

# RED CLOVER PEDIATRICS, PLLC

## PATIENT AGREEMENT

This Patient Agreement (Agreement) is entered into between Red Clover Pediatrics (Practice, Us or We), and \_\_\_\_\_ (Patient, Member and You, Your).

### Background

The Practice, located at 5 Main St, North Bennington, VT 05257, provides ongoing, pediatric primary care services to its patients 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. Patient.** "Patient" or "Member" means the persons party to this Agreement, for whom the Physician shall provide care, are entitled to the services described in Appendix A, and whose name/s appear in Appendix B, which is attached to this Agreement and incorporated by reference.
- 2. You.** "You" or "Your" means the parent or legal guardian of the minor Patient/s named within, who is a signatory to, and bound by, this Agreement.
- 3. Services.** "Services" means the collection of medical and non-medical services provided by the Practice to the Patient in exchange for the Membership Fees and which are identified in Appendix A (attached and made a part of this Agreement).

### 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 and Refunds.** Either party can end this Agreement at any time by giving 30 days written notice to the other, of intent to terminate and the Practice shall return any unused portions of paid Membership Fees (if any) on a per diem basis.
- 7. Payment Amount and Methods.** In exchange for the Services, You agree to pay a monthly Membership Fee in the amount described in Appendix C (attached and incorporated by reference).

(a) Upon execution of this Agreement, Patient shall pay a one-time, non-refundable

enrollment fee in the amount identified in Appendix C, as well as the regular monthly Membership Fee. Thereafter, the Membership Fee shall be due on the 20th day of each month.

- (b) The Parties agree that the required method of payment shall be automatic, electronic payment through a debit card, credit card or bank draft.
- (c) Any services not explicitly included in appendix A are specifically excluded. Unless otherwise provided within, You are responsible for costs associated with any laboratory testing, specimen analysis, or product provided in relation to the services specified in Appendix A. The practice staff shall inform You in advance if such additional costs may apply and You will have the following options:
  - (i) You shall be advised of the cost and availability of the above products/ procedures, most of which may be available at highly discounted, cash-pay rates from select vendors. If available, and You select this option, payment is due at time of service;
  - (ii) You may also purchase necessary products/procedures at any provider or facility of Your choice. You are responsible for all charges from such outside facility. You may request that the outside provider submit their charges to Your health plan (if any) for possible reimbursement. You are responsible for understanding coverage policies of Your health plan and we cannot guarantee reimbursement.

**8. Non-Participation in Insurance.** We do not participate with third- party payors, including private health insurance plans, HMOs, and government-sponsored plans. Further, You have been advised that We are prohibited from, and do not submit charges to any third-party payor for the reimbursement of any Services included under this Agreement.

**9. Medicare.** The Physician and the Practice do not participate with Medicare. As a result, Medicare cannot be billed for any services We personally provide to the Patient. You agree not to bill Medicare or attempt to obtain Medicare reimbursement for any such services.

**10. Medicaid.** The Practice does not bill or seek reimbursement from Medicaid. Patients who are Medicaid beneficiaries understand that they are joining the Practice under private contract and not as a Medicaid member. Therefore, the Patient is personally responsible for the membership fees and charges for any services personally provided by the Practice staff under this Agreement. Neither the Practice nor the Patient may submit such fees and charges to Medicaid for reimbursement. Prescriptions, lab testing, imaging, etc., which are *not* personally provided by the Practice, may be submitted by the Patient to Medicaid for reimbursement consideration. The Practice cannot guarantee Medicaid reimbursement.

**11. This Agreement Is Not Health Insurance.** This Agreement is not an insurance plan or a substitute for health insurance. It does not satisfy any federal requirement to obtain health insurance as specified under the ACA or other federal statute, nor does it replace an employer's obligations to maintain Worker's Compensation insurance under RSA 281-A. This Agreement does not include hospital services, or any services not specifically included in Appendix A. We advise You to obtain or continue in full force, health insurance that will cover the Patient for healthcare services not personally delivered by the Practice, including but not limited to specialist care, hospitalizations, and catastrophic medical events. In addition, please note that the enrollment and monthly fees described in Appendix C would not typically count towards the deductible under the health insurance policy You obtain.

