



DIRECT PRIMARY CARE PATIENT AGREEMENT Koru Health, PLLC.

This is an Agreement between Koru Health P.L.L.C. a Washington State PLLC, located at 320 E 5th St, Port Angeles. Dr. Jessica (Nikki) Myhre DO in her capacity as an agent of Koru Health PLLC, and you, _____ (Patient).

Background

The Physician, practices family medicine and delivers care on behalf of Koru Health in Port Angeles, WA. In exchange for certain fees paid by You, Koru Health, through its Physician(s), agrees to provide (Patient) _____ with the Services described in this Agreement on the terms and conditions set forth in this Agreement. The practice website is koruhealthpa.com.

Definitions

1. Patient. A patient is defined as those persons for whom the Physician shall provide Services, and who are signatories to, or listed on the documents attached as Appendix 1, and incorporated by reference, to this agreement.

2. Services. As used in this Agreement, the term Services, shall mean a package of ongoing primary care services, both medical and non-Medical, and certain amenities (collectively “Services”), which are offered by Practice and set forth in Appendix 1 and 2. The Patient will be provided with methods to contact the physician via phone, email, and other methods of electronic communication. Physician will make every effort to address the needs of the Patient in a timely manner, but cannot guarantee availability, and cannot guarantee that the patient will not need to seek treatment in the urgent care or emergency department setting.

3. Fees. In exchange for the services described herein, Patient agrees to pay Practice the amount as set forth in Appendix 1 and 2, attached. Applicable fees are payable upon execution of this agreement. If this Agreement is terminated by either party before the end of an applicable monthly period, then the Practice shall seek only partial payment for the final month of service based on the number of days of membership provided to the patient and the itemized charges set forth in Appendix 2, for services rendered to Patient up to the date of termination. Pro rated fees received will be promptly refunded to the direct patient.

4. Non-Participation in Insurance. Patient acknowledges that neither Practice, nor the Physicians participate in any health insurance or HMO plans. Koru Health will not bill any carrier for the services covered under the Agreement. The physicians has opted out of Medicare and Medicaid. Patient acknowledges that federal regulations REQUIRE that Physicians opt out of Medicare so that Medicare patients may be seen by the Practice pursuant to this private direct primary care contract. Neither the Practice nor Physicians make any representations regarding third party insurance reimbursement of fees paid under this Agreement. 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 or Medicaid, then Patient will sign the agreement attached as Appendix 3, and incorporated by reference. This agreement acknowledges your understanding that the Physician has opted out of Medicare (or Medicaid), and as a result, Medicare (or Medicaid) cannot be billed for any services performed for you by the Physician. You agree not to bill Medicare (or Medicaid) or attempt Medicare (Medicaid) reimbursement for any such services.

5. 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 Practice, or its Physicians. Patient acknowledges that Practice 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, in isolation does NOT meet the insurance requirements of the Affordable Care Act, and is not intended to replace any existing or future health insurance or health plan coverage that Patient may carry. This Agreement is for ongoing primary care.-The Patient may need to use the care of specialists, emergency rooms, and urgent care centers that are outside the scope of this Agreement. Physician cannot guarantee 24/7 availability.

This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described in appendix 2. The Direct Practice will not bill an insurance carrier for services covered under the direct agreement.

6. Term. This Agreement will commence on the date it is signed by the Patient and Physician below and will extend monthly thereafter. Notwithstanding the above, the Patient shall have the absolute and unconditional right to terminate the Agreement at any time, for any reason. The Practice shall give thirty days prior written notice to the Patient and shall provide the patient with a list of other Practices in the community in a manner consistent with local patient abandonment laws. 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. The reasons the Practice can terminate a patient are as follows.

- (a) The Patient fails to pay applicable fees owed pursuant to Appendix 1 and 2 per this Agreement;
- (b) The Patient has performed an act that constitutes fraud;
- (c) The Patient repeatedly fails to adhere to the recommended treatment plan, especially regarding the use of controlled substances;
- (d) The Patient is abusive, or presents an emotional or physical danger to the staff or other patients of the Practice;
- (e) Practice discontinues operation

7. Privacy & 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. The practice will make an effort to secure all communications via passwords and other protective means. The practice will make an effort to promote the utilization of the most secure methods of communication, such as software platforms with data encryption, HIPAA familiarity, and a willingness to sign HIPAA Business Associate Agreements. This may mean that conversations over certain communication platforms are highlighted as preferable based on higher levels of data encryption, but many communication platforms, including email, may be made available to the patient. If the Patient initiates a conversation in which the Patient discloses “Protected Health Information (PHI)” on one or more of these communication platforms then the Patient has authorized the Practice to communicate with the Patient regarding PHI in the same format.

By providing an email address or cell phone number on attached Appendix 3, you authorize us to communicate with you by e-mail or text message regarding your “protected health information” (PHI).

8. Sever-ability. 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 extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

9. Assignment. This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient.

10. 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 the Practice address in Port Angeles, WA.

11. Complaints. In the event of a complaint. The Member will first contact Dr. Jessica “Nikki” Myhre directly via email at Koruhealthpa.com. In the event that the Member has an unresolved issue or further questions, they may call the Insurance Commissioner, Consumer Protection Division: <https://www.insurance.wa.gov/file-complaint=or=check-your-complaint-statuscap@oic.wa.gov>; Toll Free: 800-562-6900

12. Patient Understandings (initial each):

**Signing the document online is equivalent for initialing and signing below.*

_____ This Agreement is for ongoing primary care and is NOT a medical insurance agreement.

_____ I do NOT have an emergent medical problem at this time.

_____ In the event of a medical emergency, I agree to call 911 first.

_____ I do NOT expect the practice to file or fight any third party insurance claims on my behalf.

_____ I do NOT expect the practice to prescribe chronic controlled substances on my behalf. (These include commonly abused opioid medications, benzodiazepines, and stimulants.)

