3900 West Coast Highway Suite 310
Newport Beach, CA 92663
Ph: (949) 478-8858 Fax: (949) 242-2465
info@shankleclinic.com
www.shankleclinic.com

PATIENT PARTNERSHIP AGREEMENT

Welcome to Shankle Clinic. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and Shankle Clinic. As our "partner in health," we ask you commit to helping us in the following ways:

- **Maintain a Primary Care Physician and schedule visits with them for routine physical exam and other recommended health screenings**

  I understand that I must have a primary care physician for routine health exams and other recommended health screenings, and for management of medical conditions that are not a specialty of Shankle Clinic. These health screenings include mammograms, immunizations, pap smears etc. These health screenings and tests can help detect life-threatening diseases and conditions.

- **Keep follow-up appointments and reschedule missed appointments**

  I understand that my doctor at Shankle Clinic will want to know how my condition progresses after I leave the office. Returning to Shankle Clinic as recommended provides the doctor the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor at Shankle Clinic might order tests, refer me to another physician, or prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my doctor at Shankle Clinic may not be able to detect and treat serious health conditions. I will make every effort to reschedule missed appointments as soon as possible.

- **Call Shankle Clinic when I do not receive the results of laboratory or other tests**

  I understand that my doctor's goal at Shankle Clinic is to report my laboratory and other test results to me as soon as possible. However, if I do not hear from Shankle Clinic within a reasonable timeframe, I will contact the office for my test results.

- **Inform my doctor at Shankle Clinic if I decide NOT to follow the doctor's recommended treatment plan**

  I understand that after examining me, my doctor at Shankle Clinic may make certain recommendations based on what they feel is best for my health. This might include prescribing medication, referring me to another physician, and ordering labs and tests. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor at Shankle Clinic know whenever I decide not to follow his or her recommendations so that they may fully inform me of any risks associated with my decision to delay or not follow treatment.

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Thank you for your partnership. As our patient at Shankle Clinic, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Name (Print): _____

Signature: _____ Date: _____

Signature of personal representative, if patient is unable to sign:

Patient Name (Print): _____

Personal Representative Name (Print): _____

Relationship to Patient: _____

Signature: _____ Date: _____

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MEDICAL MEMBERSHIP PROGRAM AGREEMENT

This Program Agreement (the "Agreement") is made and entered into as of _____ (the "Effective Date") between you, the undersigned patient ("you" or "Patient"), and William R. Shankle, M.D., Inc. d/b/a Shankle Clinic, a California Corporation, (the "Practice") under which the Practice will make certain amenities and enhanced services available to you which are not otherwise covered by commercial insurance, managed care, Medicare, and/or other third-party payers. You may participate in the Practice's Medical Membership Program (the "Program") by voluntarily entering into this Agreement and remitting the Annual Membership Fee, as set forth below.

1. **The Program.** The Program's Annual Membership Fee covers the following services and amenities provided by the Practice, as set forth below:
    - **Expedited Appointment Requests** – Appointment requests from established patients, those already seen for consultation and diagnostic evaluation, will be accommodated in 10 business days or fewer.
    - **Personalized Coordination** – Coordination of advanced care with specialists, health systems, and approved clinical trials.
    - **Premier Event Access** – Invitations to presentations by leading physicians and healthcare professionals at the forefront of medical treatment.
    - **Patient Newsletter** – Delivery of the periodical Shankle Clinic Newsletter, designed to raise awareness for issues related to cognitive health and memory disorder, and to announce highlights from Shankle Clinic.
    - **Patient Webinars** – Semi-annual lecture by Dr. Shankle on cognitive health and memory disorder scientific education. Open question and answer period.
    - **Life Coach** – A Life Coach referral program is being created.

2. **Program Year.** A "Program Year" is defined as a period of twelve (12) calendar months comprising the calendar year (i.e., January 1 through December 31).

3. **Annual Membership Fee and Payment Information.**
    a. By entering into this Agreement, you authorize the Practice to charge the Annual Membership Fee to your designated billing account at the time of initial payment and each annual renewal. You agree to make the payment using your chosen payment method. The Practice may, at its sole discretion, allow Patients to remit payment for the Annual Membership Fee on a modified schedule (e.g., semiannual payments).
    b. The Practice may modify the Annual Membership Fee from time to time. The Practice will attempt to notify you in advance of modifications to the Annual Membership. To facilitate timely notification, please be sure that the Practice has your updated email address on file.

