MONTHLY MEMBERSHIP AGREEMENT, She Soars Psychiatry, LLC, This is an Agreement between She Soars Psychiatry, LLC, an Oregon- based practice located at 102 E Main Avenue Suite 300A Sisters, OR 97759 and 602B Front Street Silverton, OR 97381, Audry Van Houweling, PMHNP (nurse practitioner) in her capacity as agent of She Soars Psychiatry and You (Client).

Background The nurse practitioner practices psychiatry and delivers care on behalf of She Soars Psychiatry, LLC. In exchange for certain fees paid by the client, the nurse practitioner agrees to provide the client with the Services described in this Agreement on the terms and conditions set forth in this Agreement. The practice website is https://www.shesoarspsych.com.

Definitions 1. Client. Client is defined as those persons for whom nurse practitioner shall provide Services, and who are signatories to and incorporated by reference to this agreement.

2. Services. As used in this Agreement, the term Services shall mean a predetermined package of psychiatric visits services, both medical and non-medical and certain amenities (collectively Services), which are offered by Practice, and set forth in Appendix 1. Client will be provided with methods to contact the nurse practitioner via phone, email, and other methods of electronic communication. Nurse practitioner will make every effort to address the needs of the Client in a timely manner, but cannot guarantee availability, and cannot guarantee that the patient will not need to seek treatment in the urgent care or emergency department setting.

3. Fees. In exchange for the services described herein**, Client agrees to pay Practice the amount as set forth in Appendix 1, attached**. Applicable enrollment fees are payable upon execution of this agreement. These fees may change with time. Client will be notified 30 days in advance of any fee changes.

4. Non-Participation in Medicare. Audry Van Houweling, PMHNP has opted-out of Medicare. Client acknowledges that federal regulations REQUIRE that providers opt out of Medicare so that Medicare clients may be seen by the Practice pursuant to this concierge client agreement. Neither Practice nor nurse practitioner make any representations regarding third party insurance reimbursement of fees paid under this Agreement. Client shall retain full and complete responsibility for any such determination. If Client is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Client will sign the agreement attached as Appendix 2, and incorporated by reference. This Agreement acknowledges your understanding that Physician has opted out of Medicare, **and as a result, Medicare cannot be billed for reimbursement for any such services.**

5. Insurance or Other Medical Coverage. Client acknowledges and understands that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage. It will not cover hospital services, or any services not personally provided by Practice, or its nurse practitioner. Client acknowledges that Practice has advised that Client obtain or keep in full force such health insurance policy(ies) or plans that will cover Patient for general health care costs. Client acknowledges

that THIS AGREEMENT IS NOT A CONTRACT THAT PROVIDES HEALTH INSURANCE, in isolation does NOT meet the insurance requirements of the Affordable Care Act, and is not intended to replace any existing or future health insurance or health plan coverage that Patient may carry.

This Agreement is for outpatient mental health services, and Client may need to visit the emergency room or urgent care from time to time. Nurse practitioner will make every effort to be available via phone, email, other methods such as “after hours” appointments when appropriate, but nurse practitioner cannot guarantee 24/7 availability.

6. Disclaimer. This agreement does not provide health insurance coverage, including the minimal essential coverage required by applicable federal law. It provides only the services described herein. It is recommended that health care insurance be obtained to cover medical services not provided for under this direct primary care agreement.

7. Term. This Agreement will commence on the date it is signed by Client and Nurse Practitioner below and will extend at the predetermined length of time designated in Appendix 1. Notwithstanding the above, both Client and Practice shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination. Client may terminate the agreement with fourty-eight hours prior notice. **If the client terminates before the term period is over, a fee equal to one-month of the predetermined package is charged. (180.00 for 3 month term, 150.00 for 6 month term, 120.00 for 12-month term).**

Reasons Practice may terminate the agreement with the Patient may include but are not limited to: (a) Client fails to pay applicable fees owed pursuant to Appendix 1 per this Agreement; (b) Client has performed an act that constitutes fraud; (c) Client repeatedly fails to adhere to the recommended treatment plan, especially regarding the use of controlled substances; (d) Client is abusive, or presents an emotional or physical danger to the staff or other patients; (e) Practice discontinues operation; and (f) Practice has a right to determine whom to accept as a Client, just as a Client has the right to choose his or her physician. (g) Practice may also may terminate a Client without cause as long as the termination is handled appropriately (without violating patient abandonment laws).

