PEDIATRIC WORKS

Table of Contents

PEDIATRIC
WORKS

PATIENT AGREEMENT
PEDIATRIC WORKS, LLC

PEDIATRIC WORKS MEMBERSHIPS

This is an Agreement between Pediatric Works, LLC. a Georgia Limited Liability Corporation (Clinic, Us or We), and _____ (You) .

Background

The Clinic is a direct pay pediatric practice which provides primary care services to its patients in a membership-based direct pay (DPC), at 6065 Lake Forrest Dr. Ste 250 Atlanta, GA 30328. As the parent or legal guardian of the Patient/s enrolled under this Agreement, You to pay certain fees in exchange for a collection of medical and non-medical Services which We agree to provide, and which are described in Appendix B —which is attached and incorporated by reference.

The Parties agree to the following terms and conditions:

Definitions

1. **Services**. In this Agreement, "Services," means the collection of services both medical and non-medical, offered to you as a Member, under this Agreement which are identified and incorporated into this Agreement as in Appendix A.

2. **You**. In this Agreement, "You" means the Party to this Agreement who is the Parent or Guardian of the Patient/s listed in Appendix B, and who has executed this Agreement.

3. **Patient or Member**. In this Agreement, "Member," or "Patient," means the person/s for whom we shall provide care under this Agreement; who are listed in Appendix B; are beneficiaries to this Agreement; and for whom You are the parent or legal guardian.

1. AGREEMENT

4. **Term**. This Agreement will last for one year, starting on the date the Agreement is executed by the Parties.

5. **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 of termination.

6. **Termination.** Either Party Party may terminate this Agreement this Agreement by giving the other 30 days written notice of intent to terminate.

7. **Fees and Manner of Payment.**

(a) The Parties agree that the Patient is entitled to the Services described in Appendix A, in exchange a monthly periodic fee (Membership Fee) and a non-refundable enrollment fee, which You shall pay to the Clinic in the amounts described in the attached Appendix C, which is incorporated by reference.

(b) The enrollment fee as well as the monthly Membership Fee (prorated to first of the month) shall be due upon execution of this Agreement. Thereafter the Membership Fee shall be due on the first day of each month.

(c) If client chooses to pay the entire year's membership in full, there will not be any refunds.

(d) You are responsible for all costs associated with any procedures, laboratory testing, or specimen analysis and any other service not personally provided by the Practice staff and/or not listed in Appendix A. You shall be advised in advance of any costs associates with the above, for which payment is due at time of service. The Practice will make most of the above services available from selected vendors at wholesale or close to wholesale price. Payment for such costs are due at the time of service. Alternatively, You have the right to obtain the above procedures and products at any place of your choosing, and submit the charges to insurance for reimbursement consideration.

(e) The Parties agree that the required method of monthly payment shall be through one of the following:

(i) automatic payment through credit card (4% service fee shall passed on to Patient payment);

(ii) automatic payment through debit card

(iii) Auto draft via ACH

(f) Current options for vaccines: listing your local health clinic or purchasing vaccines from Pediatric Works. Pediatric Works acquires vaccines, individually, from a 3rd party.

Vaccines will be stored, transported, administrated, and logged into the Georgia Registry of Immunization Transactions and Services (GRITS). There is a 21.00 dollar administration fee per vaccine; which is standard.

Vaccines are obtained on the day of the appointment. If an appointment cancellation is less than 24 hours, those vaccines will still be charged to the member's account.

Provide our office a 24-hour notice in the event that you need to reschedule or cancel your appointment. This will allow us the opportunity to provide care to another patient. A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, may be charged a $50 fee

Members can seek vaccine reimbursement with their insurance carrier. A Health Care Financing Administration Form (HCFA) form can be provided upon request. Those who refuse vaccines **must** sign the AAP (American Academy of Pediatric) Refusal to Vaccine form. (Those who refused Vitamin K via intramuscular **must** also sign the Vitamin K Refusal form; even if Vitamin K oral is used.

9. **Early Termination**. If You cancel this Agreement before the initial termination date, We will review and settle your account as follows:

(a) We will refund the unused portion of your fees to You on a per diem basis; or

(b) If the fair market value of the Services which Member/Patients have received over the term of the Agreement (up to the date of early termination) is more than the amount of membership fees You have paid over the same time period, You shall reimburse the Clinic in an the difference between the Fair Market Value for the Services You received and the amount You paid in membership fees up until the early termination. The Parties agree that the Fair Market Value of services is equal to the Clinic usual and customary fee-for-service charges. A copy of these fees is available upon request.

