediate attention, the Patient should proceed to an urgent care or other suitable facility for care. Charges from Urgent Care or any other outside provider are not included under this Agreement and are the Patient's responsibility. The Patient may, however submit such charges to their health plan for reimbursement consideration or request that the outside provider do the same. The Patient is responsible for understanding the coverage rules of their health plan, and We cannot guarantee reimbursement.

15. **Dispute Resolution**. Each party agrees not to make any inaccurate or untrue and 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 Patient concerns.

Therefore, in the event that a member is dissatisfied with, or has concerns about, any staff member, service, treatment, or experience arising from their membership in this Practice, the Member and the Practice agree to refrain from making, posting or causing to be posted on the internet or any social media, any untrue, unconfirmed, inaccurate, disparaging comments about the other. Rather, the Parties agree to engage in the following process:

A. Member shall first discuss any complaints, concerns, or issues with their physician;

B. The physician shall respond to each of the Member's issues or complaints;

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

16. **Monthly Fee and Service Offering Adjustments.** In the event that the Practice finds it necessary to increase or adjust monthly fees or Service offerings before the termination of the Agreement, the Practice shall give 30 days' written notice of any adjustment. If Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled monthly payment.

17. **Change of Law.** If there is a change of any relevant law, regulation or rule, which affects the terms of this Agreement, the parties agree to amend it only to the extent that it shall comply with the law.

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

19. **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.

20. **Assignment**. Neither this Agreement nor any rights arising under it may be assigned or transferred without the agreement of the Parties.

21. **Legal Significance**. The Patient acknowledges that this Agreement is a legal document that gives the parties certain rights and responsibilities. The Patient agrees that they are suffering no medical emergency and has had reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and is satisfied with the terms and conditions of the Agreement.

22. **Miscellaneous.** This Agreement is to be construed without regard to any rules requiring that it be construed against the drafting party. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

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

24. **No Waiver.** Either party may choose to delay or not to enforce a right or duty under this Agreement. Doing so shall not constitute a waiver of that duty or responsibility and the party shall retain the absolute right to enforce such rights or duties at any time in the future.

25. **Jurisdiction.** This Agreement shall be governed and construed under the laws of the State of Tennessee. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the

Practice.

26. **Notice**. Written Notice, when required, may be achieved either through electronic means at the email address provided by the party to be noticed or through first-class US Mail. All other required notice must be delivered by first-class US mail to the Practice at: 541 West Lamar Alexander Parkway Maryville, TN 37801 and to the Patient, at their address provided in Appendix B.

The Parties agree that throughout this agreement and its attachments, checking the appropriate box next to their name will constitute an electronic signature and shall be valid to the same extent as a handwritten signature.

For: ALL IN HEALTH

☐ By Travis Groth, DO _____
Date

Patient:

☐ _____ _____
Printed Name Date

APPENDIX A

SERVICES

1. Medical Services

Medical Services offered under this Agreement are those consistent with the physician's training and experience, and as deemed appropriate under the circumstances, at the sole discretion of the physician. The Patient is responsible for all costs associated with any medications, laboratory testing, and specimen analysis related to these Services unless otherwise noted. The specific Medical Services provided under this Agreement include the following:

- Acute and non-acute office visits
- Chronic disease management (e.g. diabetes, high blood pressure, asthma, heart disease)
- Preventive care
- Wellness visits
- Well-woman care
- Well-child care
- Sports physicals
- School physicals
- Weight loss
- Smoking cessation
- Hormone replacement consults
- Healthy Lifestyle Counseling
- Removal of benign skin lesions / warts
- Simple dermatology procedures
- Aspiration and/or injection of joints
- Abscess Incision and Drainage
- Wound repair and sutures
- Ear wax removal
- Trigger point injection

2. **Non-Medical, Personalized Services**. The Practice shall also provide Members with the following non-medical services:

    - **After-Hours Access**. Subject to the limitations of paragraph 14, Members shall have direct telephone access to the physician for guidance in regard to urgent concerns that arise unexpectedly after office hours. All other non-urgent concerns should be addressed during normal work hours Monday-Friday 8AM-5PM. Medical emergencies should ALWAYS seek immediate emergency medical attention.

