HENDERSON
INTERNAL MEDICINE

Membership Contract

Dear Patient: Henderson Internal Medicine ("HIM") is committed to delivering high quality healthcare services to each and every patient. HIM treats far fewer patients per full- time doctor than the average primary care practice. This low patient to doctor ratio is a benefit not available with traditional health insurance reimbursement, and it allows us to be more responsive to your healthcare needs both during and between office visits. HIM appreciates that patients may desire to purchase service amenities above and beyond what is covered by health insurance and managed care programs. In response to this need we are pleased to provide you with these amenities to complement your insurance-covered healthcare services. If you would like to join our HIM practice please review our Program Agreement ("Agreement") outlined below and provide your signature in the space provided.

Sincerely,
Paige Hixson, MD

Patient Name:_____

Date:_____

I am requesting services by Henderson Internal Medicine and agree to the following terms and conditions:

Henderson Internal Medicine Patient Program-
The Program's Annual Fee includes these enhanced service amenities:
• Unhurried office visits 15-90min depending on the patient's care needs
• Telehealth visits
• In-house pharmacy non-controlled substance medications only
• Direct physician text/phone contact (office hours)
• Same day or next day appointments[1]
• Family care conference availability
• FMLA/ disability paperwork/ other medical related paperwork

1 Staffing limitations may occasionally make this appointment time frame be longer

These amenities are not intended to encourage additional medical utilization or increased medical billing for the patient, but rather are intended to provide the patient a broader array of health and wellness options, education, and support. Our intention is to decrease the need for medical care or plan utilization.

Should you require hospital admission, hospital care will be delivered by a designated hospital medicine specialist, with involvement and help with transition care coordination by Dr. Hixson.

Provider coverage will be provided during times Dr. Hixson is not available due to scheduled leave/ time off.

I understand and agree to pay the Fee selected below for the above-described amenities with Henderson Internal Medicine

- Initial signup fee: $160 (one time fee)

- Individual Membership: (Select one)
  ____$60 per month per individual
  ____$180 per quarter per individual (Quarterly Plan)
  ____$360 biannually per individual (Biannual Plan)
  ____$720 per year per individual (Yearly Plan)

Renewals and Termination:

The Agreement shall auto-renew until canceled by the member. In the instance that the behavior agreement is violated the termination of membership is immediate. I understand that failure to make timely payment of my membership fees may result in termination of my membership in Henderson Internal Medicine. Accounts >30days in arrears will be frozen and then deactivated after a 45days.[2,3]

2 If terminating your plan you must sign a HIPAA compliant request to transfer records to your new physician. One copy of your records will be provided to your new physician at no charge. Additional copies of your records will be charged at the current rates.

3 Failure to renew or to make payment in a timely fashion will be taken as your decision to immediately establish yourself with a new physician. Your physician will provide emergency care only for 30 days at which time you will be terminated from the program. After this time Dr. Hixson will no longer be responsible for any aspect of your medical care and you should see your new physician for all medical issues. You and/or your insurance company as the case may be, will be responsible for any charges incurred for emergency care provided during this time

Cancellation Policy

_____ (Initial) I understand that cancellations are permanent

_____ (Initial) I understand that when I cancel I will call or email **before my autopay date**

_____ (Initial) I understand that after canceling, no more services will be provided such as consultation, medications and procedures

_____ (Initial) I understand that upon cancellation my account will be inactivated and will no longer be billed monthly

_____ (Initial) I understand I can request a copy of my medical records

_____ (Initial) I agree to use one of these forms of communication to cancel my membership: **email, phone call**

I understand that I, or my insurance company, are responsible for all healthcare services that are traditionally covered by a health insurance program. These services exclude the services that are provided under my Membership Fee. Regardless of health coverage, I understand that all co-payment, co-insurance and/or deductibles will apply as defined by my insurance policy. In the event that the services are not covered by my Payor, I understand that I am responsible for payment.

Entire Agreement:

This Agreement constitutes the entire understanding of the parties with respect to the subject matter outlined in this Agreement. The undersigned agrees to the terms and conditions of this agreement and acknowledges there are no promises or representations except as specifically listed in this Agreement.

Governing Law:

This Agreement shall be governed by and constructed in accordance with the laws of the State of Nevada

This Membership Contract is entered into as of the _____ day of _____, and is effective as of the _____ day of _____ between you, the undersigned Patient ("You"), and Henderson Internal Medicine ("HIM"). By voluntarily entering into this Agreement and remitting the Membership Fee (as set forth above), you may participate in the HIM's Personalized Primary Care beginning on the Effective Date.

