

**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 “Health Provider”) 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. Health Provider shall, as medically indicated in its clinical judgment, provide to Patient in a place or facility chosen by Health Provider, all or any of the services (herein “treatment”) stated in **Appendix A** incorporated and made part of this Agreement.
2. Health Provider 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 Health Provider 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 Health Provider as stated in paragraph (1) above only for epileptic seizure disorders; and Patient shall neither ask for nor receive treatment for any other medical conditions from Health Provider.
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 Health Provider not enforced herein are waived. Instead, Health Provider reserves all of its rights under Louisiana law; and Patient confesses money judgment in favor of Health Provider for any amount of money due and owed to Health Provider 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.

Patient’s initials

Health Provider’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 Health Provider or 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 \$630 cash at the time of initial encounter for treatment for a period of one year. This amount covers the costs of Patient's first office visit and two follow up office visits provided they occur within one year of Patient signing this Agreement. Patient shall also pay the first Brain Imaging Studies cost of \$550 directly to Imaging Center of LA if deemed necessary after initial encounter. Initial Laboratory Diagnostics costs range from \$487 - \$1820 at Labcorp. The cost of initial routine EEG at Ochsner is \$358 and payable directly to Ochsner prior to scheduling. Patient understands that MRI and/or EEG will not be scheduled without full payment by Patient, nor would follow up appointment be scheduled without completion of ordered tests and labs from initial encounter.

Patient's initials

Health Provider's initials

_____II. Patient acknowledges and understands that the services provided in this contract are for uninsured patients only therefore the Health Provider will not submit any claims to any insurance provider for reimbursement. Patient also understands that the costs stated in paragraph I are the discounted self pay rates at their respective facilities and those facilities will not submit any claims to any insurance provider for reimbursement. Patient also 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 follow up visits.

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 Health Provider's specified bank account seven (7) days prior to scheduled appointment, or the Health Provider may cancel the appointment and notify the patient about the cancellation 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 Health Provider's designated address to allow Health Provider to receive the check payment at least ten (10) business days BEFORE scheduled appointment. Health Provider 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 Health Provider's website at the time of scheduling an appointment.

CANCELATION POLICY:

_____VII. Health Provider 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.

Patient's initials

Health Provider's initial