10. Timely Payment. Membership is dependent on timely payment of membership fees, and fees 60 days past-due will be cause for termination of membership and services**.**

11. Non-Participation in Insurance. You acknowledge by placing your initials at the end of this clause of the Agreement that you understand and agree that *neither the Clinic, nor its Physician, participate in any health insurance or HMO plans or panels and panels, have opted out of Medicare and do not participate in Medicaid.* We may not and do not bill or seek reimbursement from any third party payers, We do not provide Patients with coded, fee for service invoices invoices of fee for service because these reflect individual charges for services. The Practice does not bill individual fee for service _____ **(Initial)**

12. Medicaid: By signing this you agree to NOT be a member of Medicaid.

13. This Is Not Health Insurance. Your initials at the bottom of this clause, acknowledge Your understanding that *this Agreement is neither an insurance plan nor a substitute for health insurance. Furthermore, You understand that this Agreement does not replace any health insurance or health plan coverage that You now carry.* You understand that this Agreement does not include hospital services, or any other services procedures or products not personally provided by the Clinic, or its employees. You acknowledge that We have advised You to obtain or keep in full force, health insurance that will cover Patients for hospitalizations, catastrophic events,

and all other healthcare needs not personally delivered by the Clinic staff. _____ **(Initial)**

14. **Communications**. The Practice endeavors to provide Patients with the convenience of a wide variety of electronic communication options. And although We are careful to comply with patient confidentiality requirements, and make every attempt to protect Your privacy, communications by e-mail, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed to be secure or confidential methods of communications. By placing your initials at the end of this Clause, You understand and acknowledge the above and You agree that by initiating the clause, and 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 receiving care from this Practice, that you are not required to agree this clause*, that you can refuse to above communication methods by withholding your initials from the bottom of this clause 12, and that You always have the option to decline any particular means of communication. _____ **(Initial)**

15. **Email and Text Usage**. By providing an e-mail address and cell phone number on the attached Appendix B, the You and the Patient authorize the Clinic, and its Physicians to communicate with You by e-mail or text message regarding the Patient's "protected health information" (PHI). You further understand and agree that:

(a) E-mail and text message are not necessarily secure mediums for sending or receiving PHI, and there is always a possibility that a third party may gain access;
(b) Although the Physician will make all reasonable efforts to keep e-mail and text communications confidential and secure, neither the Clinic nor the Physician can assure or guarantee the absolute confidentiality of these communications;
(c) E-mail and text messaging are not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. Therefore, in an emergency, or a situation that could reasonably be expected to develop into an emergency, you agree to call 911 or go to the nearest emergency room, and follow the directions of emergency personnel.

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

tions by a third party which is unauthorized by the Clinic; or (v) Patient's failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

16. **Physician Absence.** From time to time, due to vacations, conferences, illness, or personal emergencies, the Physician may be temporarily unavailable to provide the services referred to in Appendix A. In order to assist You in scheduling non-urgent visits, Clinic will notify You of any planned Physician absences as soon as those dates are confirmed with Physician. In the event of an unplanned physician absence, The Clinic shall make reasonable efforts to provide alternative coverage for Patients. Any treatment rendered by the substitute provider is not covered under this Agreement, but may be submitted to Patient's health plan.

17. **Service or Fee Adjustments.** In the event that the Practice finds it necessary to increase or adjust monthly fees before the termination of the Agreement, Practice shall give Patients 60 days written notice of any adjustment and if Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled monthly payment. The same procedure shall apply in the event that the Practice either expands or eliminates certain Services contained in Appendix A.

18. **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 and their parents, especially if we fail to meet expectations and We are committed to resolving all Patient concerns.

Therefore, in the event that a Parent or Guardian is dissatisfied with, or has concerns about, any staff member, service, treatment, or experience arising from their membership in this Practice, the Parent or Guardian 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. Parent or Guardian shall first discuss any complaints concerns or issues with Dr. Works;

B. Dr. Works shall respond to each of Parent or Guardians concerns and complaints;

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

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

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

21. **Reimbursement for Services Rendered.** If this Agreement is held to be invalid for any reason, and the Clinic is required to refund fees paid by You, You agree to reimburse the Clinic in an amount equal to the Fair Market Value of the medical services Patient received during the time period for which the refunded fees were paid.

