The Thrive Clinic LLC
1755 NW Kings Blvd.
Corvallis, OR, 97330

MEMBERSHIP AGREEMENT

THIS MEMBERSHIP AGREEMENT ("Agreement") is entered into on_____, 20____, ("**Effective Date**") by and between The Thrive Clinic, located at 1755 NW Kings Blvd., Corvallis, OR, 97330 ("**Practice**"), and _____("**Patient**"). Practice and Patient may be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

WHEREAS, Practice provides functional medical services and delivers personalized care, as enumerated in **Attachment A**, Health Restoration Plan, incorporated herein by reference; and

WHEREAS, Patient, according to the terms of this Agreement, desires to contract with Practice to obtain such services and care.

NOW, **THEREFORE**, in consideration of the foregoing recitals, which are incorporated as covenants, and the mutual promises herein made and exchanged, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

AGREEMENT

1. **Definitions**. Throughout this Agreement, the following terms shall have the following meanings:

(a) "**Practice**" shall mean The Thrive Clinic, together with any and all of its medical practitioners.

(b) "**Patient**" shall mean the individual (or individuals) specifically listed above and documented on the appropriate Client Intake Form(s). If one or more minors, incapacitated persons or persons subject to a power of attorney are documented on the appropriate client intake form(s), "Patient" shall include, jointly and severally, the parent, legal guardian, or surrogate decision maker of the Patient.

(c) "**Services**" shall mean those services specifically enumerated in Attachment A, Health Restoration Plan, and shall exclude any and all other services not specifically enumerated, including, but not limited to, specialized services, emergency services,

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prescriptions, supplements, lab work, x-rays, ultrasound, MRI or those services Practice is not equipped, licensed or otherwise capable of providing.

2. **Term**. This Agreement shall be an initial _____ (6 or 12) month contract, commencing on the Effective Date, after which this Agreement shall automatically renew for additional half year terms until either Party shall terminate as provided pursuant to this Agreement.

3. **Fees**. In consideration for the Services provided, Patient agrees to pay Practice, the amount as set forth in Attachment A. This fee is payable upon execution of this Agreement, and is in payment for the Services provided to Patient during the term of this Agreement. Patient agrees that Practice may charge his or her credit card monthly to collect the monthly fees and any early termination fees as described herein and on **Attachment B**, Credit Card Recurring Payment Authorization Form, incorporated by reference.

4. **Additional Services.** If Patient requires or requests Services that surpass those described in Attachment A, Patient shall pay Practice at its standard rate for the Services provided.

5. **Termination**.

(a) **By Practice.** Practice may terminate this Agreement for any reason whatsoever, with or without cause, upon giving thirty (30) days' written notice to Patient. If the effective date of termination occurs on a day other than a monthly anniversary of the Effective Date of this Agreement, Practice shall refund Patient a prorated portion of Patient's final Monthly Recurring Charge, defined in Attachment A.

(b) **By Patient.** Patient may terminate this Agreement for any reason whatsoever, with or without cause, upon giving thirty (30) days' written notice to The Thrive Clinic and paying the applicable early termination fee. Patient shall pay The Thrive Clinic an early termination fee of three hundred dollars ($300). In addition to the foregoing, if Patient receives any Services during the membership Term, and the reasonable value of those Services exceed the amount paid in membership charges to date, Patient shall pay The Thrive Clinic the reasonable value of the Services actually rendered to Patient, less the membership charges already paid. At present, the reasonable value of the Services is: four hundred dollars ($400) per doctor visit and seventy five dollars ($75) per nutritionist visit. For example, if Patient paid $100 per month in membership charges, saw the doctor twice, and decided to terminate the membership after 3 months, Patient would be obligated to pay The Thrive Clinic the early termination fee of $300, plus $500 (which is the reasonable value of 2 doctor visits – membership fess paid, or $800 - $300) for the value of the Services actually rendered. In this example, Patient would pay $800 to The Thrive Clinic.

6. **Non-Participation in Insurance**. Patient understands and acknowledges that Practice does NOT participate in any private or government funded health insurance, PPO or HMO plans or panels and has opted-out of Medicare. Patient shall not submit bills to any government or private insurer or federal or state health care program (including Medicare, Medicaid, Tri-Care, Veterans Affairs, Federal Employee Health Benefits, etc.) for Services even if deemed to be a covered service under such third-party insurance plan, and acknowledges that neither Practice nor its professionals will bill any third-party health insurance plan for the Services provided to Patient. Patient shall, therefore, remain fully and completely responsible for payment to Practice. Practice does not make any representation or warranty whatsoever that any fees paid under this Agreement are covered by Patient's health insurance or other third-party payment plans applicable to the Patient. Patient hereby represents and warrants that Practice has advised Patient to either obtain or keep in full force such health insurance policy(ies) or plan(s) that will cover Patient for general health care costs. Patient acknowledges that this Agreement does not cover hospital services, or any services not personally provided by Practice.

