LANTERN HEALTH | direct primary care

Patient Member Agreement – Individual or Family Plan

Patient Name: _____

Additional Patient Member Name(s) and Age(s) (if applicable):

_____

_____

Parent/Legal Representative Name (if applicable): _____

Commencement Date of Membership: _____

Plan Name: Lantern Membership

This PATIENT MEMBER AGREEMENT (this "*Agreement*") sets forth the terms and conditions pursuant to which you ("*you*" or "*Patient*") will become a patient member of Lantern Health, PLLC. (the "*Clinic*") under the Lantern Membership. If your Type of Membership is for more than one person (*e.g.* for you and your spouse, your children under age 26, *et cetera* covered under the same Plan) then the term "you" or "Patient" as used in this Agreement shall include all family members accessing the Clinic under a single Membership.

1. BENEFITS AND SERVICES.

A. Scope of Services. The Clinic is a direct primary care practice serving patients ages of all ages. For details on the primary care medical services provided by the Clinic, please refer to www.lanterndpc.com. A printed copy of the Complete List of Membership Services is available from the Clinic upon request.

B. What Is Included in Membership Fee; Payment for Additional Services Provided by Clinic. Some medical care will be provided to you (and to each family member covered by this Membership Agreement) each year at no additional cost (the "Included Services"). The Clinic may charge a fee for additional services such as (i) services or products of a type not included in the Included Services, or (ii) because you exceed the number of the Included Services provided in a year without an additional fee. Included Services do not accumulate from year-to-year if not used and are not transferable among family members. The Complete List of Membership Services includes additional information regarding pricing for services not included in the Included Services.

C. Appointment Scheduling. Appointments may be scheduled by (i) calling the Clinic office during office hours (available on the Clinic website) or (ii) texting the Clinic through the dedicated communications app. Details regarding the dedicated communications app will be provided to you as part of your membership.

D. Specialty Services. The Clinic is a primary care practice. If you need a referral for specialty services, our Clinic will work with you to arrange those services. The Clinic maintains relationships with some healthcare providers to arrange for services in a timely manner and at a negotiated rate. If you have health insurance, it is your obligation to inform the Clinic if you would prefer to be seen by a physician or provider who participates in your insurance plan.

E. Emergency Services. If you believe that you are suffering a life-threatening condition or other condition requiring emergency treatment, **call 911 or go to the emergency department at your local hospital**. DO NOT contact the Clinic before seeking care for a condition requiring emergency treatment. Please DO have a family member contact us, or contact us after the emergency condition has been stabilized if you believe the Clinic could offer any assistance. Medical concerns that may require emergency treatment should never be raised or addressed through the dedicated communications app.

F. Travel Outside of North Carolina. When you are traveling outside of the State of North Carolina and have urgent or emergency healthcare needs, please seek care from a local healthcare provider.

2. YOUR RESPONSIBILITIES.

A. Participation in Your Healthcare. In order to allow us to be involved in your care in a comprehensive manner, we recommend that complete an Authorization for Release of Medical Records authorizing any health care provider or facility where you receive health care services to release your information to the Clinic upon our request.

B. Payment of Fees. As detailed in Section 5 below, you are obligated to (i) pay the Membership Fee, and (ii) to compensate the Clinic for those services and products provided to you by the Clinic that are not Included Services.

3. PRESCRIPTION POLICY. Our providers are licensed to write prescriptions and will provide prescriptions (to be filled at the pharmacy of your choice) as necessary for treatment or management of medical conditions that are within the scope of medical services provided by the Clinic. Our providers may also be able to provide a prescription for a short-term refill of your existing prescriptions in emergency situations if (i) we have had an in-person encounter with you prior to such date, and (ii) we have sufficient records on file.

4. OPIOID AND PAIN MANAGEMENT POLICY. The Clinic will never issue new prescriptions, or refill existing prescriptions, for chronic opioids. In addition, the Clinic does not provide long-term pain management services. Acute pain management will be provided in accordance with the North Carolina Strengthen Opioid Misuse Prevention (STOP) Act of 2017.