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c. You must cancel your membership in accordance with Section 4 (Renewals and Termination) in advance of the annual renewal to avoid being charged the Annual Membership Fee.

d. Payment by Check.

i. Checks should be made payable to "Shankle Clinic" and mailed to the following address:

1. Shankle Clinic
   Attn: Medical Membership Program
   3900 West Coast Hwy # 310
   Newport Beach, CA 92663

e. Payment by Credit or Debit Card.

i. Payments by Credit or Debit Card will be processed by the Practice at the time of initial payment and each annual renewal. If you prefer to pay with a credit or debit card, please complete Attachment A (Payment Authorization Form) and return to the Shankle Clinic offices, or call the Shankle Clinic offices at (949) 478-8858.

4. **Renewals and Termination**. The term of this Agreement shall commence on the Effective Date and continue in effect through the end of the Program Year (the "Initial Term"). At the end of the Initial Term, this Agreement shall automatically renew for successive terms of twelve (12) months (each a "Renewal Term") unless either party provides written notice of non-renewal at least thirty (30) days prior to the start of the next Renewal Term. The terms and conditions of this Agreement may be changed with notification to you, via email or by mail, to your address on file. Either you or the Practice may terminate this Agreement with thirty (30) days' notice to the other party. Should you choose to terminate this Agreement, the Practice will assist you in the transfer of your care to another practice or physician of your choosing. The Practice will continue to provide you with care until the transition to another practice or physician has taken place.

5. **Medicare Care Services Excluded from Annual Retainer Fee.** The Practice will not seek reimbursement for the Annual Membership Fees from Medicare or any other third-party payer plans. You are solely financially responsible for payment of the Annual Membership Fees and agree not to submit the Annual Membership Fees to Medicare or your private insurance carrier, except for reimbursement from your health savings account ("HSA"), medical savings account ("MSA"), or Flexible Benefits Account ("FBA").

6. **Co-payments.** Medicare and private insurance companies require the Practice to collect applicable co-payments and other charges from patients for health care services. Therefore, you will be financially responsible for all co-payments, co-insurance payments, and/or deductibles as defined by the terms of your insurance coverage.

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7. **Non-Participating Provider.** If you have insurance with which the Practice does not participate, the Practice will file a claim with your insurance company as a courtesy only with respect to covered services provided to you by the Practice as defined by your insurance company.

8. **Email Communication/Privacy.** You acknowledge that traditional email is not a secure means of sending or receiving personal health information, and that the Practice has provided you with access to a secure patient portal as an alternative to communicating via traditional email. Should you choose to send confidential personal health information by non-secure email, you specifically authorize the Practice to reply with personally identifiable protected health information. At the discretion of the Practice, email communications may become part of my permanent medical record.

   You also acknowledge that time-sensitive communications with the Practice and/or your provider(s) should be handled by direct contact in-person or via telephone, and that you will not use email to seek an urgent appointment, ask questions about an urgent issue, or for any other time-sensitive issue.

9. **Amendments and Waivers.** One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach of the same provision or of any other covenants or conditions.

10. **Section Headings.** Any section, section title, or caption contained in this Agreement is for convenience only and in no way defines, limits, or describes the scope or intent of this Agreement or any of the provisions hereof.

11. **Invalid Provisions.** The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

12. **Entire Agreement.** This Agreement constitutes the entire understanding of the parties with respect to the subject matter outlined in this Agreement. The undersigned agrees to the terms and conditions of this Agreement and acknowledges there are no promises or representations except as specifically listed in this Agreement.

13. **Notices.** Notice from one party to the other shall be in writing shall be deemed to have been duly given when delivered in person, sent via U.S. mail to the addresses listed in this Agreement, or sent to the email addresses listed in this Agreement.
    a. Notices to the Practice shall be delivered to the following mailing address or email address/ Mailing Address:
        i. Mailing Address:
            1. Shankle Clinic

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Newport Beach, CA 92663
Ph: (949) 478-8858 Fax: (949) 242-2465
info@shankleclinic.com
www.shankleclinic.com

Attn: Medical Membership Program
3900 West Coast Hwy Ste 310
Newport Beach, CA 92663

ii. Email Address:
1. info@shankleclinic.com

b. Notices to the Patient shall be delivered to the mailing address or email address listed below.
c. The Practice and Patient agree to make best efforts to notify the other party of changes to its mailing address or email address.

