ALTRIX DIRECT
AFFORDABLE PRIMARY CARE

ENROLLMENT FORM

Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the ALTRIX DIRECT Membership Agreement Form.

Print Name _____ Date of Birth *(MM/DD/YYYY)* _____ Age ____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Preferred email _____

Fill out the information below ***only*** if you are requesting coverage for additional family members.

Spouse/Partner/Significant Other:

Spouse Name _____ Date of Birth *(MM/DD/YYYY)* _____ Age ____

Home Phone _____ Work Phone _____

Cell Phone _____ Preferred email _____

Child/Children:

Print Name _____ Date of Birth *(MM/DD/YYYY)* _____ Age ____

Print Name _____ Date of Birth *(MM/DD/YYYY)* _____ Age ____

Print Name _____ Date of Birth *(MM/DD/YYYY)* _____ Age ____

Print Name _____ Date of Birth *(MM/DD/YYYY)* _____ Age ____

Do you have insurance coverage? No ◯ Yes ◯ If yes, Insurer _____

Do you have Medicare? Yes ◯ No ◯ Do you have Medicaid? Yes ◯ No ◯

Patient represents and acknowledges that neither the patient nor any family member enrolled in ALTRIX DIRECT are enrolled in or covered by Medicare, Medicaid, or any private healthcare plan offering primary care benefits. (see section 4B on page 3)

SIGN HERE Signature _____ Date _____

Please go to page 2

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AFFORDABLE PRIMARY CARE

ALTRIX DIRECT Membership Fees:

Family membership rates: The older spouse/ significant other/partner will be billed at the monthly membership fee outlined here; their younger spouse/ significant other/partner and children will be billed half of the monthly membership fee for their age bracket.

Age	*Membership Fee*
17 and younger	$50/month
18 and older	$70/month

Credit/Debit Card Number Storage Consent Form

Preferred Payment Method ◯ Yearly *(Credit/Debit Card)* ◯ Monthly *(Credit/Debit Card)*

I authorize ***Altrix Primary Care – Nashua, LLC*** to keep my credit/debit card information and signature on file in order to charge my credit/debit card for balances due.

Card Type ◯ Mastercard ◯ VISA ◯ Other _____

Cardholder Name *(as shown on card)* _____

Card Number _____

Expiration Date *(mm/yy)* _____ Security code _____

Billing Address _____

City _____ State _____ Zip _____

SIGN HERE Cardholder Signature _____ Date _____

This ALTRIX DIRECT Membership Agreement for primary care services ("Agreement") is made as of the below date, by and between ***Altrix Primary Care-Nashua, LLC***, a Delaware limited liability company, registered to do business in New Hampshire, located at 57 Northeastern Blvd, Unit 202, Nashua, New Hampshire 03062 (the *"Practice"*) and ***The Undersigned*** *("Patient")*, who is an employee, retiree, or family member of an employee or retiree of

_____(*"Company"* or *"Employer"*). I certify that I have read, understand, and agree to the terms set forth in the Altrix Direct Membership Agreement Form. I further certify that I have received a copy of this form.

In Witness Whereof, the parties have caused this Agreement to be effective as of the date of the Patient's below signature.

Patient Name (please print) _____ Date _____

SIGN HERE Patient Signature _____

Send pages 1 & 2 of this form to: office@altrixpc.com
or fax to: (603) 821-4039.
or mail to: Altrix Primary Care – Nashua, LLC
57 Northeastern Blvd, Suite 202, Nashua, NH 03062

ALTRIX DIRECT
AFFORDABLE PRIMARY CARE

ALTRIX DIRECT MEMBERSHIP AGREEMENT

1. **Membership.** Membership is available under this Agreement to Employees/Retirees, spouses/partners, and dependent family members of Employees/Retirees to join at any time. Membership shall begin on the first day of the first full month after enrollment, continues for a term of 1 year, and automatically renews for successive 1-year terms unless or until the agreement is terminated as set forth herein. Patient hereby agrees to enroll as a member of the Membership Program beginning on the Effective Date set forth below. By being a member of the Membership Program, Patient shall be eligible to receive certain basic healthcare services described in Exhibit A ("Included Services"), attached hereto and incorporated to the Agreement by reference, and shall be subject to the conditions and limitations described therein. Membership in the Practice's Membership Program includes only the Included Services. The Practice may add or discontinue Included Services at any time, as it may choose in its sole discretion. The Practice shall provide at least sixty (60) days' advance written notice upon any change to the Included Services listed in Exhibit A.

2. **Membership Fees.** Patient, with or without contribution from the Employer, agrees to pay the Patient's portion (if any) of the monthly fee ("Membership Fee") in accordance with the scheduled attached hereto as Exhibit B, including any applicable Family rate, which is incorporated by reference. Membership Fees shall be due by the 22nd of each month for the following month's services. If Employer elects to offer rolling enrollment at the time of hire, Membership Fees shall be pro-rated for the first month only. Any fees or charges that are not included in the Membership Fee (i.e., fees for Services not included) shall be due at the time of the service. For the purposes of this Agreement, "Family" includes only legal dependents and is limited to two (2) adults and their children.