I, _____, agree to the terms and conditions herein.
Patient Printed Name

I, further, acknowledge I understand the "Program," is not an insurance product, and that I have been advised I will need to continue my own health insurance. I have read and agree to the terms of the HIM's payment policies.

_____ _____
Patient Signature Date

_____ _____
Paige Hixson, MD Date

Terms and Exclusions:

I understand that the Membership Fee payable to HIM strictly covers healthcare, amenities and service that are not reimbursed or covered through the Medicare, Medicaid and third-party payers (health insurance) programs. As such, HIM will not seek reimbursement for services provided as part of your Membership Fees with your medical insurance. I understand that I am solely financially responsible for payment of my Membership Fees and that this fee is not reimbursable by my private insurance carrier, Medicare or Medicaid. However, some of the fees for my membership fee may be submitted to my health savings account (HSA), medical savings account (MSA) or flexible benefits account (FBA) for reimbursement but please consult a tax expert or your tax preparer for guidance in this regard.

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Patient History Form	
Name:	Birth date:
Marital Status:	Occupation:

Allergies to Medications, Latex or Dyes	☐None ☐ Yes (please list)

Medications (Prescriptions, non-prescriptions, vitamins and supplements) ☐None ☐ Yes (please list)	

Surgeries/Hospitalizations/Serious Injuries	Year

Immunizations	N	Y		Immunizations	N	Y
Hepatitis B Series				Recent Pneumonia Vaccine		
Gardasil Series				Recent Flu Vaccine		
Chicken Pox immunization or disease				Positive TB Screening		

Health Maintenance	No	Yes	(Year)		Health Maintenance	No	Yes	(Year)
Colonoscopy					Bone Density			
Mammogram					Eye Exam			
Pap Smear					Physical Exam			

Social History	No	Yes	
Smoking			Pack(s)/day /years ☐ Quit
Alcohol			Drinks/day drinks/week
Caffeine			Drinks/day
Recreational Drugs			
Special Diet			If yes describe:
Regular Exercise			If yes describe:
Sexually Active			☐ Men ☐ Women ☐ Both

GYN History	OB History
Age of first mensus: ( ) Menopause ☐ N ☐ Y (if yes Age:)	Total Number of Pregnancies: ( )
Regular Periods ☐ N ☐ Y Painful Periods ☐ N ☐ Y	Full Term ( ) Pre Term ( )
PMS ☐ N ☐ Y – if yes describe	Miscarriages ( ) Abortions ( )
Abnormal Pap: – if Yes approximate date ( )	Tubal ( )
Pain with intercourse: ☐ N ☐ Y	Content with sex life: ☐N ☐ Y

Medical History (please check if positive)

ENT		GENITOURINARY		SKIN	
	Eye Problems		Urinary Infections		Psoriasis
	Sinus Problems		Kidney Disease/Stones		Skin Disorders
	Hearing Loss		Erectile Dysfunction		Melanoma
			STD		
CARDIOVASCULAR			Urinary Incontinence		
	Abnormal EKG	MUSCULOSKELETAL		PSYCH	
	Chest Pain		Arthritis/Osteo		ADD/ADHD
	Heart Attack		Arthritis/Rheumatoid		Anxiety
	Heart Disease		Gout		Depression
	High Blood Pressure		Neck/Spinal Problems		Memory Loss
	High Cholesterol	NEUROLOGICAL			OCD
	Stroke		Concussion		Suicidal Thoughts/attempt
	Peripheral Vascular Disease		Headaches		
PULMONARY			Migraines		
	Asthma		Epilepsy/Seizures		
	Emphysema/COPD	HEMATOLOGICAL			
	Shortness of Breath		Anemia		
	Sleep Apnea		Bleeding Disorders		
GASTROINTESTINAL			Blood Clots		
	Acid Reflux		Cancer		
	Constipation		Sickle Cell Disease		
	Diarrhea	ENDOCRINE			
	Irritable Bowel		Diabetes		
	Gall Bladder Disease		Thyroid Disease		
	Hernia		Pancreatitis		
	Liver Disease				

Family History (please check all applicable boxes)

Illness	Father	Mother	Sibling	Child	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Other
Asthma									
Bleeding Disorders									
Breast Cancer									
Colon Cancer									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Leukemia									
Liver Disease									
Lung Cancer									
Osteoporosis									
Ovarian Cancer									
Pancreatic Cancer									
Rheumatoid Arthritis									
Stroke									
Thyroid Disease									
Other:									

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Patient Behavior Contract

Our clinic is a place of safety, wellness and healing. In order to provide this environment for our patients we have a zero tolerance policy for any verbal or physical abuse. All patients and their family/ guests will be expected to adhere to this policy.

