PATIENT DIRECT MEDICAL CARE CONTRACT

By signing below, you are agreeing to participate in the Maine Direct Medical Care Cooperative Patient-Physician Program (the AProgram@) with HIGHER GROUND MEDICAL, LLC (the APractice@). This Contract defines both your obligations as well as those of the Practice.

1. What the Practice Provides. As an enrollee in the Program, the Practice will provide you with the following services:

(a) Annual Exams, including a pap smear if indicated and a complete blood count (CBC) test and basic metabolic profile;
(b) Consultations as required for gynecological issues;
(c) Urgent care during office hours;
(d) Telehealth visits as appropriate;
(e) Access to discounted medications and laboratory services as negotiated by the Practice with third party vendors;
(f) Forty percent (40%) off of the Practice's posted rates for medical procedures (which posted rates will be provided from time to time upon your request); and
(g) Access to a Practice Physician by email.

2. Limitations. The Practice can only provide those services which are within its physicians= training and capabilities. For example, the Practice will not cover hospital care nor specialty services. Lab work other than listed in Section 1 above are not included. There may be times when the Practice=s physician(s) are not available due to vacations, illness, etc. and during those times, you may need to seek urgent care elsewhere and you will be responsible for the costs associated with such urgent care services.

3. Costs. Your total costs for the above services are as follows:

(a) A one-time initial registration fee of $125.

(b) A monthly membership fee of $125 payable in advance of, or on the date of, initial service under the Program with a six (6) month minimum. You must provide the

Practice with a valid credit card and hereby authorize the Practice to charge the monthly membership fee on the first day of each month.

(c) A re-enrollment fee of $175 if a you drop out of the program (or don=t pay the monthly membership fee on time), and then wish to re-enroll. Failure to update invalid credit cards on file will be considered termination by you of participation in the Program.

(d) A penalty fee of $40 for late payments, invalid credit cards or a bounced check.

4. Term, Termination. This Agreement is for an initial term of 6 months and continues from month to month thereafter. Either you or the Practice can terminate your participation in the Program at any time by giving at least 30 days' notice. After the initial 6-month term, any amount prepaid by you beyond those 30 days will be refunded.

5. Program is Not Insurance. You recognize that membership in the Program is not insurance and is not intended to replace any existing or future health insurance or health plan coverage that you may carry. It simply gives you access to some medical care for a fee. It is not intended to cover all medical care you may ever need. The Practice will not be submitting any of the services to your insurance company for reimbursement. If you need a receipt for services rendered in order to submit your own claim for insurance, the Practice will provide you with one. The Practice in no way can assure that you will receive reimbursement from you insurer for such claims.

6. Not Participating in Insurance. You acknowledge that the Practice does not participate in any health insurance or HMO plans or panels, and that the Practice does not make any representations whatsoever that any amounts paid under this Contract are covered by your health insurance or other third party payment plans. You retain full and complete responsibility for any such submissions and acknowledge that you may not by law or regulation be allowed to submit such claims for reimbursement.

7. Health Savings Accounts. The Practice does not make any representation about your ability to pay Program fees from your Health Savings Account, if you have one. The IRS regulations about the use of such accounts are complicated and you should seek the advice of a tax professional before using your HSA to pay the Program fees.

8. Not a Medicare Participant. You recognize that the Practice does not accept patients participating in Medicare. You are signing this Contract to evidence your understanding and agreement regarding payment for any services to be provided by the Practice and are representing to the Practice that you are not covered by Medicare and that you will immediately notify the Practice should you later be covered by Medicare which will result in an automatic termination of this Contract.

9. Communications. You acknowledge that although Practice will comply with State and Federal privacy requirements, communications with the Practice Physicians using e-mail, facsimile, video chat, cell phone, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communications. As such, you expressly waive the Practice Physician's obligation to guarantee confidentiality with respect to the above means of communication.

You further acknowledge that all such communications may become a part of the medical record. By providing an e-mail address, you authorize the Practice, and its Physicians to communicate with you by e-mail regarding your health information. You further acknowledge that:

(a) E-mail and other electronic communications are not necessarily a secure medium for sending or receiving health information and, there is always a possibility that a third party may gain access;

(b) Although the Practice will make all reasonable efforts to keep all electronic communications confidential and secure, neither the Practice, nor the Physician can assure or guarantee absolute security and confidentiality;

(c) Electronic communications may be made a part of your permanent medical record;

(d) You understand and agree that e-mail is not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. In an emergency, or a situation in which you could reasonably expect to develop into an emergency, you understand and agree to call 911 or the nearest emergency room, and follow the directions of emergency personnel.

(e) If you send e-mail to the Physician or staff and do not receive a response within 24 hours, you agree to contact the Physician by telephone or other means.

(f) Neither the Practice, nor any individual Physician will be liable for any loss, injury, or expense arising from a delay in responding to you when that delay is caused by technical failure. Examples of technical failures (i) failures caused by an internet service provider, (ii) power outages, (iii) failure of electronic messaging software, or e-mail provider (iv) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of email communications by a third party which is unauthorized by the Practice, or (v) your failure to comply with the guidelines for use of email described in this Agreement.

10. Miscellaneous.

(a) This agreement is governed by the laws of the State of Maine.

(b) Any notice that the Practice gives to you can be sent to the address you provide below. Any notice to the Practice shall be sent to 66 Leighton Road Falmouth, ME 04105.

YOU ACKNOWLEDGE THAT YOU HAVE READ THIS CONTRACT AND UNDERSTAND WHAT THE PRACTICE INTENDS TO PROVIDE TO YOU AND WHAT IT WILL NOT PROVIDE. YOU ALSO ACKNOWLEDGE THAT YOU HAVE HAD AN OPPORTUNITY

TO ASK ANY QUESTIONS YOU MAY HAVE ABOUT THIS CONTRACT AND THEY HAVE BEEN ANSWERED TO YOUR SATISFACTION.

Dated: _____ _____

Signature

Print Name: _____

Print Address: _____

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