_____ In the event I have a complaint about the Practice I will first notify the Practice directly. Notify Jessica “Nikki” Myhre DO at koruhealthpa@gmail.com.

_____ This Agreement (without a “wrap around” compliant insurance policy) does not meet the individual insurance requirement of the Affordable Care Act.

_____ I am enrolling (myself and my family if applicable) in the practice voluntarily.

_____ I may receive a copy of this document upon request.

_____ This Agreement is non-transferable.

_____ This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described.

Patient Name _____

Patient (or Guardian) Signature _____

Physician Name _____

Physician Signature _____

Date _____

APPENDIX 1 Koru Health PLLC Patient Membership Fee Schedule

Patient Membership Fee Schedule

Membership	Monthly Fee
1st Member	\$80/month
2nd Family * Member	\$65/month
3rd Family * Member	\$ 30/month
Family Maximum	\$175/month
Single Parent + Children	\$140/month
Enrolled but has moved away (snow-birding, etc): available for questions/care	\$40/month
Local Full Time College Student	\$55/month

Monthly Periodic Fee (billed at the beginning of the service period) – This fee is for ongoing primary care services. We prefer that you schedule visits more than 24 hours in advance when possible. Some ancillary services will be passed through “at cost” (no markup by us). Examples of these ancillary services include laboratory testing and Kenalog injections. Many services available in our office (such as EKGs) are available at no additional cost to you. Items available at no additional cost will be listed on our website and are subject to change.

**If signing this document online, you agree to the current membership monthly price.*

The periodic fee will be billed on the date the membership starts, and monthly thereafter. The patient is entitled to leave the practice at any time, and will be refunded a prorated final bill based upon the date of withdrawal from the practice.

Patients are billed each month in advance of services being provided. Practice will not bill for more than one month in advance. If a patient chooses to pay more than one monthly fee in advance, the funds shall be held in a trust account and paid to the direct practice as earned at the end of each month. Any unearned direct fees held in trust following receipt of termination of the direct agreement shall be promptly refunded to the direct patient. The amount of the direct fee earned shall be a proration of the monthly fee for the then current month as of the date of the notice of the termination.

Patients will be notified of additional charges prior to their administration or delivery.

Disclosure: Changes to the fee schedule or the health care services provided under the Agreement can only be changed once annually, and with 60 days advance written notice to existing patients. Fees for comparable services will not vary between patients based on health status or sex.

After-Hours Visits

There is no guarantee of after-hours availability. This agreement is for ongoing primary care, not emergency or urgent care.

Acceptance of Patients

Koru Health may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of health care services in the direct practice.

Appendix 2

Koru Health PLLC, Covered Services, Excluded Services, and Itemized Fees

Covered Services	Services Not Covered
Comprehensive Physical- including pap smears	Immunizations
Sports/School Physical	Pathology Fees
Preventative Care	Lab work cost (3)
Management of Chronic Disease	Imaging Cost
Dietary/Nutrition Counseling	Specialist care
Exercise Counseling	Hospitalization Care
Acute Visits	Emergency Room Visits
House Calls (2)	
Hospitalization Coordination	
Specialist Coordination	
Procedures:	
OMT (1)	
Laceration Repair	
Skin Biopsy	
Cryotherapy	
Mole Removal/ Skin Tag removal	
Ear Wax removal	
EKG	
Joint Injections (shoulder, knee) (4)	

IUD Removal	
Nebulizer treatments	

1 **OMT** : Full Body or OMT focus visit are \$65/visit.

2 **Home visits** as needed (at the discretion of Dr. Myhre)- extra charge of \$100 (Port Angeles)/\$150 (Sequim) per visit.

3 **Labs**: The following labs are included in your membership; urinalysis, urine pregnancy test, and urine drug screening when indicated. Other labs are either ordered through Olympic Medical Center, discounted prices from Quest, or the lab of your choice.

4 **Joint Injections/Trigger point injections**: \$25/joint or 10 trigger points

- * Pathology: Patient is responsible only for the price of the pathology report (for skin biopsies and pap smears). Specimens are sent to Olympic Medical Center or Northwest Pathology for a discounted rate. You can also use your insurance to cover these costs.
- * Imaging: Not included. If you have insurance that covers imaging cost, Dr. Myhre will order your imaging at Olympic Medical Center. If you do not, then InHealth Imaging or Rayus Radiology in Poulsbo of low cost imaging.
- * Hospitalization: Dr. Myhre does not admit patients, but will help coordinate care with your hospitalists if needed, and help as you transition out of the hospital.
- * Immunizations: It is not financially feasible to do immunizations in the clinic but you can get these from Public Health or through your pharmacy.

Appendix 3 Koru Health PLLC Protected Health Information

By providing an email address or cell phone number below, you authorize us to communicate with you by e-mail or text message regarding your “protected health information” (PHI).

Email address _____

Phone to communicate via Text Message _____

Executed on: _____ / _____ / 20_____ By: _____

Patient or his/her legal representative

And: _____ On behalf of Koru Health PLLC

Appendix 4 Koru Health PLLC Medicare Patient Understandings

This agreement is between Koru Health PLLC, and

Medicare Beneficiary (Print name) : _____

Address: _____

Medicare ID #: _____ Date: _____

Patient is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Practice has informed Beneficiary or his/her legal representative that Physicians at the Practice have opted out of the Medicare program. The Physicians in the Practice have not been excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial each:

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Patient Signature _____

Date _____