14. **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of California.

I, _____, agree to the terms and conditions herein.
Patient Name (Print)

I acknowledge that I understand the "Program," that this is not an insurance product, and that I have been advised that I will be responsible for obtaining my own health insurance. I have read and agree to the terms of the Practice's payment policies.

_____ _____
Patient Signature **Date**

Patient Mailing Address:

Street _____
_____

City _____ State_____ ZIP_____

Patient Phone: _____

Patient Email Address: _____

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Attachment A

Medical Membership Program Payment Authorization

Annual Membership Fee (Initial Term):	**$1,500.00**

Payable as one annual payment ($1,500.00) or two semi-annual payments ($750.00 each)

AUTHORIZED PAYMENT SCHEDULE
Please select the authorized payment option below for the Annual Membership Fee • **Annual Payment Option (**$1,500.00 for Initial Term) Your card will be charged the Annual Membership Fee on or after January 1. **Or** • **Semi- Annual Payment Option** ($750.00 x 2 for Initial Term) Your card will be charged half of the Annual Membership Fee on or after January 1, and half of the Annual Membership Fee on or after July 1.

I, _____ agree to pay the Annual Membership Fee
Patient Name (Print)
according to the Authorized Payment Schedule selected above. I acknowledge that the amount shown represents the Annual Membership Fee for the Initial Term, and that such Fee for each Renewal Term may differ, per Section 3(b) of the Medical Membership Program Agreement.

_____ _____
Patient Signature **Date**
–

Preferred Payment method (**choose one**):	• Check	• Credit/Debit Card

Note: Patients may change their preferred payment method by contacting the Shankle Clinic offices.

Payment by check:
Checks should be made payable to "Shankle Clinic" and mailed to the following address:

Shankle Clinic
Attn: Medical Membership Program
3900 West Coast Hwy # 310
Newport Beach, CA 92663

Payment by Credit or Debit Card:
Please complete the form on the following page to facilitate payment by credit or debit card. The form should be delivered to Shankle Clinic in person or mailed to the address above.
Authorization for Payment of Annual Membership Fee by credit or debit card:

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Newport Beach, CA 92663
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info@shankleclinic.com
www.shankleclinic.com

CARDHOLDER INFORMATION		
Name on Card:		
Cardholder Billing Address:		
City:	State:	Billing Zip:

PAYMENT AUTHORIZATION

Card Number:
_____

Expiration Date (mm/yr) : _____ Card CVV#: _____
(3 or 4 security digits)

By providing your credit or debit card information and signing below, you certify that you have the authority to authorize debits or charges to the payment card identified and you authorize Shankle Clinic to electronically debit or charge this card for the initial Term and each Renewal Term based on the AUTHORIZED PAYMENT SCHEDULE selected above.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF FEES

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The following agreement is intended to provide transparency regarding the Shankle Clinic's fees and help avoid misunderstandings. If you have any questions or concerns, please bring those up with our staff during your next appointment, or contact our offices via phone or email:

Phone: (949) 478- 8858
Email: info@shankleclinic.com

Shankle Clinic is a participating provider for many PPO insurance carriers. We also accept **MEDICARE. For billing purposes, patients who plan to use insurance should contact their insurance carrier and provide the following information to verify that Dr. William Shankle is an in-network provider:**

NPI	**1932246584**
Tax ID	**47-3132940**

*The following fees and services are subject to change **without** notice.*

MEDICAL MEMBERSHIP PROGRAM FEES

Annual Membership Fee (Initial Term)	**$1,500.00**

Payable as one annual payment ($1,500.00) or two semi-annual payments ($750.00)

All patients who receive care from The Shankle Clinic must join the Clinic's Medical Membership

Program and pay the program's annual fee. This fee will not be billed to any insurance providers and is solely the responsibility of the patient and/or responsible party. Patients may elect to pay the annual fee on an annual or on a semi-annual basis. More information about the Program (including program services, fees, and payment options) can be found in the Medical Membership Program Agreement.

Please note: Medical insurance does not cover the membership fee.

