betterdoc

DR. JAMES V. BONDS
DIRECT PRIMARY CARE PATIENT AGREEMENT

This Direct Primary Care Patient Agreement ("Agreement") is entered into by and between _____ the undersigned patient ("Patient") and Betterdoc ("Practice") and is effective as of the _____ day of _____, 202_____ ("Effective Date").

In exchange for certain fees paid by Patient in accordance with this Agreement, the Practice, through James V. Bonds, M.D. ("Physician") and its clinical and administrative staff, agrees to provide Patient with the "Services," as defined below, pursuant to the terms and conditions set forth in this Agreement.

TERMS OF AGREEMENT

1. Services. In exchange for the fees, set forth in Paragraph 3 below, Physician agrees to provide all "Services" listed in Exhibit 1 to this Agreement. Patient understands and agrees that the Services listed on Exhibit 1 are the only Services that will be provided under the terms of this Agreement. Patient understands and agrees that the list of Services may be amended from time to time. However, the Practice will provide Patient with an updated list of the Services covered by this Agreement no later than thirty (30) days prior to the date any change in the Services will take effect.

Patient acknowledges and agrees that Physician does not provide inpatient care and will not admit, treat, or follow Patient at any hospital should Patient need the services of a hospital. Patient further acknowledges and agrees that neither the Physician nor the Practice provide obstetrical services, including midwife, doula, or similar services.

To the extent Patient requires medical care not covered by this Agreement, The Physician will refer Patient to another health care provider and/or assist Patient in finding a provider and will work with the provider of Patient's choosing to coordinate and ensure appropriate transfer of Patient's care, including providing him/her with copies of any relevant medical records.

2. Physician Availability. Direct Primary Care medicine is intended to provide Patient with excellent, primary care services in a convenient, professional manner. In that regard, Physician will make every effort to accommodate Patient's

health care needs as quickly as possible. To ensure that Patient is provided with efficient yet exceptional health care, the Practice has limited membership in its Direct Primary Care medicine program. The Patient's prompt care is important to us, and we intend to make every effort to ensure that the Patient experience with our Direct Primary Care practice is a positive one. However, there may be times when Physician or another clinical staff member is not immediately available to treat Patient. By signing this Agreement, Patient acknowledges that Physician may not be immediately available.

3. Fees. In exchange for the Services described on Exhibit 1, You agree to pay Practice a fee in accordance with the schedule selected by Patient below:

(Initial by Fee Option selected)

_____ Fee Option 1: Annual Payment Plan

Age	Fee
13-25	$330 annual
26-40	$660 annual
41+	$660 annual

Fee Option 1: Annual Payment Plan, payment is due within three (3) business days of the Effective Date of this Agreement.

_____ Fee Option 2: Monthly Payment Plan

Age	Fee
13-25	$30 monthly
26-40	$60 monthly
41+	$60 monthly

Fee Option 2: Monthly Payment Plan, payment is due on the 1st business day of the month for the duration of the 12-month contract period.

In addition to the fees above, if Patient requests and Physician agrees to a home or out-of-office visit the following charges may apply:

Additional Trip Charges

Home/Out-of-Office Appointments	Monday-Friday
8:00 am – 4:00 pm	$100 per visit
4:00 pm – 10:00 pm	$150 per visit
10:00 pm – 8:00 am	$200 per visit

Home/Out-of-Office Appointments	Saturday-Sunday & Holidays*
8:00 am – 4:00 pm	$150 per visit
4:00 pm – 10:00 pm	$200 per visit
10:00 pm – 8:00 am	$250 per visit

***Christmas Day, New Year's Day, Thanksgiving, July 4th**

The Practice will bill Patient in accordance with the Fee Option selected above and the payment instructions provided by Patient in Exhibit 2. The Practice will bill Patient Additional Trip Charges to the payment instructions provided by Patient in Exhibit 2 within 10 days of the Home/Out-of-Office Appointment.

Patient agrees to pay a $35 charge for all scheduled/recurring charges that are retuned unpaid. Patient understands and agrees that after 2 payments are returned unpaid, Physician reserves the right to terminate this Agreement immediately.