Patient (or Parent/Legal Representative) Acknowledgment of Opioid and Pain Management Policy (initials): _____

5. FEES.

A. Membership Fee. Participation as a member in the Clinic requires payment of a Membership Fee for the Lantern Membership. The Membership Fee will be withdrawn directly from your selected method of payment, either your bank account via ACH (preferred) or charged to your credit/debit card on a monthly basis.

B. Additional Fees. You are financially responsible for services and products provided by the Clinic beyond those included in the Included Services. Such services and products may include, for example, complex imaging or complex lab services arranged through our partners, prescriptions or over-the-counter medications provided in the Clinic, health-related and other retail items that you purchase from the Clinic, and services not included in the Membership Fee, or in a quantity beyond the number included in the Included Services, as designated on the Complete List of Membership Services.

C. Method of Collection. You understand that bank account information (preferred) or credit or debit card is required to establish membership and that bank account information or a valid credit/debit card remains on file with Clinic. The Membership Fee will be billed to your selected method of payment as described above. All fees and costs for those services and products provided to you that are not Included Services will be charged to selected method of payment at the time that the services or products are provided or ordered unless other arrangements for payment are made with the Clinic. You authorize the Clinic to charge your

selected method of payment for your Membership Fee as well as any other fees incurred by you, including those described in the Complete List of Membership Services.

D. Changes to Fees. The Membership Fee may change from time to time, but no more often than once every twelve (12) months. Any changes to the Membership Fee will be posted on the Clinic's website at www.lanterndpc.com, and the Clinic will send a secure message to you at least thirty (30) days in advance of any such change. Any change in the Membership Fee will be applied only for subsequently billed Membership Fees charges and will not be applied to months for which the Membership Fee has already been paid. The fees for services and products other than Included Services may change from time to time based upon relationships with other providers, costs incurred by the Clinic and other factors. Such fee increases will be posted on the Clinic's website at www.lanterndpc.com at least thirty (30) days prior to the effective date of such fee increase.

E. Fees at Termination and Reinstatement of Agreement. If you elect to terminate this Agreement, you will continue to be a Member, and will continue to be obligated to pay the Membership Fee, until the effective date of such termination as described in Section 7(C). If you elect to reinstate this Agreement following a termination, you may be obligated to pay a reinstatement fee as outlined in Section 7(F).

6. LANTERN HEALTH IS NOT INSURANCE AND DOES NOT BILL INSURANCE COMPANIES. This Agreement is not a contract for insurance. The Clinic is not an insurance company. Your membership is not health insurance, and your membership is not a substitute for health insurance. Any healthcare products and services not specifically described in this Agreement, including but not limited to hospital, surgical, emergency, and specialist care, are not the responsibility of the Clinic. The Clinic does not pay for, or reimburse, for such services. The financial responsibility for such services is your sole responsibility. The Clinic recommends that you arrange for health insurance coverage. **Patients are encouraged to consult with their own health insurance advisor and/or tax advisor to understand how this Agreement will impact their own health insurance coverage, eligibility to secure other coverages and overall costs. The Clinic does not advise patients regarding these issues.**

A. Notice Regarding Individual Mandate to Purchase Health Insurance. The Affordable Care Act (also called Obamacare) formerly required most US residents to have a basic level of health insurance. This requirement is commonly known as the "individual mandate." Health insurance is usually acquired through an employer or by purchasing individual insurance. The law formerly imposed a tax penalty on individuals who do not have the required coverage. Your membership in the Clinic does not satisfy the requirement of the individual mandate.

B. Notice to Medicare Patients and Medicare Private Contract. For patients who are Medicare Part B beneficiaries seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997, please be informed that our physicians are opted out

of the Medicare program, with current effective two year period of January 1, 2021 to December 31, 2022. The physician opt out period auto-renews every two years unless terminated prior to the renewal date. You agree that at no time will you submit a claim or request that the Clinic submit a claim to the Medicare program for any services provided to you at the Clinic, even if covered by Medicare Part B. You agree that you are not currently in an emergency or urgent health care situation. You acknowledge that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for healthcare services provided by the Clinic. You acknowledge that Medi-Gap plans will not provide payment or reimbursement for healthcare services provided by the Clinic because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement. You acknowledge that you have a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that you are 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. The Clinic does not participate in any form of Medicare and will not submit a claim to Medicare for reimbursement. You agree to be responsible to make payment in full for healthcare services provided by the Clinic. You understand that Medicare payment will not be made for any items or services furnished by the Clinic that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