- **Email Access.** Subject to the limitations of paragraph 12, above, The Patient shall be given the physician's email address to which non-urgent communications can be addressed. The Patient understands and agrees that neither email nor the internet should be used to access medical care in the event of an emergency or any situation that could reasonably develop into an emergency. The Patient agrees that in this situation, when s/he cannot speak to the physician immediately in person or by telephone, to call 911 or go to the nearest emergency medical assistance physician, and follow the directions of emergency medical personnel.

- **Same Day/Next Day Appointments**. When a Patient contacts the Practice prior to noon on a regular office day to request a same-day appointment, every reasonable effort shall be made to schedule the patient for that same day; or if this is not possible, patient shall be scheduled for the following office day (subject to the limitations of paragraph 14).

- **No Wait or Minimal Wait Appointments.** Every 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. If physician foresees more than a minimal wait time, Patient shall be contacted and advised of the projected wait time. Patient shall then have the option of seeing the physician at the later time or reschedule at a time convenient to the Patient.

- **Telehealth.** Telehealth (virtual visits) will be available when desired and deemed appropriate by the Patient and physician.

- **Specialists Coordination**. The physician shall coordinate care with medical specialists and other practitioners to whom the Patient needs referral. The Patient understands that fees paid under this Agreement do not include specialist's fees or fees due to any medical professional other than the Practice staff.

APPENDIX B

PATIENT ENROLLMENT FORM

PATIENT ENROLLMENT FORM

CHECK YES WHERE INDICATED *ONLY* IF YOU AGREE TO TEXT MESSAGE COMMUNICATION. PROVIDE EMAIL ADDRESS *ONLY* IF YOU AGREE TO EMAIL COMMUNICATION.

THE FEES AS SET OUT IN THE ATTACHED APPENDIX C, SHALL APPLY TO THE FOLLOWING PATIENT(S), WHO BY SIGNING BELOW (OR AS LEGAL REPRESENTATIVE), CERTIFY THAT THEY HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT:

Patient 1

Print Patient Name_____ Date of Birth_____

Street Address_____

City, State, Zip_____

Cell Phone_____ Alternate Number _____Email_____

I Agree to Text Communication: (check one below)

- ☐ Yes
- ☐ No

Printed Name: _____ Relationship to Patient: _____

Patient 2

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number _____Email_____

I agree to Text Communication: (check one below)

- ☐ YES
- ☐ NO

Printed Name: _____ Relationship to Patient: _____

Patient 3

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number_____ Email_____

Agree to Text Communication: (check one below)

- ☐ YES
- ☐ NO

Printed Name: _____ Relationship to Patient: _____

Patient 4

Patient Name_____ Date of Birth_____

Cell Phone_____ Alternate Number _____ Email_____

I agree to Text Communication: (check one below)

- ☐ YES
- ☐ NO

Printed Name: _____ Relationship to Patient: _____

APPENDIX C

FEE ITEMIZATION

Re-enrollment fee.

If, after allowing membership to lapse or be terminated, Patient desires to re-join the practice, the Patient shall be accepted on a space-available basis, subject to a $ 150 re-enrollment fee.

Monthly Membership Fees

20 years and under*	$ 50 per month	X ____ Members	$_____
21 years and older	$100 per month	X ____ Members	$ _____

Total Monthly Membership Fee $ _____

Initial Payment

Prorated Membership Fees $ _____

Total Due on Signing

$ _____

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Upon approval, you will have the option to make monthly payments or set up a monthly auto-deduction. Payments are made directly through our secure link accessed through your electronic statement sent to your email. Your statement will include monthly fees and incidental charges which you will receive prior to any payments or deductions.

