

MEMBERSHIP FEE SCHEDULE

DIRECT FAMILY MEDICINE DIRECT CARE PRICE LIST

Option A (no fee per visit)

Monthly Membership Fee	Single Adult	\$70.00
	Family (no more than 2 adults)	\$170.00
	Child (with a registered adult) first two, each	\$15.00

Option B (includes visit fee due at time of service, per visit)

Monthly Membership Fee	Single Adult	\$52.00
	Family (no more than 2 adults)	\$135.00
	Child (with a registered adult) first two, each	\$15.00
	Fee per visit	\$30.00

DIRECT PRIMARY CARE MEMBERSHIP AGREEMENT

This **DIRECT PRIMARY CARE MEMBERSHIP AGREEMENT** (this “Membership Agreement”) is made this ____ day of _____, 2026 (“Effective Date”) by and between **DIRECT FAMILY MEDICINE, LLC**, an Ohio limited liability company, located at 6621 Centerville Business Pkwy, Centerville, OH 45459 (the “Practice”) and _____ (“Patient”).

1. Membership. Patient hereby agrees to enroll as a member in the Practice’s direct primary care membership program (“Membership Program”) beginning on the Effective Date set forth above. By being a member of the program, Patient shall be eligible to receive certain basic medical services described on Exhibit A (“Covered Services”), attached hereto and made a part hereof, and shall be subject to the conditions and limitations described therein. Membership in the Practice’s Membership Program includes only the Covered Services specifically described in Exhibit A. The Practice may add or discontinue Covered 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 Covered Services listed in Exhibit A.

2. Membership Fees. Patient agrees to pay a monthly fee (“Membership Fee”) in accordance with the schedule attached hereto as Exhibit B, and made a part hereof (“Membership Fee Schedule”). Membership Fees shall be due in arrears on the first day of each month following the Effective Date, and will cover the Patient’s membership for the month immediately prior (e.g. if the sign-up date is May 15th, patient’s membership is effective on May 15 and the Membership Fee for the month of May is due on June 1). Any fees or charges that are not included in the Membership Fee (i.e. fees for non-covered services) shall be due at the time of service. For purposes of this Membership Agreement, “Family” includes only legal dependents and is limited to two (2) adults.

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 Membership Agreement in accordance with section 5A. It is the patient's responsibility to maintain a correct and up to date credit/debit card number on file.

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 sixty (60) days’ advance written notice.

3. Non-Covered Services. Patient understands and acknowledges that Patient is responsible for any charges incurred for health care services performed outside of the physical office space location as set forth above, including, but not limited to, 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 health care 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 MEMBERSHIP AGREEMENT TO COVER SERVICES THAT ARE NOT PROVIDED UNDER THIS MEMBERSHIP AGREEMENT. PATIENT SHOULD PURCHASE HEALTH INSURANCE TO COVER, AT A MINIMUM, UNPREDICTABLE AND CATASTROPHIC EXPENSES.

4. Insurance. PATIENT ACKNOWLEDGES AND UNDERSTANDS THAT THIS MEMBERSHIP AGREEMENT OR MEMBERSHIP IN THE PRACTICE DOES **NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE, NOR IS IT A CONTRACT OF INSURANCE.** PATIENT REPRESENTS THAT PATIENT HAS CONTACTED PATIENT'S INSURANCE HEALTH INSURANCE COMPANY TO DISCUSS ANY LIMITATIONS OR RESTRICTIONS THAT MAY BE IMPOSED UPON PATIENT BY SIGNING THE AGREEMENT FOR SELF PAY STATUS ATTACHED HERETO AND INCORPORATED BY REFERENCE HEREIN.

A. Insurance Claims. Patient acknowledges and understands that the Practice is not a participating provider in any Medicaid or private health care plan. Patient acknowledges and understands that the Practice will not bill insurance carriers on Patient's behalf for Covered Services provided to Patient and the Practice will not bill any health care plan of which the Patient may be a subscriber or beneficiary for Membership Fees due and owing to the Practice under this Membership Agreement. Membership Fees may not be submitted to insurance companies for reimbursement.

B. Tax-Advantaged Medical Savings Accounts. As of the date hereof, it is unlikely that the Membership Fees described in Section 2 constitute eligible medical expenses that 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 health plans similar thereto (collectively referred to as a "tax-advantaged savings account"). Every health plan is uniquely different. Patient should consult with their health benefits advisor regarding whether Membership Fees may be paid using funds contained in Patient's tax-advantaged savings account, as may be applicable.

C. Health Plans. Because the Practice is not a participating provider in any Medicaid or private health care plan, third party payers may not count the Membership Fees incurred pursuant to this Membership 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 Membership Agreement shall cause the termination of Patient's membership in the Membership Program described herein.

A. Termination By Practice. The Practice may terminate this Membership Agreement upon providing Patient advance written notice. Termination will be effective starting five business days after notification. Upon termination, the Practice shall comply with all

rules and regulations of the State of Ohio Medical Board regarding the provision of emergent care for 30 days after termination and cooperate in the transfer of Patient's medical records to the Patient's new primary care physician, upon the Patient's written request and direction.