7. **Private Contract**. If Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient agrees to sign a Private Contract in the form designated by Practice. To the extent required by law, Patient agrees to enter into a renewed Private Contract every two (2) years, as requested by Practice.

8. **Communications**. Patient understands and agrees that e-mail communications (outside of the secure patient portal), facsimile, video chat, instant messaging, and cell phone are not guaranteed to be encrypted, secure or confidential methods of communications. Patient agrees that any communications made outside of the patient portal are made at Patient's risk with respect to all e-mail communications. Patient understands that use of electronic communication outside of the secure patient portal has inherent limitations, including possible breach of privacy or confidentiality, difficulty in validating the identity of the parties, and possible delays in response.

Practice will not respond to e-mails or other messages that contain sensitive medical information. If a response is requested, Practice will respond through the secure patient portal. Though it is Practice's policy only to respond through the patient portal, by initiating correspondence through an unsecure and/or unencrypted channel, Patient hereby expressly waives Practice's obligation to guarantee confidentiality with respect to correspondence using such means of communication. Patient understands and acknowledges that Practice may retain any communications between Practice and Patient and include such communications in Patient's medical record.

Patient understands and agrees that portal messaging or e-mail are not appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. **In the event of an emergency, or a situation which Patient reasonably believes could develop into an emergency, Patient shall call 911 or proceed to the nearest emergency room, and follow the directions of emergency personnel.**

Practice checks telephone and portal messages during business hours and responds to them on a regular basis throughout the week. Portal messages are to be used for non-urgent messages only, and a response will generally be sent within 3 business days. By leaving a telephone or portal message, Patient acknowledges and agrees that a prompt reply is NOT required or expected and acknowledges that Patient will not use portal messages to deal with emergencies or other time sensitive issues.

Practice expressly disclaims any liability associated with any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient as a result of any action, inaction, technical issues, or activity outside Practice's control, including but not limited to, (i) technical failures attributable to any Internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address portal messages, (iii) failure of Practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third-party; or (v) Patient's failure to comply with the guidelines regarding use of e-mail communications set forth in this Section.

9. **Change of Law**. If there is a change of any law, regulation or rule, federal, state or local, ("Applicable Law") which affects this Agreement, or the duties or obligations of either Party under this Agreement, or any change in the judicial or administrative interpretation of any such Applicable Law, and Patient reasonably believes in good faith that the change will have a substantial adverse effect on his/her rights, obligations or operations associated with this Agreement, then Patient may, upon written notice, require Practice 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 forty-five (45) days after the date of the effective date of change, then either Party may immediately terminate this Agreement by written notice to the other Party.

10. **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 this Agreement shall not be affected. Any invalid or unenforceable provision shall be modified to the minimum extent necessary so as to remove the basis for invalidity or unenforceability.

11. **Reimbursement for Services Rendered**. 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 fees paid by Patient, Practice may charge Patient and/or retain an amount equal to the reasonable value of the Services actually rendered to Patient.

12. **Amendment**. No amendment of this Agreement shall be binding on Practice unless it is made in writing and signed by Practice. Practice may unilaterally amend this Agreement, to the extent permitted by Applicable Law, by sending Patient a thirty (30) day advance written notice of any such change. Any such changes are hereby incorporated by reference into this Agreement

without the need for signature of Patient and are effective as of the date established by Practice, except that Patient shall initial any such change upon Practice's request. 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.

13. **Assignment**. This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient. Practice may assign this Agreement in whole or in part provided Practice provides Patient with written notice of such assignment. To the extent Practice assigns this Agreement in whole or in part, the transferee or assignee shall enjoy and undertake the same rights and obligations herein as Practice has hereunder to the extent incorporated in such assignment.

14. **Relationship of Parties**. Patient and Practice intend and agree that Practice, in performing Services pursuant to this Agreement, is an independent contractor, as defined by the guidelines promulgated by the United States Internal Revenue Service and the United States Department of Labor, and Practice shall have complete control over the manner in which the Services are performed.

15. **Legal Significance**. Patient understands and acknowledges that this Agreement is a legal document that creates certain rights and responsibilities. Patient represents and warrants that he/she has had reasonable time to seek legal advice regarding this Agreement and has either chosen not to do so or has done so and is satisfied with the terms and conditions of this Agreement.

16. **Force Majeure**. Neither Party shall be liable to the other for the failure or delay in the performance of any of the obligations under this Agreement when such failure or delay is due, directly or indirectly, to any act of God, acts of civil or military authority, acts of public enemy, terrorism, fire, flood, strike, riots, wars, embargoes, governmental laws, orders or regulations, storms or other similar or different contingencies beyond the reasonable control of the respective Parties.

17. **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.

18. **Entire Agreement**. This Agreement contains the entire agreement between the Parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement.

