Grounded Serpent
Family Practice

DISABILITY EVALUATION SERVICE AGREEMENT

Grounded Serpent Family Practice, LLC

This is an agreement between Grounded Serpent Family Practice, LLC (the Clinic, Us, or We) and the Patient.

Background

The Clinic is a medical practice that provides specialized medical consulting and evaluation services through its physician, Dr. Katelynn "Katie" Brown (Dr. Brown, the Physician). The Clinic is located at 1219 Ohio St. STE 1 Terre Haute, IN 47807.

For the purposes of this agreement, the Clinic agrees to provide the Patient with the disability evaluation services described below.

Definitions

1. **Patient.** In this Agreement, "Patient" means the person for whom the evaluation services are provided and who has entered into this Agreement.

2. **Services.** In this Agreement, "Services" means the collection of disability evaluation services provided by the Clinic and described below, also referred to as the "Disability Evaluation Package."

Services

3. **Purpose.** This service is an independent medical disability evaluation. The purpose of the evaluation is to assess medical conditions and functional limitations and to prepare documentation that may be used in support of applications for long-term disability benefits, including Social Security Disability Insurance or other disability programs.

4. **Treatment Relationship Limitation.** This evaluation is not intended to establish an ongoing medical treatment relationship. Participation in this service does not create a physician-patient relationship for purposes of continuing medical care.

5. **Scope of Services.** The disability evaluation package includes the following services:

    - One in-person physical examination at the clinic in Terre Haute, Indiana.
    - Up to three hours of Dr. Brown's time to complete disability documentation.

- Preparation of disability documentation, which may include a written disability recommendation letter and completion of a functional residual capacity form.

6. **Timeline.** Final documentation will typically be completed and delivered to the Patient within four weeks following receipt of all required information.

7. **Delivery Format.** Completed documentation will be delivered to the Patient through the SigmaMD secure messaging platform.

8. **Independent Medical Opinion.** Payment for this service compensates the Physician for the time and expertise required to review medical information, conduct the evaluation, and prepare documentation.

   Payment does not guarantee any specific outcome or conclusion. The Physician's medical opinion will be based on the available medical records, the Patient's history, examination findings, and professional judgment. The Physician may determine that the Patient does not meet criteria for disability.

9. **Communication With Third Parties.** Communication with third parties is not included but may be added on for an additional fee at the discretion of the Physician. If the Patient wishes the Physician to communicate with attorneys, disability examiners, insurance companies, or other third parties regarding the evaluation, such communication will require the Patient's written authorization. Time spent communicating with third parties will be billed at $100 per hour.

10. **Record Requests.** Faxing or emailing documents to third parties is not included but may be added on for an additional fee. If the Patient wishes the Physician to send records to attorneys, insurance companies, or other third parties, the Patient will be billed $10 per fax or email. Mailing hard copies of records is not an offered service.

Fees

11. **Fee for Services.** The standard fee for the Disability Evaluation Package is $800.

12. **Payment Due Date.** A $150 non-refundable payment is due when the patient signs up for the Disability Evaluation Package. Payment for services is due in full at the time of the first appointment.

13. **Financial Aid.** Patients who require financial assistance may choose to defer up to $650 of the fee for up to 12 months. Following this, the payment will be due in full. A payment plan may be negotiated at Dr. Brown's discretion. If the 12 months elapse without payment or a payment plan being negotiated then the Clinic will seek to garnish wages from your disability or SSI check. A $150 non-refundable payment is due when the patient signs up for the Disability Evaluation Package.

Patient Responsibilities

14. **Medical Records.** Patients are responsible for obtaining and submitting their own prior medical records. The Physician's evaluation and conclusions depend on the accuracy and completeness of the information provided. Missing or incomplete records may affect the Physician's ability to form a medical opinion.

15. **Patient Forms.** Patients are responsible for completing provided medical forms. The Physician's evaluation and conclusions depend on the accuracy and completeness of the information provided. Missing or incomplete records may affect the Physician's ability to form a medical opinion.

16. **Physical Exam.** Patients are responsible for traveling to the Clinic in Terre Haute for a physical examination.

Cancellations and Missed Appointments

17. **Cancellations.** Patients may cancel appointments up to 24 hours before the scheduled appointment time. Appointments cancelled within 24 hours of the scheduled appointment time or that are missed but not cancelled are considered missed appointments.

18. **Missed Appointments.** Patients may miss up to two scheduled appointments without penalty. Continued missed appointments may be billed at $100 per missed appointment.

Legal

19. **Limitations of the Service.** This evaluation is not emergency medical care and is not intended to replace ongoing care from the Patient's personal physician or treating medical team. Patients should continue to seek routine and urgent medical care through their usual healthcare providers.

20. **Severability.** If any part of this Agreement is considered legally invalid or unenforceable, that part will be amended to the extent necessary to be enforceable and the remainder of the contract will stay in force as originally written.

21. **Legal Significance.** This Agreement is a legal document and gives the parties certain rights and responsibilities. The Patient agrees that they have had a reasonable time to seek legal advice regarding this Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

22. **No Waiver.** In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce the other party's requirement or duty under this Agreement (for example, notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

23. **Jurisdiction.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of Indiana.

24. **Acknowledgment.** By participating in the disability evaluation process, the Patient acknowledges that they have read and understood this Agreement and consent to the terms described above.

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Patient Signature Date