8. Privacy & Communications. You acknowledge that communications with Nurse Practitioner using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communication. Practice will make an effort to secure all communications via passwords and other protective means and these will be discussed in an annually updated Health Insurance Portability and Accountability Act (HIPAA) “Risk Assessment.” Practice will make an effort to promote the utilization of the most secure methods of communication, such as software platforms with data encryption, HIPAA familiarity, and a willingness to sign HIPAA Business Associate Agreements. This may mean that conversations over certain communication platforms are highlighted as preferable based on higher levels of data encryption, but many communication platforms, including email, may be made available to Client. If Client initiates a conversation in which Client discloses “Protected Health Information (PHI)” on one or more of these communication platforms then Client has authorized Practice to communicate with Client regarding PHI in the same format.

9. 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 the provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

10. Reimbursement for Services if Agreement is Invalidated. If this Agreement is held to be invalid for any reason, and if Practice is therefore required to refund all or any portion of the monthly fees paid by Client, Client agrees to pay Practice an amount equal to the fair market value of Services actually rendered to Client during the period of time for which the refunded fees were paid.

11.Assignment. This Agreement, and any rights Client may have under it, may not be assigned or transferred by Client.

12. Jurisdiction. This Agreement shall be governed and constructed under the laws of the State of Oregon and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for Practice address in Sisters, Oregon.

13. Client Understandings (initial each):

Beneficiary or legal representative accepts full responsibility for payment of Nurse Practitioner's charge for all services furnished by Nurse Practitioner. _____

Beneficiary or legal representative understands that Medicare limits do not apply to what the Nurse Practitioner may charge for items or services furnished by the Nurse Practitioner. _____

Beneficiary or legal representative agrees not to submit a claim to Medicare or to ask Nurse Practitioner to submit a claim to Medicare. _____

Beneficiary or legal representative understands that Medicare payment will not be made for any items or services furnished by Nurse Practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted. _____

Beneficiary or legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out. _____

Beneficiary or legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare. _____

Beneficiary or legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care solution. _____

Beneficiary or legal representative acknowledges that the beneficiary is not currently struggling with active addiction to illicit substances and/or alcoholism (not including cannabis). _____

Beneficiary or legal representative acknowledges that if client is at anytime having thoughts of self-harm, harming others, or exhibiting signs of psychosis, they will be asked to seek emergency services at an emergency room, residential facility, or crisis center. _____

Beneficiary or legal representative acknowledges that a copy of this contract has been made available to him/her _____

This Agreement is for mental health services for a predetermined length of time and is not a medical insurance agreement. I do NOT have an emergent medical problem at this time. I am enrolling (myself and my family if applicable) in Practice voluntarily.

In the event of a medical emergency, I agree to call 911 first or go to the nearest emergency room. I understand Audry Van Houweling, PMHNP at She Soars Psychiatry, LLC will make every effort to be available but may not always be able to see me within 2 business days.

I do NOT expect the practice to file or fight any third party insurance claims on my behalf.

This Agreement does not meet the individual insurance requirement of the Affordable Care Act. This Agreement is non-transferable.

I do NOT expect the practice to prescribe chronic controlled substances on my behalf. (These include commonly abused opioid medications, benzodiazepines, and stimulants.)

I understand failure to pay the membership fee will result in termination from Practice.

Patient Name _____Date _____

Patient (or Guardian) Signature _____

APPENDIX 1: She Soars Psychiatry, LLC Enrollment Fees and Services

This Agreement is for mental health services. This Agreement is not health insurance. Patient may need to use the care of specialists, ERs and/or urgent care centers that are outside of the scope of this Agreement. Examples of conditions we treat and medications we prescribe are attached herein, listed on our website and are subject to change.

She Soars Psychiatry, LLC Concierge Services: Enrollment Fee - The first month's membership fee is charged at the time of registration and is nonrefundable. **This first month's fee fulfills the cost for the 2 hour comprehensive evaluation (for adults) or 1.5 hour evaluation (for children). This fee is 175.00 per adult and 125.00 per child**. **If a client discontinues membership and wishes to re-enroll in the practice we reserve the right to decline re-enrollment or to require a re-enrollment fee of $250.00. We prefer that you schedule visits more than 72 hours in advance when possible. We do not provide walk-in or crisis services.**

Enrollment fee is as stated above (175.00 per adult and 125.00 per child). Thereafter, services may be elected on a monthly or per visit basis per the following:

- 3 month membership at 180.00 per month (includes 2 sixty-minute sessions monthly). OR purchase 6 sixty-minute sessions to use as needed at $90.00/60 minute session for a total of $540.00. Sessions must be used within a calendar year from the time of purchase.
- 6 month membership at 150.00 per month (includes 2 sixty-minute sessions monthly). OR purchase 12 sixty-minute sessions to used as needed at $75.00/60 minute session for a total of $900.00. Sessions must be used within a calendar year from the time of purchase.
- 12 month membership at 120.00 per month (includes 2 sixty-minute sessions monthly). OR purchase 24 sixty-minute sessions to be used as needed for a total of $1440.00. Sessions must be used within a calendar year from the time of purchase.