Patient understands and agrees that Services will not be provided by Physician if any fees are unpaid and outstanding.

4. Insurance. Patient understands and acknowledges that this Agreement is not an insurance plan. **It is not intended to replace any health insurance plan or coverage that Patient may carry. Patient understands and acknowledges that the fees paid under this Agreement are not covered by any health insurance plan or coverage, including Medicare, that Patient may carry.** Patient's current health insurance/Medicare/Medicare Supplement Plan will be billed for any services provided; however, Patient will not be responsible for any co-insurance or co-payments under this Agreement.

5. Term and Renewal. The term of this Agreement is for a period of twelve (12) months from the Effective Date ("Initial Term"). Agreement will automatically renew at the end of the term ("Renewal Date') for a period of twelve (12) months ("Renewal Term") if not cancelled by Patient 30 days prior to the Renewal Date. During the Initial Term, Patient may cancel the Agreement any time within the first ninety (90) days of the Initial Term.

6. Notices. Any notice required to be provided to Patient under this Agreement will be delivered to the most recent address in Patient file at the Practice. Any notice that Patient may be required to provide under this Agreement may be delivered to the following address: 3201 University Dr #360 Bryan, TX 77802 or at such other address as may be provided to Patient by the Practice from time to time.

7. Legal Significance. Patient acknowledges and understands that this is a legal document that creates certain legal rights and responsibilities. Patient has

the right to seek legal counsel of Patient's choosing and at their own cost to advise Patient of their rights and responsibilities prior to entering into this Agreement.

8. Amendment and Severability. No amendment of this Agreement shall be binding unless made in writing and signed by all parties. Notwithstanding the foregoing, the Practice may unilaterally amend this Agreement to the extent required by federal, state, or local law, upon providing Patient with timely written notice as may be dictated by the circumstances. If for any reason any provision of this Agreement is deemed by a court of law to be legally invalid or unenforceable, the validity of the remaining provisions shall not be affected, and the Agreement shall be considered modified and amended to the extent necessary to comply with the law.

9. Entire Agreement. This Agreement contains the entire agreement between the parties and supersedes all prior oral or written agreements or understandings between the parties with respect to the subject matter of this Agreement.

10. Assignment. This Agreement, nor any rights Patient may have under it, may not be assigned or transferred by Patient to any other individual and any such attempt to assign or transfer this Agreement shall be considered null and void.

11. Governing Law. This Agreement shall be governed by the laws of the State of Texas and venue shall be in Brazos County, Texas.

[SIGNATURES OF ADULT PATIENTS BELOW]

_____ _____

Patient/Legal Representative Signature Date:

_____

Print Patient Name

_____ _____

Print Legal Representative Name Relationship to Patient

_____ _____

James V. Bonds, M.D. Date:

EXHIBIT 1

COVERED SERVICES

The term "Services," as used in this Agreement, refers to the medical/clinical services provided to Patient by Physician and/or other clinical staff employed by the Practice, depending on the Physician's and the clinical staff's respective scope of practice; training; certification(s); limitation(s) of licensure, if any; and experience and expertise.

By entering into this Agreement, Patient is entitled to the following Services:

Medical Services

- Physical Exam
- In-Office Lab Tests*
  - *Urinalysis*
  - *Strep Throat*
  - *Influenza A&B*
  - *Glucose*
  - *Urine Pregnancy Test*
  - *Stool/Colon Cancer Test*
  - *Coronavirus Antigen (Rapid)*
  - *Coronavirus PCR (next day) for an additional fee*
- Laboratory Services*
  - *CBC*
  - *CMP*
  - *TSH (Thyroid)*
  - *Lipid Profile*
  - *GGTP*
  - *Uric Acid*
  - *LDH*
  - *Iron Level*
  - *Phosphorus*
  - *Urinalysis*
  - *FIT Test for Colon Cancer*
  - *PSA*
  - *HBA1C, as medically necessary*

