NED ZALLIK, M.D., PLLC
PATIENT AGREEMENT

THIS PATIENT AGREEMENT (the "**Agreement**") is entered into by and between **NED ZALLIK, M.D., PLLC**, an Illinois professional limited liability company, located at 2101 Waukegan Road, Suite 303, Bannockburn, Illinois 60015 (the "**Practice**"), and the undersigned patient ("**You**").

1. Services. In exchange for the Fee (as defined below), the Practice agrees to provide all services listed in Appendix 1 to this Agreement, which are attached hereto and incorporated by this reference (the "**Services**"). You understand and agree that the Services are the only services that will be provided under the terms of this Agreement. You understand and agree that the list of Services may be amended from time to time in Practice's discretion. If the list of Services is amended, the Practice will provide You with an updated list of the Services covered by this Agreement no later than thirty (30) days prior to the date any change in the Services will take effect. You must be sixteen (16) years of age or older to be a party to this Agreement.

2. Term. The initial term of this Agreement shall begin on such date as agreed by the parties (the "**Effective Date**"), and will continue thereafter for a period of one (1) year (the "**Initial Term**"). This Agreement shall thereafter automatically renew for successive one (1) year terms (each, a "*Renewal Term*") upon payment in advance of each subsequent Term's Fee, unless either party provides written notice of non-renewal to the other party at least thirty (30) days prior to the end of a Term. For the purposes of this Agreement, "**Term**" shall be deemed to include the Initial Term and any Renewal Term(s).

3. Fee. In exchange for the Services, Patient agrees to pay Practice the Fee set forth on Appendix 1. This Fee is payable upon execution of this Agreement for Services provided during the Initial Term, and you will be required to pay a Fee in advance of each subsequent Term. If approved in advance by Practice, the Fee may be payable in four (4) equal installments. Payment transactions declined due to insufficient funds or expired cards will result in an additional fee of $50, and failure to comply with payment terms may result in immediate termination of this Agreement by Practice. Services will not be rendered to You if Your account is past due. The Fee may be modified in the Practice's sole discretion on an annual basis. You will receive thirty (30) days' notice of any change in the Fee prior the start of the Term in which the revised Fee will take effect. Notice is satisfied by the Practice publishing its Fee increase on its website at *www.nedzallikmd.com*. If requested by Practice, You authorize the Practice to keep Your credit card information on file and to automatically charge the Fee to your credit card without prior authorization and will execute an "Credit Card Authorization" form contemporaneous with this Agreement.

4. Termination. Notwithstanding anything to the contrary in this Agreement, both You and the Practice have the unconditional right to terminate the Agreement, for any reason or no reason, by giving thirty (30) days' prior written notice to the other party. In addition, Practice shall have the right to terminate this Agreement immediately without such notice (i) if You fail to pay any Fee when due; and/or (ii) as designated on Appendix 1.

In order to terminate this Agreement, You must complete, sign and submit (via U.S. mail, overnight carrier or email) written notice to the Practice. In the event the Practice terminates this Agreement, You will be notified in writing at the address on file with the Practice. The date of termination shall be the last day of the month in which the notice was received. If this Agreement is terminated for any reason, Practice has the sole right to determine whether You may enter into a similar agreement with Practice at a later date.

a. Refunds for a Termination Initiated by the Practice. If a termination is initiated by the Practice and You paid in full for a Term that has not yet been completed, You will be refunded for any remaining months of Your Agreement by taking the total amount You paid, dividing by twelve (12), and multiplying that number by the number of unused months.

b. Refunds for a Termination Initiated by Patient. If a termination is initiated by You, no refund of the Fee will be given under any circumstances.

c. Refunds for a Cancellation Because of Patient Death. If the Agreement terminates in the event of Your death and You paid in full for a Term that has not yet been completed, Your estate will be refunded for any unused months of the Agreement by taking the total amount You paid, dividing by twelve (12), and multiplying that number by the number of unused months.

5. Medicare Beneficiaries. The Practice has opted-out of Medicare. If You are eligible for Medicare, or during a Term of this Agreement become eligible for Medicare, to continue with the Practice You must sign a "Private Medicare Opt-Out Contract" (the "**Medicare Contract**"). Due to the Practice's opt-out Medicare status, **You acknowledge that Medicare cannot be billed, either by You or the Practice. for any Services provided by the Practice. You agree to inform the Practice within five (5) days from the date when you become eligible for Medicare and execute the Medicare Contract at that time. You must sign a form of Medicare Contract every two (2) years**.

6. Insurance or Other Medical Coverage. You acknowledges that the Practice participates in and accepts NO insurance plans for provision of the Services. The Practice makes no representations whatsoever that any Fee paid under this Agreement is covered by Your health insurance. You acknowledge and understand 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 or PPO). The Services provided as part of this Agreement do not include hospital services, specialist services, ambulance services, pharmacy or laboratory services (except those that may be set forth in Appendix 1) or any services not provided by the Practice. You acknowledge that the Practice recommends that You obtain or keep in full force such health insurance policy(ies) or plan(s) that will cover You for healthcare costs.

