HEALTH SERVICES AGREEMENT ONLY FOR TREATMENT OF SEIZURE DISORDERS FOR CASH PAYING UNINSURED PATIENTS

THIS AGREEMENT is made BETWEEN NEW ORLEANS PHYSICIANS ON-CALL, INC., a professional medical corporation registered and doing medical services business in the State of Louisiana, with its registered office in Baton Rouge, (herein "Healthprovider") on the one hand, AND the undersigned consumer of health services herein ("PATIENT"), on the other hand.

IN CONSIDERATION of mutual promises to perform the obligations herein and for other good and valuable consideration the sufficiency and receipt of which is herein acknowledged, the parties AGREE as follows:

Treatment, Payment & Other Obligations

1. Healthprovider shall, as medically indicated in its clinical judgment, provide to Patient in a place or facility chosen by Healthprovider, all or any of the services (herein "treatment") stated in ***Appendix A*** incorporated and made part of this Agreement.
2. Healthprovider shall provide the services as stated in paragraph (1) above only in regard to seizure disorder of Patient.
3. Patient shall present evidence of referral from Patient's primary care provider as a condition for receiving treatment herein.
4. Patient represents that Patient has no health insurance coverage, and is uninsured.
5. Patient understands that Patient shall receive treatment from Healthprovider as stated in paragraph (1) above upon Patient signing this agreement and complying with the payment and other requirements stated in ***Appendix B*** incorporated and made part of this Agreement
6. Patient understands that Patient is to receive treatment from Healthprovider as stated in paragraph (1) above only for seizure disorders; and Patient shall neither ask for nor receive treatment for any other medical conditions from Healthprovider.
7. Patient shall present a state government or United States government photo identification card as a condition for receiving treatment.

Dispute Resolution

8. To the full extent permitted by the Louisiana State laws, any disputes arising under this Agreement shall be submitted to a binding arbitration by either party to be held in a location within the Parish of Orleans or East Baton Rouge Parish in the State of Louisiana.
9. The parties are aware of their right to bring their grievances to a court of law but instead have agreed to, and do herein waive this right in preference to a binding arbitration as herein stated.
10. The parties agree that the arbitration administrator shall be the American Arbitration Association or any comparable arbitration administrator recognized or recommended by the Louisiana State Bar Association.
11. The cost chargeable by the arbitration administrator shall be borne equally by the parties; and the losing party shall be assessed 25% attorney fee payable to the prevailing party.

No Waiver & Confession of Judgment

12. No rights of Healthprovider not enforced herein are waived. Instead, Healthprovider reserves all of its rights under Louisiana law; and Patient confesses money judgment in favor of Healthprovider for any amount of money due and owed to Healthprovider under this Agreement as permitted under Louisiana law.

Severability

13. If any part or clause of this Agreement is found to be unenforceable or contrary to law, this shall not affect the validity or enforceability of the rest of this Agreement.

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Patient's initials Healthprovider's initials

Duration and Termination of this Agreement

14. At the end of one year from the date signed, this Agreement shall automatically renew for another one year unless either party terminates it by giving a thirty (30) days written notice in advance by hand delivery or sent to last known address of a party; or, the Patient failing to make due payment prior to treatment.

Agreement not Drafted by Either Party

15. Neither Healthprovider nor Patient shall be considered the drafter of this Agreement.

Applicable Law

16. This Agreement shall be construed and enforced under the laws of the State of Louisiana.

WHEREOF, the parties hereto have executed this Agreement effective as of the day and year indicated below, understanding fully the provisions herein and agreeing to waive any requirement of witnesses.

SIGNED:

___________________________	____
PATIENT or Patient's legal representative	NEW ORLEANS PHYSICIANS-ON CALL, INC. Per: Its authorized legal representative
___________________________	______________________________
Date	Date

APPENDIX A:

i) Initial office visit including clinical examinations
ii). Follow up office visits including clinical examinations
iii). Brain Imaging studies
iv). Laboratory diagnostics
v). EEG

APPENDIX B:

TREATMENT COSTS & PAYMENT OBLIGATIONS:

_______I. Patient shall pay $2,500.00 cash at the time of initial encounter for treatment for a period of one year. This amount covers: (a) the costs of Patient's first office visit and two (2) follow up office visits provided they occur within one year of Patient signing this Agreement; (b) first Brain Imaging Studies cost; (c) first Laboratory diagnostics cost and (d) first EEG cost. Patient understands that Patient shall pay additional amount of money to cover the costs of subsequent Brain Imaging Studies; Laboratory diagnostics and EEG, and the cost of office visits beyond the first and two (2) follow-up visits described above – all of which are not included in the $2,500.00; **or**

______II. Patient shall pay initial deposit of $500.00, and eleven (11) subsequent payments of $200.00 per month for treatment within a one year period, provided Patient's payment for each subsequent visit covers the cost of office visit and any diagnostics prescribed. The cost of a subsequent office visit is $125.00, and the costs of prescribed Brain Imaging Studies, laboratory diagnostic or EEG (or other screening) tests are the amounts set by the providers of these services. Patient shall pay a total of $125.00 **plus** the costs of a prescribed Brain Imaging Studies, Lab and/or EEG (screening) tests as a condition for approval to schedule a follow-up visit.

COSTS OF MEDICATION AND THERAPEUTIC DEVICES:

_______III. Patient shall pay the costs of any prescribed medications or therapeutic devices. Patient understands that the costs of these items are not included in the costs and payments described in the above paragraphs I and II of this Appendix.

PAYMENT METHODS:

_______IV. *Cash Payment:* Patient shall make payment for treatment directly into the Healthprovider's specified bank account seven (7) days prior to scheduled appointment, or the Healthprovider may cancel the appointment and notify the patient about the cancelation by a telephone call.

_______V. *Check Payment:* Patient shall send a check payment post-marked at least three (3) weeks prior to a scheduled appointment to the Healthprovider's designated address to allow Healthprovider to receive the check payment at least ten (10) business days BEFORE scheduled appointment. Healthprovider may cancel a scheduled appointment and notify Patient by a telephone call if check payment is not received ten (10) business days BEFORE the scheduled appointment.

_______VI. *Credit/Debit Card Payment:* Patient shall make this payment online at Healthprovider's website at the time of scheduling an appointment. In choosing this payment method, Patient understands that payment enables website appointment scheduling.

CANCELATION POLICY:

_______VII. Healthprovider shall charge Patient $50.00 if Patient cancels a scheduled appointment within two (2) business days prior to the appointment.

_______VIII. Patient shall not pay any penalty for canceling a scheduled appointment three business days prior to the appointment.

_______IX. Patient understands that this cancellation policy is different and separate from the duration and termination of this Agreement specified in paragraph 14 of this Agreement.

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Patient's initials Healthprovider's initial