C. Notice to Patients with Private Health Insurance. The Clinic does not participate in private health insurance plans and will not submit a claim to your private health insurance company for reimbursement. You may be entitled to receive reimbursement from your private health insurance plan for some of the healthcare services provided by the Clinic by submitting a request for reimbursement for out-of-network services. Please note that, while coverage for specific services by private insurance varies significantly from plan to plan, private health insurance plans are unlikely to reimburse you for all of our services. It is unlikely that private health insurance plans will credit the Membership Fee toward any deductible. Upon request, we will prepare an invoice, including any applicable CPT codes, in form appropriate for you to submit to your private health insurance company in order to request reimbursement for services provided by Clinic providers. The Clinic can also provide you with a statement of all services you have received through the course of your membership upon request. We will not, however, be able to provide you with an invoice for services provided by our partners (such as for radiology or clinical laboratory services), even if we arrange for, or collect payment for, such services.

D. Impact on Tax-Advantaged Healthcare Accounts. Please consult with your own health insurance advisor regarding how membership in the Clinic may impact eligibility for medical expense payable or reimbursed under a tax advantaged savings account such as a health

savings account (HSA), medical savings account (MSA), flexible spending arrangement (FSA) or health reimbursement arrangement (HRA).

Patient (or Parent/Legal Representative) Acknowledgment of Insurance Notifications (initials): _____

7. TERM; RENEWALS OF MEMBERSHIP; CHANGE IN PLANS; TERMINATION.

A. Effective Date. Following execution and delivery of this Agreement by you and payment of the first installment of the Membership Fee, the Clinic will provide you a signed copy of this Agreement with the Commencement Date completed. Until the occurrence of those events, Clinic shall have the option to terminate this Agreement, in its sole and absolute discretion. In such an event, the Clinic will return any fees previously paid by you to the Clinic.

B. Term and Renewals. This Agreement commences on the Commencement Date set forth above. Subject to dismissal from the Clinic or termination of this Agreement, your membership is auto-renewing. We will continue to bill your selected method of payment for the Membership Fee until termination.

C. Termination for Non-Payment. Your membership will be terminated if (i) we are unable to bill your selected method of payment and you fail to provide an alternative payment source within ten (10) days of notification, or (ii) you fail to pay any other amounts due to the Clinic within ten (10) days of notification.

D. Termination of Membership; Changes to Type of Membership. You may not terminate your membership during the initial six (6) months of this Agreement. You may terminate your membership at any time after the six (6) months of this Agreement by providing no less than thirty (30) days advance notice of termination. Any notice by you of an election to terminate during the initial six (6) month term of this Agreement, shall be effective on the latter of (i) the six month anniversary of the Commencement Date, or (ii) thirty (30) days following delivery of such notice. Any Membership Fees prepaid by you that are in excess of amounts due will be refunded within thirty (30) days. Any change to the Type of Membership (for instance, adding additional family members to your membership) must be coordinated with the Clinic.

Patient (or Parent/Legal Representative) Acknowledgment of Six (6) Month Term (initials): _____

E. Dismissal from the Clinic; Disruptive Behavior. The Clinic may dismiss you (or if you are enrolled as a family membership, any member of your family) as a member of the Clinic at any time by providing you with written notice. Examples of reasons that may trigger a dismissal include if you engage in behavior that is disruptive for our staff or other patients,

you violate our opioids policy, you develop a pattern of missed appointments or you are non-compliant with the recommendations of our healthcare providers. Membership Fees that have been paid the date of such termination shall be refunded to you. In the event that you are enrolled as a family membership, and any member of your family (but not your entire family) is dismissed as a patient, then the Membership Fee shall be refunded and/or adjusted based on the current Membership Fee for family members based on the number of members of your family who remain as members of the Clinic following such dismissal.

F. Effect of Termination or Non-Renewal. Any excess Membership Fees will be refunded to you (on a prorated basis and less amounts that you owe to the Clinic) within sixty (60) days of the termination or expiration of your membership. Termination or expiration of membership does not relieve you of the responsibility to pay all fees incurred through the date of termination.