MISCELLANEOUS FEES

Missed Appointment or Late Cancellation	**$200.00**
Returned Check Fee	**$25.00**

- **Missed Appointment or Cancellation**: Due to the high volume of patients seen by Shankle Clinic, patients must cancel or reschedule appointments at least 48 hours in advance of the original appointment. Patients who fail to do so may be charged the cancellation fee specified above.
- There is a $500.00 fee for a cancellation of appointment during evaluation. This fee applies if a patient and/or responsible party checks into an appointment and walks out before the visit has been completed. This charge is not covered by Medicare or insurance and is solely the responsibility of the patient and/or the responsible party.
- **Returned Checks**: All returned personal checks are subject to $25.00 fee, which will be the responsibility of the patient and/or the responsible party.

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The following fees are only for patients who DO NOT have Medicare or medical insurance contracted with the Shankle Clinic.

INITIAL CONSULTATION CASH FEES

Initial Neurological Evaluation	**$500.00**
Brief Neuropsychological Assessment	**$250.00**

- The initial consultation includes a neurological evaluation based on the patient's history and conditions. Based on our review of the forms submitted by the patient, our clinical team will determine what type of consultation(s) is/are necessary.

FOLLOW UP VISIT CASH FEES

Follow- Up Visit	**$500.00**
Brief Neuropsychological Assessment	**$250.00**

- Follow up visits are necessary for the physician and physician extenders to re-evaluate and make any adjustments to treatment that may be necessary. Any appointment scheduled after the initial consultation will be considered as a follow-up visit. The frequency of these visits will vary based on medical necessity determined by the provider(s). Once a patient is stabilized on treatment, visits will typically be scheduled every 4-to-6 months.

CHRONIC CARE MANAGEMENT (CCM) CASH FEES

CCM Calls	**$50.00**

- Our CCM team will provide regularly scheduled calls, at the providers' direction, to monitor chronic care management. The CCM team is composed of Licensed Vocational Nurses to act as a liaison between patients and providers between visits.

I have read and understand the above fee information, and I agree to these terms. I hereby grant perpetual authorization for payment of insurance benefits to be made directly to Shankle Clinic, or any affiliated physicians, for services rendered. I understand that I am financially responsible for all charges, regardless of whether those charges are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary, including medical information, to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____

Patient Name (Print)

_____ _____

Patient Signature Date

PATIENT'S PRIMARY CONTACT FORM

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info@shankleclinic.com
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Patient Name: _____ Date of Birth (DOB) :_____

The patient named above authorizes The Shankle Clinic to

- Discuss health information with
- Request health information from
- Send health information to

The following primary contact:

Patient's Primary Contact Name:_____
Relationship to Patient: _____
Primary Contact Phone Number:_____
Primary Contact email address: _____

Scope: All health information regarding assessment, diagnosis and treatment of patient's condition of concern or disease.

List of other **authorized** personnel to release/discuss health information:

1. Name: _____
   Relationship to patient: _____
   Contact number: _____ Email:_____
2. Name: _____
   Relationship to patient: _____
   Contact number: _____ Email:_____
3. Name: _____
   Relationship to patient: _____
   Contact number: _____ Email:_____

List of **restricted** personnel (if any) to release health information:

1. Name: _____
   Relationship to patient: _____
   Contact number: _____ Email:_____

Note: Please provide the Shankle Clinic a copy of a Power of Attorney (POA) form (if applicable) to add on file.

Name of patient/authorized rep.: _____ Signature of patient/authorized rep.: _____

Date: _____

If not signed by the patient, indicate relationship of authorizing person to patient: _____

NEW PATIENT QUESTIONNAIRE

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PATIENT INFORMATION

Patient Name: _____ Date of Birth:_____ Age: _____
Telephone: ( )_____ Home: ( )_____ Cell: ( )_____
Address: _____ Patient Primary Language: _____
Primary Contact Person: _____ Relation to patient: _____
Email (appointment reminders will be sent here): _____
Power of attorney or Advanced Health Care Directive information**:

_____

**If applicable, please provide documentation.

INTERNIST/PRIMARY CARE PHYSICIAN AND VISIT INFORMATION

Primary Care Physician: _____ Office number:_____
Cardiologist: _____
Other Specialist: _____

INSURANCE INFORMATION

Carrier: _____ Plan (PPO/HMO): _____ ID number: _____
Group name / number: _____
Medicare #: _____
Secondary Insurance information: _____
Carrier: _____Plan (PPO/HMO): _____ID number:_____
Group name / number: _____

PHARMACY

Preferred pharmacy name: _____Phone number: _____
Address: _____

RELEASE

Do you give Shankle Clinic permission to upload prescriptions from your pharmacy record to our Electronic Health Record? Yes / No

CHIEF COMPLAINT

What is the primary reason/concern you are coming to the Shankle Clinic?