B. Termination by Patient. Patient may terminate this Membership Agreement at any time and for any reason, upon providing advance written notice to Practice. Such termination shall be effective on the last day of the then-current calendar month. Membership Fees shall not be pro-rated for any terminal month. Monthly Membership Fees will continue to accrue until Patient's written notice of termination is received by Practice at its office location set forth above.

6. Reinstatement. In the event Patient terminates this Membership Agreement after the Effective Date hereof, Patient shall be ineligible for membership for a period of six (6) months following the effective date of termination, unless Patient pays a fee in the amount of Five Hundred Dollars (\$500.00) ("Reinstatement Fee").

7. Indemnification. Patient agrees to indemnify and to 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.

8. Entire Agreement. This Membership 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 hereto.

9. Waiver. The waiver of either the Practice or Patient of a breach of any provisions of this Membership 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.

10. Change of Law. If there is a change of any law, regulation or rule, federal, state or local, which affects this Membership Agreement, any terms or conditions incorporated by reference in this Membership Agreement, the activities of the Practice under this Membership 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 Membership Agreement, then the Practice may, upon written notice, require the Patient to enter into good faith negotiations to renegotiate the terms of this Membership Agreement. If the parties are unable to reach an agreement concerning the modification of this Membership Agreement within ten (10) days after the effective date of change, then the Practice may immediately terminate this Membership Agreement upon providing written notice to Patient.

11. Governing Law. This Agreement and the rights and obligations of the Practice and Patient hereunder shall be construed and enforced pursuant to the laws of the State of Ohio.

12. Assignment/Binding Effect. This Membership 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 Membership Agreement, nor any rights hereunder, may be assigned by the Patient without the written consent of the Practice.

IN WITNESS WHEREOF, the parties have caused this Membership Agreement to be effective on the Effective Date first above written.

DIRECT FAMILY MEDICINE, LLC,

an Ohio limited liability company

PATIENT

Name [Please Print]_____

Patient Signature _____

EXHIBIT A- COVERED SERVICES

COVERED SERVICES WITH MEMBERSHIP:

Same day or next business day office appointments Monday-Friday excluding holidays. Appointment types include wellness exams, acute and chronic disease management, and multiple procedures (listed below).

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

Office care and minor procedures included, as medically indicated:

Dipstick urinalysis

Urine pregnancy test

Rapid strep test

Rapid influenza test

Rapid COVID test

Fingerstick glucose

EKG with interpretation

Pulmonary Function Test with interpretation

Nebulizer (breathing) treatment

Medication injections/vaccines—medications are included, except for Vivitrol and all vaccinations, of which the cost is the patient's responsibility

Venipuncture (blood draws)

Tuberculosis screening

Microscopic examination for yeast, bacterial, or trichomonas infection

Microscopic examination of skin or urine

FIT stool test for blood

Ear wax removal

Joint, Bursa, and Trigger Point injections

Abscess drainage (I+D) and Wound Care

Foreign Body removal

Suture (stitches) placement and removal

Ingrown toenail treatment

Cryotherapy (freezing) for skin lesions and warts

Skin tag, sebaceous cyst, and wart removal

Skin biopsies and mole removal*

Well woman exams and Pap smears*

For those Patients >18, an annual set of screening labs including BMP, CBC, lipids, and A1c, **

Exceptions to the above:

In office Urine Drug Screen - \$10

*Patient will be responsible for the laboratory processing fee

**Diagnostic lab test fees (other than the once a year screening lab tests, which are covered) are available at a significant discount to members if paid at the time of service

One page forms, such as work excuses are included. Forms of more than one page (for example, but not limited to, disability, FMLA, attorney correspondence) will be charged additional fees.

Other Benefits:

Access to cash pay discounts we are able to negotiate on the Patient's behalf from various third parties. Examples: Xrays, CT scans, MRIs, Ultrasounds, Mammograms, Home Sleep Studies, Stress Test, ECHO, Heart Monitor, Colonoscopy

Organization and review of historic and outside medical records.

Coordination of care with patient's specialist physicians

EXCLUDED SERVICES:

Anything not specifically listed as a Covered Service shall be a non-covered service

Any health care services not performed on or within the premises of Direct Family Medicine, LLC, including emergency room visits, hospital stays, specialist care, imaging and labs, etc.
Durable medical equipment (braces, splints, etc.)

Any care delivered by providers not affiliated with the Practice

Authorization for Credit Card Use

All information will remain confidential

Patient Name: _____

Date of Birth: _____

Name on Card: _____

Billing Address: _____

Credit Card Type: _____ Visa _____ Mastercard _____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Amount to Charge: \$ _____ (Monthly – First business day of each month)

I authorize Direct Family Medicine to charge the amount listed above to the credit card provided herein. I agree to pay for this monthly fee in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

I would like to sign up for option A or B. (Please circle one)

Place an X on the the option you choose

Single Adult _____

Family _____