Victory Health, PLLC
4000 Shipyard Blvd, Suite 120
Wilmington, NC 28412

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate:
The undersigned hereby agree that any dispute arising out of the treatment or services provided by physician assistant, including disputes as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by North Carolina law, and not by a lawsuit or resort to court process except as North Carolina law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it are giving up their rights to have any such dispute decided in a court of law before a jury; and the parties instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated:
It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician assistant, and bind their successors and assigns, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages.
Except that physician assistant may file an action to collect any unpaid fees from the patient, and such filing shall not waive the right to compel arbitration of any malpractice, damages or other patient claim against physician assistant. Following the assertion of any claim against the physician assistant, any fee dispute, whether or not the subject any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit.
The parties agree that the arbitrators have the immunity of the judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joiner in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joiner any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of North Carolina

law applicable to health care providers, shall apply to disputes within this arbitration agreement. Any party may bring before the arbitrators a notion for summary judgment or summary adjudication as permitted by arbitration rules, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable North Carolina statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the North Carolina Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician assistant within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered at any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

_____Patient's Initials

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____

Patient / Legal Guardian Name (print) Patient / Legal Guardian Signature Date

_____

Physician Assistant or (print) Physician Assistant Signature Date

Victory Health, PLLC (910) 473-3222 **Practice Policies for Patients**

Victory Health, PLLC's goal is to help you achieve optimal health while providing the highest level of personalized care possible. Please note that Teresa Holler is a physician assistant and is NOT your primary care provider. We recommend that you have a primary care provider as well.

New Patient Consultation = $279 (paid the time the appointment is booked and is non-refundable.) Follow-Ups: 45-60 minute consultation = $189; 30-44 minutes = $149; Less than 30 minutes = $109

All New Patient Visits are Payable In Full at Time of Booking and Are Non-Refundable Unless Cancelled Within 48 Hours of Payment/Booking. This is due to a high number of no shows among new patients. **If you are more than 10 minutes late for a new patient appointment, you are considered a no show as we need the full visit time to adequately assess and treat a patient. New patient visit fees will NOT be refunded if you are late**. Please leave earlier than you think is required to avoid this and have your new patient paperwork ready when you arrive.

Payment in full is due on the day of service for existing patients. Appointments must be cancelled at least 2 business days prior to the visit or a $25 fee will be incurred. You may leave a message if calling after hours. We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER, or AMERICAN EXPRESS. We DO NOT accept insurance and we CAN NOT assist you with claims or claim resolution. We ARE NOT Medicare nor Medicaid providers therefore you are not permitted to send any claims to them nor to any secondary insurance companies. We do not respond to medical necessity forms or other reimbursement requirements with any 3rd party. A $25 returned check fee will apply for any returned checks. Fees are subject to change without notice.

Office Hours and Information: Our office is open Monday through Thursday 9 a.m. to 5 p.m. Office hours are subject to change without notice. We are located at 4000 Shipyard Blvd, Wilmington, NC 28412.

It is your responsibility to keep regular follow up appointments and obtain laboratory studies as advised by Teresa Holler. We cannot be responsible for your care without your consistency. Any questions that you have regarding new information that have not yet been discussed with Teresa Holler will be addressed during your upcoming appointment unless forwarded to another treating provider.

If you have an URGENT OR EMERGENT MEDICAL PROBLEM, please go to your nearest emergency room, urgent care, or primary care provider. Most treatment changes are complicated and cannot be managed over the phone. If a treatment change is necessary, it will usually require an office visit.

If you need prescriptions refilled, please contact your pharmacy and ask them to fax over a refill request. Please allow 10 business days for refill requests, but we will return those requests to the pharmacy as soon as possible.

Patients who have not been seen in 2 or more years will be considered a new patient and will need to schedule a new patient visit. Victory Health, PLLC reserves the right to terminate the medical provider/patient relationship at any time with written notification to the patient.

Patient Acknowledgment: I understand the above policies. I understand that I am responsible for the payment of all services rendered. I understand that insurance will NOT be billed for any services provided.

I understand that Victory Health has a business only email and I understand that I am not to send any protected health information to Victory Health, Teresa Holler, or any staff members via email. Moreover, I acknowledge that communications over the Internet or using general e-mail systems are not encrypted and are inherently insecure. I understand that there is no assurance of confidentiality of information when communicating this way. I understand that email may be entered into my permanent medical record. I agree to hold Victory Health, PLLC and all individuals associated with it harmless from any and all claims and liabilities arising from, or related to this service.

Arbitration: In accordance with the terms of the Federal Arbitration Act, 9 USC 1-16, my signature below acknowledges that I agree that any dispute shall be subject to final and binding resolution through private arbitration.