_____

Do you require reminders on a regular basis from others for memory related tasks such as (check box if applies):

☐ Appointments ☐ Medications ☐ Planning to take care of something later

PATIENT HISTORY

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Please indicate with a check mark if you have had any of the following medical problems listed below:
***for any history marked please indicate the date started next to the problem.**

ALLERGIES:_____ Reaction: _____

PREVIOUS SURGERIES/Year: _____

Heart:

☐ Chest Pain ☐ High Cholesterol ☐ History of DVT/PE
☐ Congestive Heart Failure ☐ Cardiomyopathy ☐ Heart Attack
☐ Heart Valve Problem ☐ Arrhythmias, i.e., A-Fib ☐Hypertension
☐ Coronary Artery Disease ☐ Other: _____

Lungs

☐ Asthma ☐ COPD ☐ Emphysema
☐ Sleep Apnea ☐ Tuberculosis ☐ Other Lung Disorder:_____

Blood

☐ Anemia ☐ Bleeding/Clotting Disorders ☐ Stroke/Mini Stroke
☐ Leukemia/Lymphoma ☐ Other Blood Disorders: _____

Kidney/Bladder

☐ Dialysis ☐ Kidney Stones ☐ Prostate Disease
☐ Urinary Tract Infections ☐ Incontinence: Bowel/Bladder ☐ Chronic Kidney Disease
☐ Other kidney/bladder disorder: _____

Hormones (Endocrine)

☐ Diabetes Type 1 or 2 ☐ Hypo/ ☐Hyper Thyroidism ☐ Hypoglycemia
☐ Pre-Diabetes ☐ Chronic Steroid Therapy ☐ Hormone Deficiency
☐ Other hormone disorder: _____

Pain

☐ Artificial Joints ☐ Back/ Neck Pain ☐ Chronic Pain
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Other Pain Conditions: _____

Gastrointestinal

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☐ Cirrhosis ☐ Digestive Problems ☐ Gastric Reflux
☐ Hepatitis A, B, or C ☐ Irritable Bowel Syndrome ☐ Other GI: _____

Neurological

☐ Anxiety ☐ Depression ☐ Mood Disorders
☐ Migraines ☐ Muscle Weakness ☐ Seizures
☐ Attention Deficit Disorder ☐ Traumatic Brain Injury ☐ PTSD
☐ Physical/ Mental Trauma ☐ Learning Disorder ☐ Other: _____

Hearing/ Vision

☐ Cataracts ☐ Glaucoma ☐ Color Blind
☐ Macular Degeneration ☐ Hearing Loss ☐ Ringing in Ears

Female Reproductive

Hysterectomy? ☐Yes ☐No
If yes, did you receive hormone replacement therapy within 5 years? ☐Yes ☐No

Male Reproductive

Prostatectomy? ☐Yes ☐No
Are you taking testosterone? ☐Yes ☐No

Cancer

Have you had or have breast cancer? ☐Yes ☐No
Have you had or have prostate cancer? ☐Yes ☐No
Have you had radiation therapy? ☐Yes ☐No
Have you had chemotherapy? ☐Yes ☐No

Family History: Has any first degree relative had any of the following conditions?

☐ Alzheimer's Disease ☐Parkinson's Disease ☐ Lewy Body Disease
☐ Frontal Temporal Lobe Disease ☐ Other Neurocognitive Disorder: _____

Lifestyle Factors

Do you smoke? ☐Yes ☐No

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Have you ever smoked? ☐Yes ☐No
For how many years? _____ Amount: _____ Year Quit: _____
Do you drink alcohol? ☐Yes ☐No
How much alcohol do you consume and how often?
Do you use recreational drugs? ☐Yes ☐No
What kind of recreational drugs do you use? _____
Do you exercise? ☐Yes ☐No How often? _____
Is the patient still driving? ☐Yes ☐No Driver's License # _____
Do you work? ☐Yes ☐No
If yes, what is your primary occupation? _____
If not, what are your day to day hobbies? _____

Vaccines

Flu Vaccine: ☐Yes ☐No Date: _____
Pneumonia Vaccine? ☐Yes ☐No Date: _____
COVID - 19 Vaccine? ☐ Yes ☐No Date of last dose: _____

MEDICATION LIST

* Please include over the counter medications, vitamins, and supplements taken on a regular basis

MEDICATION	DOSE	ROUTE	FREQUENCY	REASON FOR TAKING

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PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any services rendered under this contractual agreement were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contractual agreement, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, 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. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete resolution of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time

SHANKLE CLINIC

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to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below.

