$180 to enroll

PATIENT AGREEMENT
Quick Medical Clinic, L.L.C.

This is an agreement between Quick Medical Clinic, L.L.C., a Washington professional corporation, located at 2526 Colonial Drive, Centralia WA 98531 **(QMC)**, Paul D Williams, M.D., Lisa Neff, D.O, Dr. Eric DeMun, MD, **(Physicians)** in their capacity as agents of QMC, and you, (Patient). Quick Medical Clinic is providing this line of business under the name Washington Park Direct Care – **(WPDC)**.

Background

The Physician, who specializes in family medicine, delivers care on behalf of WPDC, at the address set forth above. In exchange for certain fees paid You, WPDC, through its Physician, agrees to provide Patient with the Services described in this Agreement on the terms and conditions set forth in this Agreement. This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described.

Definitions

1. **Patient**. A patient is defined as those persons for whom the Physician shall provide Services, and who are signatories to, or the parent or legal guardian of the patient or family of the patient.
2. **Services**. As used in the Agreement, the term Services, shall mean a package of services, both medical and non-Medical, and certain amenities (collectively "Services), which are offered by WPDC, and set forth in Appendix 1.
3. **Terms**. This agreement shall commence on the date signed by the Patient and shall continue for a period of one month, automatically renewed. Patient's acceptance of this agreement on-line constitutes an electronic signature on this agreement and constitutes the signing date.
4. **Fees**. In exchange for the services described herein, Patient agrees to pay WPDC, the amount as set forth in Appendix 1, attached. This fee is payable upon execution of this agreement, and is in payment for the services provided to Patient during the term of this Agreement. If this Agreement is cancelled by either party before the agreement termination date, then WPDC shall refund the Patient's prorated share of the original payment, remaining after deducting individual charges for services rendered to Patient up to cancellation.
5. **Non-Participation in Insurance**. Patient acknowledges that neither WPDC, nor the Physician participate in any health insurance or HMO plans or panels and has opted out of Medicare. Neither of the above make any representations whatsoever that any fees paid under this Agreement are covered by your health insurance or other third party payment plans applicable to the Patient. The Patient shall retain full and complete responsibility for any such determination. If the Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient will sign the agreement attached as Appendix 2, and incorporated by reference. This agreement acknowledges your understanding that the Physician has opted out of Medicare, and as

a result, Medicare cannot be billed for any services performed for you by the Physician. You agree not to bill Medicare or attempt Medicare reimbursement for any such services. Patient shall renew and sign the agreement in Appendix 2, every two years.

6. **Insurance or Other Medical Coverage**. Patient acknowledges and understands that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services, or any services not personally provided by WPDC, or its Physicians. Patient acknowledges that WPDC has advised that patient obtain or keep in full force such health insurance policy(ies) or plans that will cover Patient for general healthcare costs. Patient acknowledges that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that Patient may carry.
7. **Term; Termination**. This Agreement will commence on the date first written above and will extend monthly thereafter. Notwithstanding the above, both Patient and WPDC shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving 30 days prior written notice to the other party. Unless previously terminated as set forth above, at the expiration of the initial one-month term (and each succeeding monthly term), the Agreement will automatically renew for successive monthly terms upon the payment of the monthly fee at the end of the contract month.
8. **Communications**. You acknowledge that communications with the Physician using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. As such, you expressly waive the Physician's obligation to guarantee confidentiality with respect to correspondence using such means of communication. You acknowledge that all such communications may become a part of your medical records.

   By providing Patient's email address, Patient authorizes WPDC, and its Physicians to communicate with Patient by e-mail regarding Patient's "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and it's implementing regulations). By giving us your email, Patient acknowledges that:

   (a) E-mail is not necessarily a secure medium 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 communications confidential and secure, neither WPDC, nor the Physician can assure or guarantee the absolute confidentiality of e-mail communications;
   (c) In the discretion of the Physician, e-mail communications may be made a part of Patient's permanent medical record; and
   (d) Patient understands and agrees that E-mail is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. **In the event of an emergency, or a situation in which a member could reasonably expect to develop into an emergency, Member shall call 911 or the nearest Emergency room, and follow the directions of emergency personnel.**

   If Patient does not receive a response to an e-mail message within one day, Patient agrees to use another means of communication to contact the Physician. Neither WPDC, nor the Physician will be liable to Patient for any loss, cost, injury, or expense caused by,

or resulting from, a delay in responding to Patient as a result of technical failures, including, but not limited to, (i) technical failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages, (iii) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third party; or (v) your failure to comply with the guidelines regarding use of e-mail communications set forth in this paragraph.