Name _____ Signature_____ Date_____

Victory Health, PLLC
Teresa Holler, MS, PA-C
4000 Shipyard Blvd, Suite 120
Wilmington, NC 28403

PHONE: (910) 473-3222 FAX: (910) 769-0063

PATIENT RECORDS RELEASE AUTHORIZATION

Date:_____

Patient Name:_____Birth Date:_____

Address:_____

Patient Home Phone:_____Social Security Number:_____

I hearby authorize _____ to release my Protected Health Information contained in my medical records to: Victory Health Consultants, Teresa Holler, PA-C

Description of information to be disclosed:

_____

Purpose of disclosure: _____

Patient, please read the following and sign:

1. **I may revoke this authorization at any time by providing a WRITTEN notice to Victory Health. I may not be able to revoke this authorization once the practice has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.**
2. **I understand that if my record contains information relating to HIV, AIDS, alcohol abuse, drug abuse, psychiatric conditions, or other communicable diseases, this disclosure will include that information.**
3. **This authorization is valid for six months from date signed.**
4. **I understand that 1 copy of my records will be provided to myself or to another medical office at no charge; additional copies are $15/copy.**
5. **I understand that if I have any old records from other medical offices here, these old records will not be copied. I must request to receive these old records. The original copy of these old records will then be given to me or to another medical office and will no longer be available at this office.**
6. **I have reviewed this authorization and understand the purpose and intent.**
7. **I will be able to obtain a copy of this authorization upon my request.**

PATIENT SIGNATURE_____DATE_____

Victory Health, PLLC
4000 Shipyard Blvd, Suite 120
Wilmington, N.C. 28403
Phone (910) 473-3222 Fax (910) 769-0063

Registration Form

Today's Date_____

First:_____ Middle: _____ Last: _____Nickname:_____

Gender (circle one): Male/Female Birth Date _____/_____/_____ Age _____

Address: _____Apt #_____

City: _____State:_____ Zip: _____

Home Phone: (____)_____ Cell Phone: (_____)_____

Email Address: _____

Status (circle one): Single Married Divorced Widowed Separated

Spouses Name: _____

Children (names and ages): _____

Religion/Spiritual Leaning _____

How did you hear about us? _____

Primary Physician(s) Name:_____

Emergency Contact:

Name: _____Phone: (____)_____

Relationship: Spouse Relative Friend Other _____

I understand that all fees for services are due when rendered. Additionally, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Name: _____

Patient's Signature: _____

Consent to treat a Minor: _____

Signature of Guardian Authorizing Care: _____ Date: _____

Private Contract for Medicare Beneficiaries

This agreement is between Teresa Holler, MS, PA-C (“Physician Asst”) whose principal place of business is 4000 Shipyard Blvd, Wilmington, NC 28403 and patient _____ ("Patient"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on 7/5/2011 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):

New patient consultations, follow-up office consultations, sick visits, phone consultations, office procedures, injections.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- **Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B**.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient 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.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____ by _____and Teresa Holler MS, PA-C

[Patient signature]_____ [Physician signature]_____

NOTE TO VHC STAFF: New Affidavit and Contract Required ANNUALLY

HIPPA Patient Information Acknowledgement

I have read and fully understand Victory Health' Notice of Patient Information Practices. I understand that Victory Health may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Victory Health will consider requests for restriction on a case-by-case basis.

I hereby acknowledge the use and disclosure of my personal health information for purposes as noted in Victory Health' Notice of Patient Information Practices. I understand that I reserve the right to revoke this acknowledgement by notifying the practice in writing at any time. I hereby acknowledge that I have received a copy of the Notice of patient Information Practices.

_____ (Please initial) OK to leave messages on voice mail/answering machine.

_____ _____ _____

Patient name (print) **Patient/Guardian Signature** **Date**

Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of protected health information regarding my treatment, payment, or administrative operations related to treatment and/or payment.

Authorized Designees:

_____ _____

Print Name **Relationship**

_____ _____

Print Name **Relationship**

_____ _____

Print Name **Relationship**

_____ _____

Print Name **Relationship**

Informed Consent to Treatment and Therapies

I, _____, understand and have been advised that Teresa Holler, MS, PA-C practices functional medicine. While functional medicine utilizes the best of evidence-based medicine, a diagnostic or therapeutic treatment may be utilized, which is not considered a conventionally accepted medical treatment if, in her professional opinion, Ms Holler believes it may be of potential benefit to the patient, so long as the treatment poses no greater risk of harm to the patient than the comparable conventional treatments.

Initials:_____

Teresa Holler makes no specific claims or representations that the treatments and therapies that she will be providing will be effective or cure the condition or diagnosis that I have. I have been encouraged to discuss the options Ms.Holler has made with my primary care physician or the specialist who is primarily treating me prior to beginning the treatment regimen.

Initials:_____

I understand that Ms. Holler is not a physician, but a physician assistant. Physician assistants may perform medical acts, tasks, and functions under the supervision of a licensed physician. I recognize that I have the option to pursue my health care needs at any doctor's office that I choose.

Initials:_____

I understand that I may purchase any supplements or nutritional products at other establishments. For example, many of the same brands are available at Cape Fear Pharmacy, which is located at 5235 S. College Rd, Wilmington, NC. I understand that I may also shop online from a reputable retailer.

Initials:_____