Earlier effective date: ____________________________ Patient's Initials: ____________________

ARTICLE 7: I have read and understand all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

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 CONTRACTUAL AGREEMENT 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 AGREEMENT.

____ Dated: ______________________
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: ____

PHYSICIAN'S AGREEMENT TO ARBITRATE
I agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

____ Dated: __________________________
(Physician or Duly-Authorized Representative)

. . . .
Title—e.g., Partner, President, etc.   Print name of Physician, Medical Group, Partnership or Association

3900 West Coast Highway Suite 310
Newport Beach, CA 92663
Ph: (949) 478-8858 Fax: (949) 242-2465
info@shankleclinic.com
www.shankleclinic.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ RECORD

INSTRUCTION TO THE PATIENT

This form authorizes your health care provider to release your medical records to Shankle Clinic. If you would like your records to be released to Shankle Clinic, **please fill out this form and mail or fax it to the appropriate healthcare providers**. If you would like to have more than one healthcare provider release your medical record to Shankle Clinic, please feel free to make copies of this form. We would only like the records that are relative to the condition that you are seeking evaluation for. Please fill out and send only to those physician(s) that have evaluated or treated you for similar conditions.

Patient Name: _____ Date of Birth: _____

Medical Record #: _____ Social Security #: _____

I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to Shankle Clinic.

Provider Name: _____

Provider Address: _____

_____

Please provide my medical record by mail or fax to :

Shankle Clinic
3900 West Coast Hwy., Ste 310
Newport Beach, CA 92663
Ph: (949) 478-8858 Fax: (949) 242-2465

* Please include information related to diagnostic evaluation of memory loss, dementia, or cognitive impairment such as neuropsychological testing and neuroimaging studies only.

This authorization will remain effective for one (1) year from the date this authorization is signed unless I provide a written notice of revocation to the above named provider at the provider's address.The revocation will be effective immediately upon my health care provider's receipt of such notice.

Patient Signature: _____ Date: _____

Print Patient Name: _____

Signature of Legal Representative: _____

Print Name: _____ Date: _____

Relationship: _____

SHANKLE CLINIC

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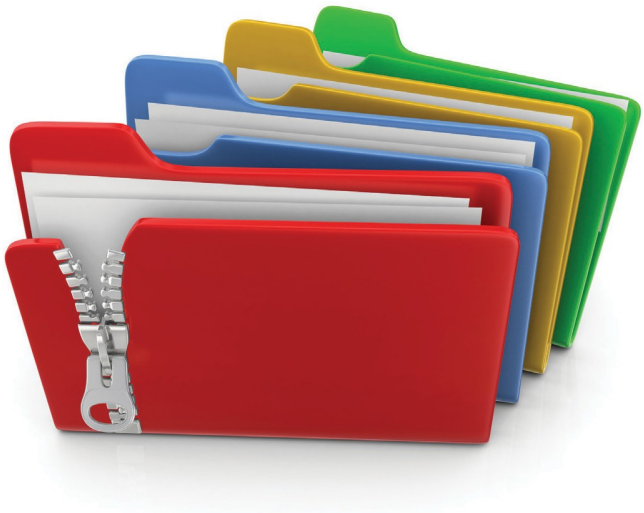

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

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Your Rights *continued*

Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Share and access your information through the Hoag Health Information Exchange (HIE)	• We are participating in the Hoag Health Information Exchange (HIE), an electronic system through which participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state laws to protect patient privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation. If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), we will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

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Comply with special laws	• There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice.