G. Reinstatement. In the event that you elect to terminate this Agreement or decide not to renew, the Clinic reserves the right to charge a reinstatement fee of Four Hundred Dollars ($400) unless there has been a period of at least eighteen (18) months between the termination or non-renewal of this Agreement and the effective date of a new Patient Membership Agreement. It is up to the discretion of the Clinic whether it will allow a reinstatement.

H. Transition of Care at Termination or Non-Renewal. In the event of a termination or non-renewal of your membership by the Clinic, the Clinic will continue to meet your urgent medical care needs (consistent with Clinic policies and procedures) and refill necessary prescriptions written by Clinic providers for a period of the shorter of (i) thirty (30) days or (ii) until you are able to secure services from another primary care provider, but care at the Clinic will not extend past the thirty (30) day period. The Clinic will work with you to try to find another provider to meet your primary care needs. The Clinic reserves the right to cancel, or to refuse to schedule, appointments with ancillary care providers for services such as nutrition counseling following the termination of this Agreement where these services are not necessary to meet an urgent care need; no such services will be provided more than thirty (30) days following termination of this Agreement.

8. PRIVACY.

A. HIPAA. The Clinic will comply with all requirements of the privacy and security provisions applicable to the Clinic pursuant to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations, and the Clinic's Notice of Privacy Practices.

B. Electronic and Cell Phone Communications. You will be able to communicate with your Clinic provider through the communications app. You will be required to provide your email

address and cell phone number upon becoming a member of the Clinic. Unless you notify the Clinic in writing, you agree that the Clinic may (i) communicate with you electronically (email, text, app) regarding appointments, test results, or other matters related to your care, (ii) contact you by telephone at any number contained in your records, including wireless (mobile) telephone numbers, for the purpose of scheduling appointments, communicating test results and collecting amounts due, and (iii) leave messages for you with respect to your medical appointments, evaluation, diagnosis or treatment at telephone numbers contained in your record. You understand that while the Clinic utilizes technology and implements policies to protect the confidentiality of electronic communications (email, text, app), the security of those communications cannot be assured or guaranteed.

C. Urgent Communications; In-Person Visits. If you have an urgent or time-sensitive need, it is best to contact the Clinic by phone instead of by electronic communications. In addition, in some cases the Clinic provider may determine that electronic communications are not sufficient and that an office visit or virtual visit is necessary to address your concern or medical problem.

9. MISCELLANEOUS PROVISIONS.

A. Notices. Any notices contemplated by this Agreement to be delivered in writing shall be delivered via mail, return receipt requested, or provided via hand delivery (i) in the case of the Clinic, to the Clinic's business address, and (ii) in the case of the Patient, to the Patient's primary residence as provided by the Patient to the Clinic.

B. Governing Law; Venue. This Agreement shall be governed by the laws of the State of North Carolina without giving effect to any conflict of law principles. Each party consents to the jurisdiction and venue of the state and federal courts having jurisdiction over Buncombe County, North Carolina for all matters related to this Agreement or the provision of medical care.

C. Entire Agreement; Counterparts. This Agreement sets forth the entire understanding of the parties with respect to the subject matter hereof. There are no promises by the Clinic or representations by the Clinic except as set forth herein. This Agreement may be executed in two or more counterparts, all of which shall constitute a single agreement. I agree that my electronic consent has the same legal effect as my handwritten signature.

D. Amendments; Waivers; Invalid Provisions. Except as contemplated herein with respect to the Complete List of Memberships Services (which may be updated by the Clinic from time to time by posting a new Complete List of Membership Services at www.lanterndpc.com) or increases in Membership Fees pursuant to Section 4(D), this Agreement may only be amended or modified by the written agreement of both parties. No waiver of any provision of this Agreement shall be valid unless in writing and signed by the party against whom such

waiver is sought. The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted. This Agreement may not be assigned by you to another person or entity.

IN WITNESS WHEREOF, the Patient has executed this Agreement and the Clinic has caused this Agreement to be executed by its duly authorized officer.

Patient or Parent/Legal Representative:

_____

Patient or Parent/Legal Representative Signature

Date: _____

_____

Legal Relationship (if applicable)
(mother/father/guardian/legal representative)

Lantern Health, PLLC

_____

By: _____

Date: _____