9. **Change of Law**. If there is a change of any law, regulations or rule, federal, state, or local, which affects the Agreement including these Terms & Conditions, which are incorporated by reference in the Agreement, or the activities of either party under the Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and either party reasonably believes in good faith that the change will have a substantial adverse effect on the party's rights, obligations or operations associated with the Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of the Agreement including these Terms & Conditions. If the parties are unable to reach an agreement concerning the modification of the Agreement within forty-five days after the date of the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party.
10. **Severability**. If for any reason any provision of this Agreement shall be deemed, by a court 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 extend necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.
11. **Reimbursement for services rendered**. If this Agreement is held to be invalid for any reason, and if WPDC is therefore required to refund all or any portion of the monthly fees paid by Patient, Patient agrees to pay WPDC an amount equal to the reasonable value of the Services actually rendered to Patient during the period of time for which the refunded fees were paid.
12. **Amendment**. No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties. Notwithstanding the foregoing, the Physician may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending you 30 days advance written notice of any such change. Any such changes are incorporated by reference in to this Agreement without the need for a signature by the parties and are effective as of the date established by WPDC, except that Patient shall initial any such change at WPDC request. 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.
13. **Assignment**. This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient.
14. **Relationship of Parties**. Patient and the Physician intend and agree that the Physician, in performing his duties under this Agreement, is 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 the Physician shall have exclusive control of his work and the manner in which it is performed.

15. **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.
16. **Indemnification**. Patient agrees to indemnify and hold Quick Medical Clinic harmless from any and all claims, actions, suits, judgments, damages, fines, and other proceedings (including attorney fees), arising out of (a) patient's breach of contract, (b) any negligent or willful act or omission of the member, and (c) those services utilized by the patient from sources other than the Quick Medical Clinic, dba Washington Park Direct Care.
17. **Miscellaneous**. 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.
18. **Entire Agreement**. 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.
19. **Jurisdiction**. This Agreement shall be governed and construed under the laws of the State of Washington and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for WPDC address in Centralia, Washington.
20. **SERVICE**. All written notices are deemed served if sent to the address of the party given by the Patient, by first class U.S. mail.

Washington Park Direct Care

Dated this ____ day of ______________, 20__.

______________________ Print Member/Company Name	______________________(________) Authorized Signature DOB
______________________ Authorization for minor/Relationship	______________________ WPDC Representative/Title
______________________ Mailing Address	______________________ Enrollment Date
______________________ City, State, Zip code	______________________ Phone Cell/Message
______________________ email	

Appendix 1

Services and Payment Terms

1. **Medical Services.** As used in this Agreement, the term Medical Services shall mean those medical services that the Physician, himself is permitted to perform under the laws of the State of Washington and that are consistent with his/her training and experience as a family medicine physician, as the case may be. A representative sample includes: Regular office visits, physical exams (pap tests extra), DOT physicals (with added fee), chronic disease management, coordination with specialists, consultations, and Blood pressure checks.

   Non-included services, provided at an additional significantly reduced costs. A representative sample of procedures include: toenail removal, skin biopsy*, lesion removal*, (*extra charge for pathology services), wart freezing, premalignant skin lesion freezing, suture and staple removal, laceration repair, and breathing treatments. A representative sample of office tests if clinically indicated include: EKG, office spirometry, ankle brachial index. In addition if you desire our pricing, we can offer reduced priced medications, labs and radiologic studies at significantly lower costs, though payment is required at the time ordered.

   Non-included services, labs, x-ray, pathology fees will be posted in the office and on-line and are subject to change. These services will be available to you at a reduced rate if you choose to utilize these services.

   Non-included services not provided. These are services we personally don't provide in our office, they include: hospital care, prenatal and obstetrical care, outside physician fees, referrals, pathology, lab and radiologic fees.

The Physician may from time to time, due to vacations, sick days, and other similar situations, not be available to provide the services referred to in this paragraph. During such times, Patient's calls to the Physician, or to the Physician's office, will be directed to a physician who is "covering" for the Physician during his absence. WPDC will make every effort to arrange for coverage but cannot guarantee such coverage.

2. **Non-Medical, Personalized Services.** WPDC shall also provide Patient with the following non-medical services ("**Non-Medical Services**"):
   a. **24/7 Access.** Patient shall have access to the Physician via instant messaging (texting), video chat, and direct phone to the Physician on a twenty-four hour per day, seven day per week basis, for medical issues that arise outside of normal office hours. Patient shall be given a phone number where patient may reach the Physician directly. During the Physician's absence for vacations, continuing

medical education, illness, emergencies, or days off, WPDC will provide the services of an appropriate licensed healthcare provider for assistance in obtaining medical services.