**12. Communications.** The Practice endeavors to provide You with the convenience of a wide variety of electronic communication options. And although We are careful to comply with confidentiality requirements and make every attempt to protect patient privacy, communications by email, facsimile, video chat, cell phone, texting, and other electronic means, can never be guaranteed to be absolutely secure or confidential methods of communications. By placing your initials at the end of this Clause, You understand and acknowledge this. By initialing this clause or agreeing to participate 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 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 means of communication.

\_\_\_\_\_ (Initial)

**13. 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, for dealing with time-sensitive issues, or for disclosing sensitive information. In an emergency or a situation which could reasonably be expected to develop into an emergency, You understand and agree to call 911 or go to the nearest emergency room, and follow the directions of emergency personnel.

<sup>1</sup> As that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations.

**14. 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 complaints concerns or issues with Dr. Gunn;
- b) Dr. Gunn shall respond to each issue and complaint;
- c) If, after such response, You remain dissatisfied, the Parties shall enter into discussion and attempt to reach a mutually acceptable solution.

**15. Physician Absence.** From time to time, due to vacations, illness, or personal emergency, the Physician may be temporarily unavailable. The Practice will notify You of any planned

Physician absence to allow for convenient scheduling of non-urgent appointments. In the event of an unplanned absence, Patients with scheduled, non-urgent appointments shall be notified and rescheduled at the Patient's convenience. Unless illness or emergency doesn't allow, I expect we will discuss any non-emergency concerns and then I can give advice and determine if you need to proceed to an urgent care facility or other appropriate care provider. Services delivered by outside providers other than a covering physician are not included in this Agreement and any related fees are Your responsibility. Charges from non-covering, outside providers may be submitted to Your insurance plan (if applicable) for reimbursement consideration. But You remain ultimately responsible for payment and for understanding Your health insurance payment policies. We cannot guarantee reimbursement.

**16. Fee and Service Offerings Adjustments.** In the event that the Practice finds it necessary to increase or adjust its Service offerings or monthly fees before the termination of the Agreement, We shall give You 30 days written notice of any adjustment. If You do not consent to the modification, You may 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, federal, state, or local, which affects the terms of this Agreement, the parties agree to amend this Agreement only to the extent necessary to 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 will 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.** This Agreement, and any rights the parties have under it, may not be assigned or transferred.

**21. Legal Significance.** You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You further 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.

**22. Miscellaneous.** This Agreement shall be interpreted without regard to rules 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.

**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.** The parties agree that they may choose not to enforce any of the other party's requirements or duties under this Agreement. Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

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

**26. Notice.** Any written notice required under this 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.

The Parties agree that checking the appropriate box next to their name shall constitute an electronic signature and shall be valid and enforceable to the same extent as a handwritten signature.

**For Red Clover Pediatrics, PLLC:**

By: Meghan Gunn, MD \_\_\_ / \_\_\_ / \_\_\_\_ Current Date

**For Patient(s):**

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

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

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

\_\_\_\_\_ / \_\_\_ / \_\_\_\_  
Patient/Legal Guardian Signature Current Date

\_\_\_\_\_  
Printed Name Relationship to Patient(s)

## Appendix A

### Services

**Note: We are not a pain management clinic and we do not store or dispense opioids or other controlled medications. If *medically necessary on a limited and temporary* basis the physician shall send an electronic prescription to your pharmacy of choice for opioids.**

**1. Medical Services.\*** Medical Services under this Agreement are those Services which are consistent with Physician's pediatric training and experience as a, and as deemed medically appropriate in the sole discretion of the Physician, to include the following:

- All routine well-child visits as per the American Academy of Pediatrics
- Acute and Non-acute Office Visits
- Chronic and/or complex care management
- School, Camp and Sports Physical form completion
  - Personalized, Annual In-Depth Wellness Examination and Evaluation
- Psycho-social Screening
- Developmental Screening
- Paternal and Maternal Postpartum Depression Screening
- Telehealth/remote care as indicated
- Immunizations as provided by the VFC and VFA State Immunization Program
- Basic Vision Screening
- Basic wound care
- Lead Screening
- Anemia Testing
- Breathing Treatments to include Nebulizer Treatments
- Urinalysis
- Urine pregnancy test
- Rapid test for Acute Group A Streptococcal Tonsillitis
- Rapid test for Influenza Virus A & B
- Fecal occult blood test (blood in stool)
- Removal of Cerumen (ear wax) and Lavage
- Simple foreign body removal (typically from ears or noses)
- Simple Laceration Repair (Sutures)
- Staple/Suture Removal
- Abscess Incision and Drainage
- In-home visits provided at an additional charge within Vermont when appropriate and based on physician availability (see website for fee information)

\*You may be responsible for some costs, including supplies, products, drugs, laboratory testing,

and specimen analysis, associated with the above services and procedures. You will be advised in advance of any such additional costs. The Practice shall make many of these products and services available to Patients for purchase through select vendors at highly discounted cash-pay rates, and in-house supplies will generally be charged at wholesale or close to wholesale. However, Patient always retains the right to obtain services from the provider or facility of their choice.