**Lab services available at 3 locations in Bryan/College Station and other select locations in the US.*

- Testing
  - *EKG/ECG*
  - *Cardiac Stress Testing*

- Treatments
  - *Nebulizer breathing*
  - *Kenalog Allergy Shot*
  - *Minor skin laceration repair*
  - *Skin biopsy*
  - *Abscess treatment*
  - *Joint injections (knee, shoulder, wrist)*
  - *Testosterone Therapy*
- Vaccinations*
  - *Flu/Influenza*
  - *Pneumonia*
  - *Hepatitis A& B*
  - *TDP (tetanus, whooping cough)*
  - *Meningitis*

**Cost of vaccinations are not included in plan cost; costs are billed at the physician's cost of the vaccine.*

Services Not Covered

- Hospital Care
- Emergency Room Care
- Urgent Care Clinics
- Surgical Care
- OB/GYN Care
- Cosmetic Services
- Radiology Services
- Other Physician or Clinic Care

In addition to the above-referenced clinical Services, Patient is entitled to the following non- medical Services:

Timely Access: Patient will have access to Physician via a direct telephone number, text messaging and email on a 24 hour per day/7 day per week basis. Physician will make every effort to provide a response as quickly as possible. As noted in the Agreement, however, there may be times when Physician cannot respond immediately.

Minimal Wait Times: The Practice will make every effort to ensure that Patient is seen promptly at Patient's appointment time or with only a minimal wait. If there is an unforeseen wait time, the Practice will contact Patient immediately to make Patient aware of the projected wait time, allowing Patient to adjust Patient's schedule or to reschedule Patient's appointment as Patient so chooses.

Same or Next Day Appointments: In addition to being seen timely upon Patient arrival, the Practice will make every effort to schedule an appointment with Patient on the day of, or the next day following, Patient's request for an appointment.

Home or Out-of-Office Visits: Patient may request that Physician see Patient in Patient's home or other Out-of-Office location. In situations in which Physician considers a home or out-of-office visit reasonable and appropriate and/or can accommodate such a request, Physician will make every reasonable effort to accommodate the request for a home or out-of-office visit.

Home or Out-of-Office evaluations and treatments are generally available during normal business hours 8:00 am – 4:00 pm Monday through Friday for an additional trip charge. Distance for home or out-of-office visits are limited to a 15-mile radius from our office location at 3201 University Dr E #360 Bryan, TX 77802.

After-Hours appointments for home visits and other out-of-office services will be billed After-Hours Additional Trip Charges for weeknights and weekends.

The above-referenced Services are the only Services provided under this Agreement. Any referrals to other providers are not covered by Patient fees. If Patient has any questions about the Services covered, Patient is encouraged to speak with the Physician directly.

EXHIBIT 2

RECURRING ACH PAYMENT AUTHORIZATION

Patient authorizes regularly scheduled charges to Patient's checking/savings account. Patient will be charged the amount indicated below each billing period. The charge will appear on your bank statement as an "ACH debit". Patient agrees that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to payment being collected.

I, _____, authorize Betterdoc/James V. Bonds M.D. to charge my

bank account indicated below for $_____ on the _____ day of each _____.

This payment if for Direct Primary Care Service Agreement.

BILLING INFORMATION

Billing Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Phone 2: _____

BANK INFORMATION

Account Type: ☐ Checking ☐ Savings

Account Name: _____

Bank/Credit Union Name: _____

ABA/Routing Number: _____ Acct #: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Betterdoc/James V. Bonds M.D. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Betterdoc/James V. Bonds M.D. may at its discretion attempt to process the charge again within 30 days and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of the bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

_____ _____

Account Holder's Signature Date

EXHIBIT 2 (CONT'D)

RECURRING CREDIT CARD PAYMENT AUTHORIZATION

Patient authorizes regularly scheduled charges to Patient's credit card. Patient will be charged the amount indicated below each billing period. The charge will appear on your credit card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize Betterdoc/James V. Bonds M.D. to charge my Credit Card

indicated below for $_____on the _____ of each _____.

BILLING INFORMATION

Billing Address _____

City _____ State _____ Zip _____

Phone: _____ Phone 2: _____

Email _____

Card Details ☐ Visa ☐ MasterCard

Cardholder Name _____

Account/CC Number _____

Expiration Date _____ /_____ CVV_____ Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Betterdoc/James V. Bonds M.D. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

_____ _____

Accountholder Signature Date