We will never market or sell your personal information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: **February 25, 2021**

SHANKLE CLINIC

Shankle Clinic Privacy Contact

900 West Coast Hwy #310
Newport Beach, CA 92663

Phone: **(949) 478-8858**
Email: **info@shankleclinic.com**
Website: **www.shankleclinic.com**

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About the Experimental Option of Immunoglobulin G (IgG) Therapy

Since about 2002, Dr. Shankle has treated approximately 50 patients with IVIG for up to 7 years. Using the FAST staging instrument to measure rate of functional decline, the results have been consistent in slowing the rate of decline compared to the patient's pre-treatment rate of functional decline.

We previously presented at conference proceedings that 80% of 16 Alzheimer's disease (**AD**) patients and 4 of 4 Lewy Body Disease (**LBD**) patients showed a 200% to 700% delay in the rate of functional decline when taking intravenous IgG (**IVIG**) for two or more years. This rate was in comparison to their pre-IgG treatment rate of decline. In patients who stopped IgG treatment, they declined at an intermediate rate between pre-IgG and on-IgG for up to 2 years, then resumed the pre-IgG treatment rate of decline.

There has been one FDA phase III trial of mild to moderate dementia AD patients treated with IVIG, which failed. There are many possible reasons why an FDA trial fails, only one of which is treatment inefficacy.

The cost of IVIG is prohibitive for most patients (thousands of dollars per month). The absorption of IgG from blood to brain is only 0.1%, which may be why it takes so much IgG when given intravenously, and why it is so expensive. I have therefore looked for other ways to deliver IgG more efficiently to the brain so that the cost can be reduced.

Intranasally delivered IgG may be much less expensive than IVIG because there is no blood-brain barrier when IgG is inhaled through the nose. This means that lower doses of inhaled IgG may deliver the same amount to the brain as higher doses of IVIG.

To date, Dr. Shankle has used intranasal IgG to treat 9 AD, 5 Lewy Body and 2 Parkinson's disease patients with very low dose IgG at a cost of $200 to $400 per month for the IgG itself. All patients have shown objective cognitive improvement in brain areas located near the points of entry of intranasally delivered IgG into the brain. One of the moderately demented Lewy Body patients showed dramatic improvement in balance, speech, hallucinations, and level of confusion within 2 months of intranasal IgG treatment.

However, brain areas further away from points of entry of intranasally delivered IgG into the brain have not shown improvement in more impaired patients given this very low dose of IgG intranasally.

The unknown factor is the percent absorption from the nasal cavity to the brain. Once that is known, then the intranasal dose can be adjusted to give an amount of IgG that is equivalent to the amount that gets into the brain when given intravenously.

The primary cost of this treatment is the inhaler technology, which currently costs $4,000 to $5,000 for the inhaler through Kurve Technology.

It is critical to deliver the IgG to the back of the nasal cavity so that IgG can pass through the pores in the bone separating the nose from the brain.

Intranasally inhaled IgG also enters the brainstem directly through the nerve fibers that provide sensation to the face (the Trigeminal Nerve), which is why it may be effective for LBD, and possibly Parkinson's disease, both of which show disease pathology early on in the upper brainstem.

With the understanding that this is an experimental treatment option with no certainty of a beneficial result, here is what needs to be done to try intranasal IgG treatment:

1. Upon your request, the Shankle Clinic will order a set of blood tests to assure that IgG is safe to give.
2. If there are no contraindications to giving IgG intranasally, then contact Marc Giroux at mgiroux@kurvetech.com, which makes the inhaler.
3. Marc can then train you on how to use the inhaler and arrange for its purchase.
4. Once obtained, Dr. Shankle will provide a prescription for intranasal IgG to Coast Hills Pharmacy, plus instructions on how to administer it.
5. The Shankle Clinic will then test cognition at 3 and 6 months after starting intranasal IgG to get one type of measure of treatment effect.
6. Other tests that can be used to measure treatment effect over a longer term
    a. (before and 1-3 years after being on intranasal IgG) are:
    b. A spinal fluid test for beta amyloid and neurofibrillary tau to measure their changes.
    c. A quantitative MRI.
    d. A PET scan for amyloid or tau, once they become clinically available.

You can find out more information by going to the Kurve technology website, www.kurvetech.com.

Dr. Shankle has no financial or proprietary interest in any aspect of treatment with intranasal IgG. He is cautiously optimistic about this form of treatment because both IVIG and intranasal IgG appear to consistently provide measurable improvement or delay in AD and LBD.

William Rodman Shankle, MS MD FACP

Shankle Clinic for Memory and Cognitive Disorders