22. **Amendment.** No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties, except for amendments made in compliance with Section 17, above.

23. **Assignment**. You may not assign this Agreement or any of rights provided within to any third party.

24. **Legal Significance**. You understand that this Agreement is a legal document which assigns the parties certain rights and responsibilities. You also acknowledge that You have had a reasonable time to seek legal advice regarding 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.

25. **Miscellaneous.** This Agreement shall be construed without regard to rules requiring that it be construed against the drafter the Agreement, and the captions in this Agreement have no legal meaning and appear only for the sake of convenience.

26. **Entire Agreement.** This contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

27. **No Waiver** The parties agree that at any time they may choose not to enforce duties or responsibilities required of the other Party under this Agreement. Such a choice shall not constitute waiver of the right to enforce those same duties or responsibilities in the future. The parties shall retain the right to enforce such terms again at any time.

28. **Jurisdiction.** This Agreement shall be governed and construed under the laws of the State of Georgia. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice in Atlanta, Georgia.

29. **Notice.** Notice as required under Section 17 of this Agreement may be affected through use email or first class US Mail. All other required notices shall be sent via first class U.S. mail; to Member at the address first appearing on Appendix B; to Practice at : Pediatric Works, LLC, 60625 Lake Forrest Dr., Ste 250 Atlanta, GA 30328

The parties may have signed duplicate counterparts of this Agreement on the date first written above.

_____

Kimberly Works, MD, for
PEDIATRIC WORKS, LLC.

_____ _____

Signature of Parent of Guardian Name (printed)

_____

Date

APPENDIX A
SERVICES

1. **Medical Services.** The Medical Services provided under this Agreement are those Services that are consistent with Physician's training and experience, and as deemed appropriate under the circumstances, in the sole discretion of the Physician. The Parent or Guardian is responsible for the costs of any medications, laboratory testing, and specimen analysis no personally provided in-house,by the Practice staff and/or any service not described in this Appendix A. The Medical Services provided under this Agreement are as follows:

    - Home visit for first Newborn Check
    - Newborn well visits
    - Lactation Consult
    - Well Baby Checks
    - Well Child Checks
    - Acute Visits
    - Ear Piercing
    - Annual Exams
    - School Physicals
    - Sports Physicals
    - Camp Physicals
    - Chronic Disease Management (eg, Asthma, diabetes, etc.)
    - Vaccine Administration
    - Rapid Strep
    - Blood Glucose
    - Dipstick Urinalysis
    - Fecal Occult
    - Minor procedures (staples, sutures, splinting)

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

(a) ***After Hours Access*.** Parent or guardian shall be given a phone number where they may reach the Physician directly for guidance regarding *urgent* concerns that arise *unexpectedly* after office hours.

(b) ***E-Mail Access*.** Patient shall be given the Physician's e-mail address to which non-urgent communications can be addressed. Such communications shall be dealt with by the Physician or staff member of Clinic in a timely manner. Parent or Guardian understands

and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that one could reasonably expect may develop into an emergency. In such situations, Parent ot guardian shall call 911 or go to the nearest emergency medical provider, and follow the directions of emergency medical personnel.

(c) ***No Wait or Minimal Wait Appointments.*** Reasonable effort shall be made to assure that 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.

(d) ***Same Day/Next Day Appointments*.** When Parent or Guardian contacts the Practice prior to noon on a regular office day to schedule an appointment, every reasonable effort shall be made to schedule an appointment with the Physician on the same day. Regardless of when the Parent contacts Us, we shall always make every reasonable effort to schedule an urgent appointment for the Patient on the same day that the request is made.

(e) ***Specialists Coordination.*** Physician shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. Parent or guardian 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

Monthly fees, as set out in Appendix C, shall apply to the following Patient(s):

PATIENT/MEMBERS

Printed Name Date of Birth (MM/DD/YYYY) Age

Printed Name Date of Birth (MM/DD/YYYY) Age

Printed Name Date of Birth (MM/DD/YYYY) Age

PARENT/LEGAL GUARDIAN INFORMATION

Printed Name Date of Birth (MM/DD/YYYY)

Street Address City, State, Zip

Home Phone Work Phone Cell Phone Preferred email

Spouse Name Date of Birth (MM/DD/YYYY)

Home Phone Work Phone Cell Phone Preferred email

You agree to text message communication regarding the above named children, which may include PHI

APPENDIX C

PEDIATRIC WORKS "PREMIUM" MEMBERSHIP

Non-refundable enrollment fee $75

Member Age	Monthly Fee
0-1 year	$250
1-5 years	$150
5-18 years	$100

There is a 10 percent discount if membership is paid for 1 year (non refundable).

