Terms and Conditions Agreement

This Terms and Conditions Agreement ("Agreement") is entered into by and between ShahMed PLLC, dba Pomegranate Health, a virtual direct primary care clinic ("Provider" or "Pomegranate Health"), and the undersigned patient ("Patient" or "You").

1. Subscription Enrollment and Consent: By signing this Agreement, you consent to enroll in Pomegranate Health's subscription program, agreeing to the terms and conditions outlined herein, including the payment of the monthly subscription fee.

2. Monthly Subscription Fee and Auto Debit Authorization: You authorize Pomegranate Health to charge your designated payment method on a monthly basis for the subscription fee. Payment is due on the first day of each month. You further authorize Pomegranate Health to automatically debit the provided payment method, utilizing autopay for the convenience of seamless transactions.

3. Auto Debit Terms: You understand and agree that the subscription fee will be automatically debited from your designated payment method each month. It is your responsibility to ensure that the designated payment method is valid and has sufficient funds. In the event of a failed auto debit, Pomegranate Health may suspend services until payment is successfully processed.

4. Cancellation Policy: You may cancel your subscription at any time by providing Pomegranate Health with a 30-day written notice. Payments made within the 30-day notice period are non-refundable.

5. Telehealth Consent: You acknowledge and consent to the use of telehealth services for consultations and medical advice. You understand that telehealth services may include the use of video, audio, and other electronic communication methods.

6. HIPAA Information and Release of Information: You consent to the collection and use of your medical information in accordance with Pomegranate Health's HIPAA policy. You also agree to allow Pomegranate Health to request medical records from other healthcare providers as necessary for your care.

7. Insurance Disclaimer: a. Pomegranate Health does not accept any form of insurance. b. You are solely responsible for the payment of all fees associated with Pomegranate Health's services. c. This agreement and Pomegranate Health are NOT an insurance plan or a substitute for health insurance or other health plan coverage. d. This agreement does not provide health insurance coverage, including the minimal essential coverage required by applicable federal law. e. We do NOT cover hospital, surgery center, or similar services, or any other medical needs not personally provided by the Provider and described below. f. It is vital that You obtain and keep in full force health insurance policy(ies) or plan(s) that will cover facility fees (hospitals, specialists, and urgent care offices, for example) and general health care costs not included in the Services. g. Employer benefits and tax-advantaged health benefits opportunities may not be used to pay membership fees. You should contact your employer, tax advisor, or health insurance representative regarding the use of HRA, HSA, FSA, medical reimbursement.

8. Release of Liability for Products: You acknowledge and agree that Pomegranate Health waives all liability for any products sold on its site or recommended pharmacies for fulfillment of prescription medications. This includes, but is not limited to, any adverse reactions, side effects, or issues related to the use of such products or medications.

9. Services Provided: Pomegranate Health offers the following virtual visit services:

- Women's Healthcare
- Skincare Consultations
- Urgent Care
- Wellness Consultations
- Weight Loss Consultations
- Telehealth Services

Additionally, skincare products may be sold on the website.

10. Termination Clause: The Practice may terminate this agreement for reasons including but not limited to: a. You fail to pay applicable fees owed pursuant to the Appendix 3 - Fee Schedule; b. You act fraudulently or engage in certain criminal acts; c. You repeatedly fail to adhere to the recommended treatment plan, especially regarding the use of controlled substances; or d. We discontinue the Program, and the Practice closes its doors.

11. Patient Responsibilities: As a patient of the practice, you agree to the following: a. To provide the Practice your contact information and to notify the Practice of any

changes. b. To provide the Practice with payment information. c. To pay the fees identified in Appendix 3 - Fee Schedule on time as established with the Practice. d. To work with the Provider and share information about your health, activities, and needs. e. Where possible, to schedule appointments with the Provider more than 24 hours in advance and to show up for an appointment in a timely fashion. f. Where possible, to notify Provider at least 24 hours in advance of any appointment cancellations. g. To complete necessary consent, HIPAA, and other documents required by regulation or practice. h. If you want to participate in tele-health visits, to agree with and complete the Consent for Tele-Health consent services.

12. Checkboxes:

[ ] I understand I may cancel my membership at any time with 30 days notice. I further understand that upon termination of my membership, for any reason, pre-paid future monthly membership fees will not be refunded. I understand that fees are earned on the first of the month for the whole month so my membership remains intact until the last day of the month that I cancel my membership.

[ ] I understand that I must pay for each membership month with an auto-deduct option on a credit or debit card. This will be auto deducted on the last day of the month prior to the month that is being paid for. Otherwise, I will be billed on a yearly basis. If I have not paid my membership fee for a given month, I will not be able to access any services unless I pay the cash fee for a one-time visit.

[ ] I understand this agreement and my membership cover only the ongoing primary care services described in Services Provided, and that this arrangement is not medical insurance. I understand I must pay for all medical services not included in Services Provided.

[ ] I am enrolling for membership in the Practice voluntarily. I understand I have other healthcare options. In the event of a medical emergency, I agree to call 911 first.

[ ] I understand I will be required to pay all medical costs to the extent they are not covered services listed in Services Provided.

[ ] I understand the Provider will make reasonable efforts to be available during clinic hours, but may not always be able to see me on a same-day basis. I may, rarely, be referred to the urgent care or emergency room for same-day service and in those circumstances I will have to pay for those services.

[ ] I understand the Practice will not file or defend any insurance claims on my behalf and that I am prohibited from filing any claims or bills to insurance for services received.

[ ] I understand this agreement does not meet the Affordable Care Act's individual insurance requirement.

[ ] I do NOT expect the Provider to prescribe chronic controlled pain medications or benzodiazepines.

[ ] I understand failure to pay the membership fee will result in termination from the program.

By signing below, you acknowledge that you have read, understood, and agree to be bound by the terms and conditions of this Agreement.

Patient's Name: _____

Signature: _____ Date: _____

Provider: Pomegranate Health

Authorized Signature: _____ Date: _____