The following benefits are extended to Concierge Clients:

1) Unlimited communication with Audry Van Houweling, PMHNP via email, phone, or text. It is requested that you go to a local crisis center or emergency room for any mental health crises or emergencies.
2) Guaranteed access to scheduling a session within 2 business days. Scheduling may also be available on evenings and weekends.
3) Unused monthly sessions roll-over and may be used in successive months.
4) Continuous discounts to supplements and in store products.

Using Sessions for Family Members

Every Client wanting to seek Concierge services is required to have a comprehensive evaluation completed. Purchased sessions may be transferred to immediate family members living in a household (spouse, partner, children, and siblings under 18). *At this time, She Soars Psychiatry, LLC is seeing men and boys on a case by case basis. Please inquire if you have a male family member you would like to be seen.*

Sessions for monthly members

For clients opting to be a monthly member of Concierge Care they will be entitled to 2 hours total of session time per month. This time can be divided into 30-minute increments. Unused sessions during a month roll over and may be used in successive months.

Sessions include the following:

Sessions will be customized per a client's needs, but always include a functional-medicine based holistic approach. The sessions may also include psychotherapy and medication management. These sessions may be completed in person or via videoconferencing if the client has difficult traveling to the office location.

Fees do not include:

Cost for recommended labs, medications, and supplements.

Acceptance of Clients:

We reserve the right to accept or decline clients based upon our capability to appropriately handle the client's needs. We may decline new clients due to having a full panel and limited space or given that a client's needs may be outside the Nurse Practitioner's scope of services.

Billing for Services:

For clients choosing to pay for a monthly membership will be billed at the conclusion of each month a client is enrolled for. **Your first payment will be charged the month of your first follow-up and thereafter on the 1st of each month for the term agreed to.**

Client's Designation of Services:

Beneficiary or legal representative commits to the following concierge care service:

Payment of 180.00 per month for 3 months. Each month includes 2 hours of session time that may be divisible by 30-minute increments _____ (initial here if yes)

Payment of $540.00 for a total of six 60-minute sessions divisible by 30-minute increments. Sessions must be used within a 12-month period. _____ (initial here if yes)

Payment of 150.00 per month for 6 months. Each month includes 2 hours of session time that may be divisible by 30-minute increments _____ (initial here if yes)

Payment of $900.00 for a total of twelve 60-minute session divisible by 30-minute increments. Sessions may be used within a 12-month period. _____ (initial here if yes)

Payment of 120.00 per month for a total of 12 months. Each month includes 2 hours of session time that may be divisible by 30-minute increments _____ (initial here if yes)

Payment of 1440.00 for a total of twenty-four 60-minute sessions divisible by 30-minute increments. Sessions may be used within a 12-month period. _____ (initial here if yes)

Automatic Payment Authorization

Name on Card: _____

Billing Address: _____

Credit Card Number _____

Expiration date _____

3-digit code _____

I authorize She Soars Psychiatry, LLC to charge the above credit/debit/HSA card for each month I am enrolled in the Concierge Program _____ (check here if 3 months)

_____ (check here if 6 months)

_____ (check here if 12 months)

Signature _____ Date _____

Appendix 2: She Soars Psychiatry, LLC and Medicare Patient Understandings

This agreement is between She Soars Psychiatry, LLC and Medicare Beneficiary: _____Medicare ID #:_____ Who resides at: _____

Patient is a Medicare Part B beneficiary ("Beneficiary") seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Practice has informed Beneficiary or his/her legal representative that Nurse Practitioner, Audry Van Houweling, PMHNP at the Practice has opted out of the Medicare program.

Nurse Practitioner in Practice have not been excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Beneficiary or legal representative accepts full responsibility for payment of Nurse Practitioner's charge for all services furnished by Nurse Practitioner. _____ (initial)

Beneficiary or legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician. _____ (initial)

Beneficiary or legal representative agrees not to submit a claim to Medicare or to ask Nurse Practitioner to submit a claim to Medicare. _____ (initial)

Beneficiary or legal representative understands that Medicare payment will not be made for any items or services furnished by Nurse Practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted. _____ (initial)

Beneficiary or legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out. _____ (initial)

Beneficiary or legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare. _____ (initial)

Beneficiary or legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care solution. _____ (initial)

Beneficiary or legal representative acknowledges that a copy of this contract has been made available to him/her. _____ (initial)

Executed on:_____ By: _____
Medicare Beneficiary or legal representative
And:_____ Audry Van Houweling on behalf of She Soars Psychiatry, LLC