19. **Notice**. All written notices are deemed received by Practice if sent to the address of Practice written above and by Patient if sent to the Patient's address appearing in the applicable client intake form(s), provided notice to either Party is sent by Certified U.S. Mail, Return Receipt

Requested. If Patient changes his/her address, Patient shall notify Practice promptly of his/her change of address.

20. **Governing Law; Venue; Waiver of Jury Trial**. Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, shall be settled by binding arbitration. The demand for arbitration shall be made within a reasonable time after the claim, dispute or other matter in question has arisen, and in no event shall it be made more than two (2) years from when the aggrieved Party knew or should have known of the controversy, claim or dispute. The number of arbitrators shall be one. If the Parties are unable to agree upon the selection of an arbitrator within twenty-one (21) days of commencement of the arbitration proceeding by service of a demand for arbitration, the arbitrator shall be selected by the American Arbitration Association. The place of arbitration shall be Benton County, Oregon law shall apply. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall pay its own proportionate share of arbitrator fees and expenses.

BOTH PARTIES EACH IRREVOCABLY WAIVE THE RIGHT TO A JURY TRIAL IN CONNECTION WITH ANY LEGAL PROCEEDING RELATING TO THIS AGREEMENT.

This Agreement is not health insurance and Practice will not file any claims against Patient's health insurance policy or plan for reimbursement of any Services covered by this Agreement. This Agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protected and Affordable Care Act, 26 U.S.C. s. 5000A. This Agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement on the Effective Date.

Practice

SIGNATURE: _____

PRINT NAME: _____

TITLE: _____

DATE: _____

Patient

SIGNATURE: _____

PRINT NAME: _____

TITLE (if parent, legal guardian, or surrogate decision maker): _____

DATE: _____

(Attachments: A and B)

Attachment A (Health Restoration Plan: Thrive Restore)

Fees for membership in the Health Restoration Plan (Thrive Restore) are as follows:

Monthly Recurring Charges: $250
If paid semi-annually: $1425
If paid annually: $2700

The Services provided by this Agreement include:

➢➢ 6 regular visits with the functional medicine doctor (60-minute visits)
➢➢ 12 visits with the health coach (60-minute visits)

➢➢ 3 urgent visits with the functional medicine doctor, as needed and deemed indicated by designated staff (15-minute visits)
➢➢ 20% discount on supplements
➢➢ advanced in House testing (BIA) included, up to 6 times/year
➢➢ Messaging with the doctor and health coach

In addition to the Services enumerated above, the Services shall also include the following benefits:

(a) **No-Wait or Minimal-Wait Appointments**. Every effort shall be made to ensure that Practice sees Patient immediately upon arriving for a scheduled office visit or after only a minimal wait. If Practice foresees anything more than a minimal wait time, Patient shall be contacted and advised of the projected wait time.

(b) **Specialists**. Practice shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. Patient understands that fees paid under this Agreement do not include and do not cover specialist fees or fees due to any medical professional other than Practice.

(c) **Notice of Unavailability.** Practice's medical practitioners may, from time-to-time, due to vacations, sick days, and other similar situations, not be available to provide Services pursuant to this Agreement. Practice shall provide Patient with up to one weeks' notice of any absence unavailability exceeding 3 business days.

What is not included?
Fees for the Services do not cover lab fees, supplements, or any other products or services not specifically enumerated herein.

Primary care services are not included. **Practice's medical practitioners are not Patient's primary care physicians.** Practice merely works with other providers and complements the care provided by Patient's primary care physician as part of the Services under this Agreement. **Patient is required to have a separate primary care physician on file with Practice.** It is best to consider Practice's medical practitioners as consultants who provide specific clinical services, rather than as primary care providers. If Patient encounters a medical emergency and is not able to obtain care from Patient's primary care physician(s), Patient will contact 911 or report to a hospital emergency department as appropriate.

Attachment B

Credit Card Recurring Payment Authorization Form

I hereby authorize Practice to charge the credit card indicated in this authorization form according to the terms and conditions of the Membership Agreement. If payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I terminate it in writing. I agree to notify Practice in writing of any changes to my account information.

I certify that I am an authorized user of the credit card listed below, and that I will not dispute the scheduled payments with my credit card company, provided the transactions correspond to the terms indicated in this authorization form and the Membership Agreement. I agree to reimburse Practice its out-of-pocket costs, plus fifty dollars ($50) for any chargebacks I request, if I do not first issue a termination request as provided for in the Membership Agreement.

Authorization:

I,_____, authorize The Thrive Clinic, to charge my credit card indicated below on the same day of the month as when my credit card was first charged and each month thereafter for payment of my monthly fee for Services and any applicable termination fees.

I understand that I will NOT receive advanced notice of the charge.

Name as it appears on card: _____

Card Number: _____

Expiration Date: _____ CSC (3 digit code on back): _____

Billing Address: _____

City, State, Zip: _____

Phone #: _____ E-mail: _____

SIGNATURE: _____

DATE: _____