We reserve the right to cancel membership and ban persons from returning to the premises to anyone who does not adhere to this contract. For any patients affected we will allow one 30day refill per active medication from the date of the incident. After that 30day window the patient will have to see another provider to obtain further medication prescriptions (controlled substance prescriptions excluded from the 30day refill window). The patient will need to seek care with another provider for any follow-up/ ongoing care from the date of cancellation/ ban from premises. Subscription fees in this instance will be reimbursed to the closest month (Example patient membership is cancelled due to violating the behavior contract Jan 15th but they have paid thru March 31st. Their fees for Feb and March will be reimbursed to the patient).

_____

(Patient Name- Printed)

_____

(Patient Signature)

_____

(Date)

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I am signing up for membership at Henderson Internal Medicine Clinic. This is a membership-based clinic. Dr. Hixson does not bill third parties (government or private health insurance) from this clinic

☐ I don't have any other health plan

☐ I currently have _____

Policy number/ Group number: _____

Contact number: _____

Patient Information Request form

In accordance with HIPAA laws, I sign this authorization for transfer of my medical records

Patient Information:

Name: _____
Date of Birth: _____
Information Requested: _____

_____

Patient Signature: _____

Or Patient Representative: _____
Relation to the Patient:_____

Information from:

Facility: _____
Phone #: _____

Fax #: _____

Information to:

HENDERSON
INTERNAL MEDICINE

90 S Stephanie St., Ste 110
Henderson, NV 89012

Phone: 702-305-3293
702-848-3420
Fax: 702-333-0822

Summary of HIPAA-- https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

Your HIPAA rights-- https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

HIPAA EXPLANATION
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with your provider or health insurer, or
- File a complaint with the U.S. Government. You also have the right to ask your provider or health insurer questions about your rights. You can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

• Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
• Health insurance companies, HMOs, most employer group health plans.
• Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

• Information your doctors, nurses, and other healthcare providers put in your medical record.
• Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
• Information about you in your health insurer's computer system.
• Billing information about you from your clinic/healthcare provider.
• Most other health information about you, held by those who must follow this law.

Providers and health insurers who are required to follow this law must keep your information private by:

• Teaching the people who work for them how your information may and may not be used and shared.
• Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

• For your treatment and care coordination,
• To pay doctors and hospitals for your healthcare,
• With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
• To protect the public's health, such as reporting when the flu is in your area, or
• Comply with Dept of Health and Human services request- if they wish to see if we comply with federal privacy law
• To respond to tissue donation request
• To work with a medical examiner or funeral director when an individual dies
• To comply with worker’s compensation, law enforcement or other governmental requests (such as national security, presidential protective services, military governmental functions)
• We can use or share your information for health research.
• Response to lawsuits and legal actions (court or administrative order, subpoena response)
• We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Your health information cannot be used or shared without your written permission unless this law allows it.

For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes
- Share private notes about your mental health counseling sessions.

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization: I authorize the following using or disclosing party:
_____Henderson Internal Medicine_____

To use or disclose the following health information:
(check one)
☐ - All of my health information
☐ - My health information relating to the following treatment or condition:
_____
☐ - My health information covering the period from _____ (date) to _____ (date)
☐ - Other: _____

The above party may disclose this health information to the following recipient:
Name(s) (or title) and organization _____
_____
Address _____
City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

The purpose of this authorization is: (check all that apply)
☐ - At my request
☐ - Other: _____
-We will never sell or share your information to a third party or for marketing purposes unless we achieve specific consent from you

This authorization ends:
- When the following event occurs: __Patient leaves the practice

II. My Rights I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign, please complete the following:
☐ - Patient is a minor: _____ years of age
☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:
☐ - Parent
☐ - Legal Guardian
☐ - Court Order
☐ - Other: _____

III. Additional Consent for Certain Conditions This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.
☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.
☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____