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 the Practice in a timely manner. Patient 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 Patient could reasonably expect may develop into an emergency. Patient agrees that in such situations, when a Patient cannot speak to Physician immediately in person or by telephone, that Patient shall call 911 or the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

c. **Minimal wait Appointments**. Every 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 a minimal wait time, Patient shall be contacted and advised of the projected wait time.

d. **Same Day/Next Day Appointments**. When Patient calls or e-mails the Physician prior to noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule an appointment with the Physician on the same day. If the patient calls or e-mails the Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with the Physician on the following normal office day.

e. **Home Visits**. Patient may request that the Physician see Patient in Patient's home if the patient is too ill to come in and the Physician considers such a visit reasonably appropriate. These visits are available in a 10 mile radius from the office and are subject to an additional fee.

f. **Specialists**. WPDC Physician shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. 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 WPDC Physician.

3. **Payment terms.** Patient will provide credit card or voided check for direct withdrawal from their checking account. Either Patient's credit card or checking account will be automatically charged the recurring monthly fee. In addition, if medications, laboratory services, pathology services, radiological services are sought from WPDC then those charges will also be charged in the same fashion. At initial sign up, 3 months prepayment membership fee will be charged for all <u>new</u> patients. (this fee is non-refundable). After the three months, the recurring monthly fee will be processed via electronic funds transfer.

4. Payment for 6 months or more can be made up front and the funds will be held in a trust account. The unused portion will be refunded upon cancellation of membership.

   If the member becomes delinquent with their monthly membership fee, no office visits will be authorized until the membership is up-to-date. Medication refills will be denied if the member either is delinquent on their monthly membership fee, or does not comply with routine follow-up appointments.

5. **Monthly Fee, subject to change:**
   a. Children 0-18 year old, $10 a month with at least one parent membership (immediate family only)
   b. Adults 19+ years old, $60/month.

6. **Insurance:** We do not accept any medical insurance, and are not contracted with any insurance companies. Medicare patients are not allowed to submit receipts for reimbursement to Medicare or their secondary insurance company, per Medicare guidelines. Patients with regular insurance may choose to submit receipts to your insurance; they may or may not pay for services provided here. We do not submit any insurance claims.
7. **Enrollment fee:** There is no enrollment fee on initial enrollment. If the membership is cancelled and later restarted, there will be a 3-month re-enrollment fee.

WASHINGTON PARK DIRECT CARE

208 Centralia College Blvd.
Centralia, WA 98531
360-736-0771
www.washingtonpark.md

ELECTRONIC FUNDS TRANSFER AGREEMENT (EFT)

Direct Payment Authorization Form

______________________________("I / we") hereby authorize Quick Clinic, dba Washington Park Direct Care ("the company") to initiate withdrawals from our/my account at the financial institution named in this application for payment of our monthly accounts payable to the company. Funds will be withdrawn once a month, on the date specified below. This contract may be terminated at any time, with written or verbal consent from the member.

Name of Financial Institution	Checking or Savings	Routing Number	Account Number	Fixed Amount

I / we have read and understand the terms of this agreement. I / we agree to be bound by the terms and will comply with all additional Rules and Regulations as they now exist, or any changes that may occur.

____
Account Holder Signature Date

____
Account Holder Signature Date

For the Company to verify bank account and routing numbers, account holders should attach a VOIDED CHECK for the account that is to be debited. The Company and account holder should retain completed copies of this form for their records.

THIS FORM IS FOR THE COMPANY / ACCOUNT HOLDERS USE ONLY.

It is not required to forward copies to Umpqua Bank.

CLINIC USE ONLY

Enrollment Fee Of:	Received On :	Received By:	EFT will begin on:
$			

***** A $10 FEE WILL BE CHARGED FOR ALL NSF*****

Dr. Paul Williams,M.D.
Dr. Lisa Neff, D.O.