Member in-office visits and telemedicine appointments are included in membership

Optional Additional Fee: Weekday Member Home Visits: $175 per child

Optional Additional Fee: Weekend Member Home Visits: $250 per child

There's a six month commitment minimum for member 0-1 years. It is imperative to have to properly monitor development.

Pediatric Works "Limited" Membership

Non-refundable enrollment fee $75

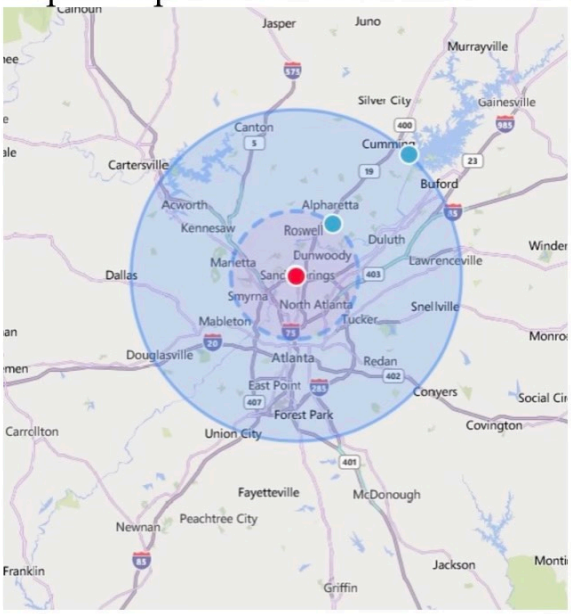
Limited Member Office Visits: $175 per child

Limited Member Home Visits: $325 per child

Limited Member Telemedicine Visit: $60

Pediatric Works' Service Area

No additional fee within a 15 mile radius from practice location
(6065 Lake Forrest Dr. Ste 250 Atlanta)
$15 per trip outside a 15 miles radius
$25 per trip outside a 25 mile radius
$35 per trip outside a 35 mile radius



PEDIATRIC WORKS

Ear Piercing (Blomdhal Medical Beauty) Agreement

This is an Agreement between Pediatric Works, LLC. a Georgia Limited Liability Corporation (Clinic, Us or We), and _____(You.)

Background

The Clinic is a direct pay pediatric practice which provides primary care services to its patients in a membership-based direct pay (DPC) at 6065 Lake Forrest Dr. Ste 250 Atlanta GA 30328. As the parent, adult or legal guardian of the Patient/s enrolled under this Agreement, you to pay one hundred dollars in exchange for a non-medical service of ear piercing.

Blomdahl Medical has development, designed and manufactured its ear piercing system to assure safe and sterile ear piercing. However, problems which are not caused by the system can occur.

Therefore, I, the undersigned, hereby certify that I am aware that there are risk inherent to ear piercing. I hereby elect, voluntarily, to undertake some, and voluntarily consent to same. In addition, I hereby assume all risk of loss or injury of any kind whatsoever that may be associated with ear piercing.

In signing the Client journal/covenant not to sue Blomdahl, its distributors and/or the practitioner, I hereby acknowledge and represent that:

1. I have read the foregoing Release Form/Covenant not to sue, understand it and sign it voluntarily.
2. I am over 18 years of age or given on behalf o f a minor under 18 years of age, that I am the parent or legal guardian of such minor and I will hold only myself liable and will indemnity Blomdahl, its disputers and/or the practitioner, in the even such as a minor makes a claim as a result of ear piercing. I further understand that minors signing as adults constitutes a fraudulent act.
3. I am/minor is in good health and do not have any ailments which makes it recommendable to retain from from ear piercing.

Important!

Redness and/or swelling and/or pain and/or rashes are indicative of a possible infection: if the hole is placed in the soft part of the ear, removed the earring and cleanse/disinfect. If there is no improvement the following day, contact your doctor. If the hold is placed in the cartilage part of the car, move the ear ring, cleanse/disinfect and seek immediate medication attention