**2. Non-Medical, Personalized Services.** The Practice shall also provide the Patient with the following non-medical services and amenities to our members in the course of care:

- *Direct Access.* Notwithstanding the limitations of paragraph 15, You shall be given direct telephone access (via text/Spruce app/phone call) to Your physician for guidance in regard to *urgent* concerns that arise *unexpectedly* after office hours. It is understood and agreed that in an emergency or any situation that could reasonably be expected to develop into an emergency — if the Physician cannot/does not respond immediately, You will call 911 or go to the nearest emergency medical facility and follow the directions of emergency medical personnel. In non-emergent situations and when the physician and Patient agree that it is appropriate, video chat and text messaging may be available.
- *Email Access.* You shall be given an email address to which non-urgent communications can be addressed and which shall be dealt with by physician or 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 be reasonably 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.* Notwithstanding the limitations of Paragraph 15, All reasonable efforts 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, You will be advised and given the option to come at the later time, or reschedule the appointment at Your convenience.
- *Same Day/Next Day Appointments.* Every reasonable effort shall be made to accommodate urgent same or next day appointments when necessary and requested.
- *Specialists Coordination.* The physician shall coordinate with the Patient's medical specialists and other 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.

**\*Note:** Fees associated with any drugs, procedures, laboratory testing, and specimen analysis associated with the above which cannot be performed onsite or must be provided through a third-party vendor are not included in the monthly fee, but shall be the responsibility of the Parent/guardian. The Practice shall dispense onsite, at wholesale or close to wholesale prices, most commonly prescribed pediatric drugs. Labs and testing that cannot be performed onsite will be offered at a discounted rate through select vendors. Payment is due at the time of service.

**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

**Parent or Guardian Information and Consents:**

**(Provide email address only if you agree to Email communication)**

\_\_\_\_\_

Printed Parent/Legal Guardian Name Relationship to Patient(s)

\_\_\_\_\_

Additional Authorized Parent/Legal Guardian Name Relationship to Patient(s)

\_\_\_\_\_

Street Address City State Zip Code

Primary Email Address:

\_\_\_\_\_

(provide only if you agree to email communication in regard to health concerns of the above named patients)

Preferred Contact Number: \_\_\_\_\_

**DO YOU AGREE TO TEXT MESSAGE COMMUNICATION IN REGARD TO HEALTH CARE CONCERNS OF THE ABOVE NAMED PATIENTS? (CHECK ONE BELOW)**

**YES \_\_\_\_\_ NO \_\_\_\_\_**

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

Parent/Legal Guardian Signature:

\_\_\_\_\_

Printed Parent/Legal Guardian Name Relationship to Patient(s)



**Appendix C**  
**FEE ITEMIZATION**

**Membership Fees**

Name	Fee (billed monthly)	Fee (billed every 3 months)	Fee (billed every 6 months)	Fee (billed yearly)
One child	\$120.00	\$350.00	\$690.00	\$1,320.00
Two children	\$210.00	\$613.00	\$1,208.00	\$2,310.00
Three/Four children	\$270.00	\$790.00	\$1,553.00	\$2,970.00

If more than four children, Dr. Gunn and family will meet to discuss an arrangement.

**Total Membership Fees \$ \_\_\_\_\_ per \_\_\_\_\_**

**Enrollment Fee**

One Time Non-Refundable \$100 per family \$ \_\_\_\_\_ (waived if already a patient of Dr. Gunn's at SVMC)

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**Initial Payment**

Billing will occur on the 20th of the month unless otherwise requested.

Membership Fees \$ \_\_\_\_\_ (prorated if needed)

Enrollment Fee \$ \_\_\_\_\_

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**Total Initial Payment \$ \_\_\_\_\_**

**Re-Enrollment Fee:** If, after allowing membership to lapse or be terminated, Patient desires to rejoin the Practice, they shall be accepted on a space-available basis, subject to a \$150 re-enrollment fee