Customer(s)Name(s):_____

PAYMENT INFORMATION

I authorize All In Health to automatically bill the card listed below as specified:
Amount: $_____ for monthly subscription and Incidental Charges;

Frequency:

Monthly Start billing on: ____/____/____

End billing when: Customer provides written cancellation

CREDIT/DEBIT CARD INFORMATION:

Credit card type: **[ ]** Visa, **[ ]** MasterCard, **[ ]** American Express, **[ ]** Discover

_____ _____ _____/_____
Credit card number: Expires:

_____ _____
Cardholder's name: As shown on credit card
CVC(Security code)

Customer's signature: Date:

_____
AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

_____
DATE

_____
SIGNATURE

APPENDIX D

MEDICARE OPT-OUT AGREEMENT

This agreement ("Agreement") is entered into by and between All In Health ("Travis Groth, DO"), whose principal medical office is located at: 541 West Lamar Alexander Parkway Maryville, TN 37801, and

_____(Patient's Name), a beneficiary enrolled in Medicare Part B ("Beneficiary"), who resides at _____

_____(Patient's address).

Introduction

The Balanced Budget Act of 1997 allows Providers to "opt out" of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, Providers are required to file an affidavit with each Medicare carrier that has jurisdiction over claims that they have filed (or that would have jurisdiction over claims had the Provider not opted out of Medicare). In essence, the Provider must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years. This Agreement between Beneficiary and Provider is intended to be the contract Provider are required to have with Medicare beneficiaries when Providers opt-out of Medicare. This Agreement is limited to the financial agreement between Provider and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

Provider Responsibilities

(1) Provider agrees to provide Beneficiary such treatment as may be mutually agreed Upon and at mutually agreed upon fees.

(2) Provider agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.

(3) Provider agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.

(4) Provider agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Provider also agrees to retain a copy of this document for the duration of the opt-out period.

(5) Provider agrees to submit copies of this contract to the Centers for Medicare and

Medicaid Services (CMS) upon the request of CMS.

Beneficiary Responsibilities

(1) Beneficiary agrees to pay for all items or services furnished by Provider and understands that no reimbursement will be provided under the Medicare program for such items or services.

(2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Provider for such items or services.

(3) Beneficiary agrees not to submit a claim to Medicare and not to ask Provider to submit a claim to Medicare.

(4) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Provider that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

(5) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered Items and services from Provider and practitioners who have not opted out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other Providers or practitioners who have not opted out of Medicare.

(6) Beneficiary understands that Medigap plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make Payments for such items and services not paid for by Medicare.

(7) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

Medicare Exclusion Status of Provider

Beneficiary understands that Provider has not been excluded from participation under the Medicare program under section 1128, 1156, 1892, or any other sections of the Social Security Act.

Duration of the Contract

This contract becomes effective on January 5, 2026. Either party may terminate treatment with a 30-day notice to the other party without cause. Notwithstanding this right to terminate treatment, both Provider and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

By Travis Groth, DO
All in Health
541 West Lamar Alexander Parkway
Maryville, TN 37801

Patient's Signature: _____ Date: _____

All In Health

Direct Primary Care Practice

Medical Records Release Authorization

I hereby authorize _____ (medical facility) to release my individually identifiable health information as outlined below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory and imaging reports, medical history, treatment, and any other such related information. I understand that this authorization is voluntary and I may refuse to sign it. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

_____

Patient name (please print) Date of birth

_____ _____

_____

Address (including City, ST, and zip code)

Phone number_____

Information to be released:

◯ Complete records from _____ to _____, including lab and imaging reports

◯ All vaccinations Ⓢ All preventive measures (colonoscopies, mammograms, paps, etc.)

◯ Other

Purpose of releasing records (circle): Transfer of care or other:

_____

Please release the above information to the following medical practice:

_____

_____

(address)

Phone Number:

_____

Patient's Signature: _____

Date: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ Date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.