   A. **Nonpayment.** In the event that the Patient is unable to pay the monthly Membership Fee in full and on time, the Practice may, in its sole discretion terminate this Agreement in accordance with Section 5.A. It is the Patient's responsibility to maintain a correct and up-to-date credit card on file, this requirement does not apply to any Patient who pays for the Membership Program via a payroll deduction (such agreement to engage in a payroll deduction is between the Patient and the Employer, and the Employer is not a party to this Membership Agreement).

   B. **Changes to Membership Fee Schedule.** The Practice may amend the Membership Fee Schedule at any time, as it may determine in its sole discretion upon providing Patient at least thirty (30) days' advance written notice.

   C. **Employer Payment.** Patient and Practice mutually agree that the Membership Fee and any additional fees or charges applicable to Patient may be paid in whole or in part by the Employer. Such payment obligations or rights shall be between the Patient and the Employer, and the Employer is not a party to this Membership Agreement.

3. **Services not included.** Patient understands and acknowledges that Patient is responsible for any charges incurred for healthcare services not performed by Altrix, or services that are performed outside of the physical office space location as set forth above, including, but not limited to, urgent care or emergency room visits, hospital and specialist care, and imaging and lab tests performed by third parties. Patient shall also be responsible for any charges incurred for healthcare services provided by the Practice but not specifically described on Exhibit A.

   The Practice strongly encourages the Patient to maintain health insurance during the term of this Agreement to cover services that are not provided under this Agreement. Patient should purchase health insurance to cover, at a minimum, unpredictable and catastrophic expenses.

4. **Insurance.**

   A. **Patient acknowledgment.** Patient acknowledges and understands that this Agreement or Membership in Altrix Direct does not provide comprehensive health insurance coverage, nor is it a contract of insurance. This agreement is not a health plan as that term is defined by statute, and is not an Employer sponsored medical insurance product. In addition, this Agreement is not workers' compensation insurance and does not replace an employer's obligations under New Hampshire Revised Statutes Annotated 281-A. Patient represents that Patient has contacted Patient's health insurance company to discuss any questions or concerns regarding limitations or restrictions that may be imposed upon patient by signing the agreement for self-pay status attached hereto and incorporated by reference.

   B. **Insurance Claims.** Patient acknowledges and understands that the Practice's Altrix Direct program is not available to individuals enrolled in Medicare, Medicaid, or any private healthcare plan offering primary care benefits. Patient acknowledges and understands that the Practice will not bill insurance carriers on Patient's behalf for Included Services provided to Patient and the Practice will not bill any healthcare plan of which the Patient may be a subscriber or beneficiary for Membership Fees due and owing to the Practice under this Agreement. Membership Fees may not be submitted to insurance companies for reimbursement.

   C. **Tax-Advantaged Medical Savings Accounts.** Only eligible medical expenses are payable or reimbursable using a tax-advantaged savings account such as a health savings account ("HSA"), medical savings account ("MSA"), flexible spending arrangement ("FSA"), health reimbursement arrangement ("HRA"), or other similar health account. Every health plan is uniquely different and different insurance providers may have internal rules that restrict the use of such funds for direct primary care services. Patient should consult with their health benefits advisor regarding whether Membership Fees may be paid using funds contained in such an account, as may be applicable.

   D. **Health Plans.** Since the Practice's Altrix Direct program is not available to individuals enrolled in Medicare, Medicaid, or certain private healthcare plans, as referenced above, third party payers may not count the Membership Fees incurred pursuant to this Agreement toward any deductible Patient may have under a health plan. Patient should consult with their health benefits advisor regarding whether Membership Fees may be counted toward the Patient's deductible under a health plan, as may be applicable.

5. **Termination of Agreement.** Termination of this Agreement shall cause the termination of Patient's membership in the Membership Program.

   A. **Termination by Practice.** The Practice may terminate this Agreement upon providing Patient advance written notice. Termination will be effective thirty (30) days following written notice. Upon termination, the Practice shall comply with all rules and regulations of the State of New Hampshire.

   B. **Termination by Patient.** Patient may terminate this Agreement at any time and for any reason, upon providing thirty (30) days' written notice to the Practice. Monthly Membership Fees will continue to accrue until the end of such 30-day period.

   C. **Termination by Employer.** In the event the Patient is no longer employed by or affiliated with an employee or former employee of Employer, no refund of the current monthly Membership Fee will be offered as Membership shall continue until the last day of the month of such termination.

ALTRIX DIRECT MEMBERSHIP AGREEMENT

D. Enrollment After Termination. If this Agreement is terminated by Patient, Patient is able to re-enroll in Altrix Direct beginning 12 months following the date of termination. If this Agreement is terminated by Employer, Patient is eligible for continued Membership under a separate agreement with the Practice.

E. Prepaid Membership Fees Refunded Upon Termination. Prepaid Membership fees beyond the current month, if any, shall be refunded to the Employer or Patient.