If You participate in a high-deductible health plan with a health savings account (HSA) feature, please consult your attorney or financial adviser to determine if entering into this Agreement will have any impact on the HSA. Practice hereby disclaims any responsibility or liability with respect to your decisions made thereto.

7. Communications. Though the Practice will exercise ordinary and reasonable care to secure and maintain the confidentiality of Your communications, You acknowledge that communications with the Practice using text, e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. You expressly waive the Practice's obligation to guarantee confidentiality with respect to using such means of communication. You agree that to the extent the Practice has established secure methods to communicate electronically, including email and text, that You will use only those methods for that type of communication. You acknowledge that all such communications may become a part of Your medical records. You acknowledge that it is the policy of the Practice to communicate primarily through a Health Insurance Portability and Accountability Act ("**HIPAA**")-compliant, secure and encrypted direct messaging application, or through the HIPAA-compliant and secure messaging feature of the Practice's electronic medical record. Both of these modes of communication offer additional security beyond email and regular cell phone texting.

In case of a medical emergency, You should call 9-1-1. For non-emergent but urgent matters, You should contact the Practice's office via patient portal or other messaging application or telephone. **Direct messaging or communication through the Practice's electronic medical record only should be used for non-urgent situations**.

By providing Your e-mail address and Your cellphone number to the Practice, You authorize the Practice to communicate with You by text and e-mail regarding Your "protected health information" ("**PHI**") (as that term is defined under HIPAA). By providing Your e-mail address and cellphone to receive texts, You acknowledge that:

a. E-mail and text communications are not necessarily a secure medium for sending or receiving PHI, and there always is a possibility that a third party may gain access to such data;

b. Although the Practice will make all reasonable efforts to keep e-mail and text communications confidential and secure, the Practice cannot assure or guarantee the absolute confidentiality of text or e-mail communications. You are responsible for informing the Practice in writing if You want to cease or limit email or text communications to and/or from the Practice. You may do so at any time without reason or explanation. You are responsible for protecting Your email account or telephone password or other means of access to Your email or text communications. The Practice is not liable for breaches of confidentiality involving Your email or telephone accounts;

c. In the discretion of the Practice, e-mail and/or text communications may be made a part of Your permanent medical record; and

d. The Practice will not be liable to You for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to You as a result of technical failures, including, but not limited to, the following: (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 or text messages; (iii) 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; or (v)

Your failure to comply with the guidelines regarding use of electronic communications set forth in this paragraph.

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

9. Amendment. Except as otherwise provided herein, no amendment of this Agreement shall be binding on a party unless it is made in writing and signed by both parties. 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.

10. Assignment. This Agreement, and any rights You may have under it, may not be assigned or transferred by You to any other person.

11. Legal Significance. You acknowledge that this Agreement is a legal document and creates certain rights and responsibilities. You also acknowledge having had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

12. Dispute Resolution. Arbitration is a private dispute resolution mechanism paid for by the parties that substitutes for resolution by a judge or jury, may entail more limited discovery than is available in court proceedings, and has very limited rights of appeal (if any). It is hereby agreed that any dispute, claim, or controversy arising out of the Agreement, including the determination of the scope or applicability of this Agreement to arbitrate, shall be settled by arbitration conducted in Chicago, Illinois using a single arbitrator and administered by Judicial Arbitration and Mediation Services, Inc. (JAMS) pursuant to its comprehensive Arbitration Rules and Procedures. Judgment on the award rendered by the arbitrator may be entered in any state or federal court located in Cook County, Illinois. Costs of such arbitration shall be split equally between the parties. You acknowledge that You are waiving Your right to a trial in a court of law, including the right to judgment by a jury, by agreeing to this arbitration provision.

13. 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.

14. Entire Agreement. This Agreement and its Appendices contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement.

15. Choice of Law. This Agreement shall be governed and construed under the laws of the State of Illinois without regard to choice of law provisions. In the event that the arbitration

provision herein is ruled unenforceable, You and the Practice agree that any claims to enforce this Agreement or concerning the services provided under this Agreement shall be brought in the Circuit Court of Cook County or the U.S. District Court for the Northern District of Illinois.

16. Force Majeure. If the Practice is unable perform its obligations of this Agreement because of any act of God, civil disturbance, fire, flood, riot, war, pandemic, declaration of emergency or governmental order, performance shall be suspended to the extent prevented or hindered by such force majeure and an equitable credit shall be applied to Your account.

17. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which when taken together shall be deemed to be one and the same instrument. Electronic, facsimile and/or .pdf signatures shall be treated the same as original signatures.

18. HIPAA Applicability. References to "HIPAA" in this Agreement are not intended as a concession or admission that any information related to, created as a result of, or used or disclosed pursuant to, this Agreement are subject to HIPAA-protection or otherwise "PHI" (as that term is defined under HIPAA).

19. Consent to Treatment / Authorization. By executing this Agreement, You consent to receive the Services designated herein as provided by Practice. You further authorize Practice to (a) communicate with Your other healthcare providers for purposes of treatment, payment or healthcare operations or as otherwise allowed by law; and/or (b) review your prescription history including, but not limited to, consulting with pharmacists and providers, and the review of any databases or other listings or records of prescription medications you currently are, or historically have been, prescribed.