2526 Colonial Drive
Centralia, WA 98531
Office 360-736-0771
Fax 844-802-4322

HEALTH HISTORY

Today's Date: ____________

Patient Name: ______________________ Date of Birth: ___________

MAIN CONCERN(S) FOR TODAY:

____
____
____
____

REVIEW OF SYSTEMS: (circle if present within the past 3 mo)

General: Fatigue, Decreased appetite, Weight loss/gain (unintentional)
HEENT: Change in vision, headaches, frequent infections, dental problems
Heart: Chest pain, palpitations, leg swelling
Lungs: Cough, wheezing, shortness of breath
GI: Heartburn, diarrhea, constipation, blood in stool
GU: pain with urination, problems with periods, menopausal symptoms, discharge
Skin: Rash, itching, change in moles
Psych: Difficulty sleeping, anxiety, depression
Neuro: Headaches, weakness, dizziness, numbness
Endocrine: Increased thirst, frequent urination, high or low blood sugar
Musculoskeletal: Joint pain, muscle pain, swelling in joints, muscle cramps

CHRONIC CONDITIONS

Diabetes, High blood pressure, High cholesterol, Thyroid disease, Asthma, Heart disease, Heartburn, Depression/Anxiety, Osteoporosis, Stroke, Prostate enlargement, Kidney stones, Sinus problems, Cancer: __________________________
Other ____

ALLERGIES: ____

CURRENT MEDICATIONS: ____
____
____

HEALTH MAINTENANCE (please provide dates)

Bone Density/DEXA: ________________ Mammogram: ____________________
Colonoscopy: ______________________ Pap smear: _____________________
Eye Exam: ________________________ Physical exam: __________________
Dental Exam: ______________________

Dr. Paul Williams,M.D.
Dr. Lisa Neff, D.O.

2526 Colonial Drive
Centralia, WA 98531
Office 360-736-0771
Fax 844-802-4322

Health History (page 2)

Patient name: ______________

SURGERIES (please provide dates)

____

____

SOCIAL HISTORY

Occupation (previous if retired): ______________
Marital status: Single/Married/Separated/Divorced/other______ Sexually Active Y/N
Who lives in the home?______________
What is your spiritual background? ______________
Who helps when you need it?______________
Habits: Smoking Y/N (how much?_________), Alcohol Y/N (how much?____________)
Recreational drugs: ______________ Special diet? ______________
Exercise:______________
Hobbies: ______________

____

FAMILY HISTORY (please indicate which family member(s)

Asthma ______________
Bleeding ______________
Cancer: ______________
Depression/Anxiety ______________
Diabetes ______________
Drug use ______________
Heart disease ______________
High blood pressure ______________
High cholesterol ______________
Kidney disease ______________
Leukemia ______________
Liver disease ______________
Osteoporosis ______________
Rheumatoid arthritis ______________
Stroke ______________
Thyroid disease ______________
Prostate disease ______________
Other:______________

GYN History

Age at first period/menarche: ______________
Age at menopause: __________
Age at first pregnancy: __________ Number of pregnancies: __________
Premature births: _____ Miscarriages: _____ Abortions: _____ Living children: _____
Contraception:______________

IMMUNIZATIONS (please provide dates)

Td/Tdap (Tetanus): ___________
Prevnar 13: ______________
Pneumovax 23: ______________
Zostavax/Shingles: ___________
Last flu shot: ______________
Hepatitis A series: __________
Hepatitis B series: __________
Did you receive routine childhood vaccinations? __________

Patient signature: ______________________________

**Controlled medications will be reviewed through the Washington State Rx Monitoring Program prior to acceptance. By signing this history form, you consent to this review.

2526 Colonial Dr.
Centralia, WA 98531
Phone: 360-736-0771
Fax: 844-802-4322
www.washingtonpark.md

I, ______________________________, authorize the following person(s) to receive

Print Patient Name

medical information about me:

____

Name | Relationship to patient | Phone number

____

Name | Relationship to patient | Phone number

____

Name | Relationship to patient | Phone number

( )

______________________________ ______________

Patient signature | Date of birth | Date

Dr. Paul Williams *Dr. Lisa Neff*
2526 Colonial Dr. – Centralia, WA 98531
Phone – 360-736-0771
Fax – 844-802-4322 – ATTN: JENNIFER

Authorization To Release Medical Records And Information

Expires 90 days from date below and may be revoked by the patient orally or in writing at any time.

Patient Name:____Date of Birth__________

Other Name, If Applicable____

Patient Address:____

Patient Phone Number:____
Reason for Request: _____Changing Doctors _____ Legal Reasons ______Personal Use

Please send the following records:

- o All Medical Records (Past 5 years)
- o Medical Records From ___________to _______________
- o Records specifically pertaining to___________________

I, ________________________, hereby authorize ___________________________
(Name) (Physician or facility)
to release my medical records to ______________________________. I understand that my records may contain information regarding the diagnosis or treatment of HIV(AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executer of estate must be provided.

______________________________________ ________________
Signature of Patient/Guardian Date

______________________________________ ________________
WPDC Representative Date