6. **Indemnification.** Patient agrees to indemnify and hold the Practice and its members, officers, directors, agents, and employees harmless from and against all demands, claims, actions or causes of action, assessments, losses, damages, liabilities, costs and expenses, including interest, penalties, attorney fees, etc., which are imposed upon or incurred by the Practice as a result of the Patient's breach of any of Patient's obligations under this Agreement.
7. **Entire Agreement.** This Agreement constitutes the entire understanding between the parties hereto relating to the matters herein contained and shall not be modified or amended except in a writing signed by both parties.
8. **Waiver.** The waiver of either the Practice or Patient of a breach of any provisions of this Agreement must be in writing and signed by the waiving party to be effective and shall not operate or be construed as a waiver of any subsequent breach by either the Practice or Patient.
9. **Change of Law.** If there is a change of any law, regulation or rule, federal, state, or local, which affects this Agreement, any terms or conditions incorporated by reference in this Agreement, the activities of the Practice under this Agreement, or any change in the judicial or administrative interpretation of any such law, regulation, or rule, and the Practice reasonably believes in good faith that the change will have a substantial adverse effect on the Practice's rights, obligations, or operations associated with this Agreement, then the Practice may, upon written notice, require the Patient to enter into good faith negotiations to renegotiate the terms of this Agreement. If the parties are unable to reach an agreement concerning the modification of this Agreement within ten (10) days after the effective date of such change, then the Practice may immediately terminate this Agreement upon written notice to Patient in accordance with Section 5 above.
10. **Governing Law.** This Agreement and rights and obligations of the Practice and Patient shall be construed in accordance with the laws of the State of New Hampshire.
11. **Assignment.** This Agreement shall be binding upon and shall inure to the benefit of both the Practice and Patient and their respective successors, heirs, and legal representatives. Neither this Agreement, nor any rights hereunder, may be assigned by the Patient without the written consent of the Practice.

Exhibit A: Included Services

Same day or next business day appointments, Monday through Friday, excluding holidays. An appointment may be conducted in-person, by virtual or telephonic telehealth methods, or via secure email. On-call after hours triage service available. Appointment types include wellness exams, management of acute and chronic conditions, mental health screenings, and multiple procedures (listed below). For emergent cases, Practice will provide a same day appointment whenever feasible.

Access to comprehensive primary care via virtual and/or telephonic methods. Not all conditions can be handled with these indirect methods and the Patient may be asked to make an in-person appointment.

Services Offered to Members, as medically indicated:

- Annual Wellness Visit, including annual set of screening labs;*
- Physicals (Employment, School, Camp, etc.);***
- Unlimited Sick Visits;
- Chronic Condition Management;
- EKG with interpretation;
- Routine Gynecologic Care, including pap smears;**
- Routine Pediatric Care;
- Healthy Lifestyle Counseling;
- Mental Health Screening;
- Screening for Surgical Procedures and Anesthesia; and
- Basic wound care.

Other Benefits:

- Coordination and integration of specialists and referred care;
- Sensitivity to pricing variation for referred care;
- Member-rate Office-based Procedures;
- Access to certain discounted rates for non-covered services provided by others; and
- Office-based Lab Work*

Exceptions to Above:

- *Patient will be responsible for certain laboratory fees.
- **Diagnostic lab test fees, including imaging, that are outside of this contract are available to members at Practice's cost if paid at the time of service. Such services are offered in accordance with the frequency guidelines recommended by the U.S. Preventive Services Taskforce.
- ***Patient will be responsible for any applicable costs of vaccines. The following vaccines are free for all children in New Hampshire through age 19: Diphtheria, Haernophilus Influenza Type B, Hepatitis A, Hepatitis B, HPV, Influenza, Measles, Meningitis, Polio, Mumps, Pertussis, Pneumococcal, Rotavirus, Rubella, Tetanus, and Varicella.
- All screenings, lab work, and preventive care services will be offered in accordance with the frequency guidelines recommended by the U.S. Preventive Services Taskforce.
- Reasonably short medical-related forms, such as work excuses or annual and sports physicals are included. Forms of more than five pages or requiring more than one hour to complete, such as disability verification, Family and Medical Leave Act forms, or lengthly attorney correspondence relating to a litigation, may be subject to additional fees; if applicable, such fees will be disclosed prior to completion of the forms.

Excluded Services:

- Any services falling outside the above categories of Included Services qualify as a non-covered service.
- In addition, any healthcare services not performed on or within the premises of the Practice, including urgent care or emergency room visits, hospital stays, specialist care, advanced diagnostics, etc. Moreover, any healthcare services performed outside of the Practice and/or performed by third parties, including referrals from Altrix Direct; payment for such excluded services shall be made directly to the performing party.
- Durable medical equipment (e.g., braces, splints, crutches).
- Most COVID-19 testing.
- Any care delivered by providers not affiliated with the Practice.

For any questions regarding the scope of covered services, or whether a specific healthcare service is covered, contact the Practice in advance of scheduling your appointment.

The Practice reserves the right to amend the above list of Included Services, for any such amendment, Patient will be provided at least sixty (60) days' advance written notice.