20. Notices. Any and all notices, designations, offers, acceptances or any other communication provided for herein shall be given (the "**Giving of Notice**") in writing by hand delivery made directly to the addressee or by registered or certified U.S. Mail, return receipt requested, postage prepaid, which shall be addressed, in the case of Corporation, to 2101 Waukegan Road, Suite 303, Bannockburn, Illinois 60015 and, in the case of You, to Your last known place of residence as reflected on Practice's records. Any notice mailed as herein provided shall be deemed to have been delivered three (3) days after deposit in the U.S. Mail.

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IN WITNESS WHEREOF, the undersigned expressly acknowledge and agree to this Agreement.

PRACTICE:	**PATIENT:**
NED ZALLIK, M.D., PLLC	
Signature:_____	Signature:_____
Its: _____	Date: _____

APPENDIX 1

SERVICES AND FEE

1. Services. As used in this Agreement, the term "**Services**" refers to the medical/clinical Services provided to You by the Practice. By entering into this Agreement, You are entitled to the following Services during each Term:

- In-person office visits, with same-day or next-day appointments.
- Home visits within a geographic area as determined by the Practice and as the Practice deems medically necessary.
- Hospital visits to coordinate care with Your hospital team.
- Coordination of medical care with Your specialists.
- Administration ONLY of Point of Care (POC) testing and in-house lab draws.
- Administration of vaccines (if offered at the Practice's discretion), with cost of the vaccine subject to a separate charge.
- Access to Your physician via the Practice's direct messaging application or through the Practice's electronic medical record for non-urgent matters. Non-urgent communications during regular business hours shall be addressed by Your physician or a staff member of the Practice in a timely manner. Any after-hours communication should be through direct messaging application. During a physician's absence for vacations, continuing medical education, illness, emergencies, or days off, the Practice will provide information about how to access a covering physician. For any medical emergency, You should call 9-1-1.
- Be part of a limited number of patients who are being offered the opportunity to receive Services from the Practice.

The following items, and any other items not included in the Services listed directly above, are NOT Services and are NOT included in Your Fee:

- Inpatient (Hospital) Care. If you are admitted to the hospital, Practice physician may visit you to coordinate your hospital care, but your direct care will be provided by the Hospitalist team at the hospital per the current standard of care or such other healthcare provider you designate, other than a Practice physician.
- While the concierge medicine format and our Practice model allow for increased access and prompt communications with your physician, we expect that after-hours communications will be limited to urgent needs only. Repetitive unnecessary (as determined by the Practice) use of after-hours access will be cause for immediate termination of this Agreement.
- There may be occasions when your preferred appointment date is unavailable, your preferred physician is unavailable, or we cannot accommodate an immediate request. The Practice will make every effort to accommodate each request, but there may be times when this is impossible.
- Bloodwork that is drawn in our office and sent out for testing will be billed directly to You or Your insurance by the provider of the services and not by the Practice directly.

- Costs of vaccines.
- Imaging (CTs, MRIs, Xray, ultrasounds, etc.).
- Visits with specialists.
- Emergency Room Visits.
- Any service not listed as part of the Services.

If there is a dispute between what is considered part of the Services and what is excluded, the Practice's determination shall control.

2. Fee. The annual Fee is (a) Once Thousand Five Hundred Dollars ($1,500) per Term if you are age 16-29 at the time the Term begins; or (b) Three Thousand Dollars ($3,0000) per Term, if you are age 30 or older at the time the Term begins.

3. Miscellaneous. You acknowledge that the Practice's physician may, from time to time, not be available to provide the Services. 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 the absence. While the Practice will make every effort to arrange for coverage for an unavailable physician, such coverage cannot be guaranteed.

NED ZALLIK, M.D., PLLC
CREDIT CARD AUTHORIZATION

NED ZALLIK, M.D., PLLC ("**Practice**") has implemented a credit card "payment on file" policy. Your credit card information will be held securely by the Practice and will be used to charge for services for which you have an out-of-pocket balance due.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ THIS CREDIT CARD AUTHORIZATION AND HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS. I AUTHORIZE PRACTICE TO CHARGE MY CREDIT CARD ON FILE IN ACCORDANCE WITH SUCH POLICY. I AGREE TO UPDATE MY CREDIT CARD ON FILE IN THE EVENT OF ANY CHANGES OR UPON REQUEST. I CERTIFY THAT I AM AN AUTHORIZED USER OF THIS CREDIT CARD AND THAT I WILL NOT DISPUTE THE PAYMENT WITH THE CREDIT CARD COMPANY SO LONG AS THE TRANSACTION CORRESPONDS TO THE TERMS INDICATED IN THIS FORM.

Patient Name: _____

Account #: _____

Card Holder's Name (as shown on card): _____

□ Visa □ Master Card □Discover □ American Express

Credit card #: _____

Expiration date (mm/yy): _____

Security code: _____

Email: _____

****

Card Holder's Signature: _____

Printed Name: _____ Date: _____

If signed by someone other than patient, name and relationship to patient:

_____