MASTER SERVICES AGREEMENT (MSA)

Healthcare Practice Benefit Investigation & Administrative Support Services

> **NOTICE & DISCLAIMER:** This legal agreement template has been prepared for **True USA Senior Concierge LLC** (trueusasenior.com) for preliminary operational setup. It is designed for review and final execution under the supervision of a qualified healthcare compliance attorney.

This Master Services Agreement ("Agreement") is entered into as of _____ , 20 ___ ("Effective Date"), by and between **True USA Senior Concierge LLC**, a Delaware/Maryland limited liability company with its principal place of business at trueusasenior.com ("Service Provider"), and _____ ("Client" or "Medical Practice").

1. PURPOSE & SCOPE OF SERVICES

Client is a professional medical practice requiring independent administrative support for patient coverage, insurance benefit verifications, and prior authorization inquiries. Service Provider agrees to perform non-clinical administrative Benefit Investigation (BI) services as specified herein.

2. DESCRIPTION OF SERVICES & WORKFLOW

Upon receipt of a complete Benefit Investigation Request Form and valid Patient Authorization from Client, Service Provider shall perform the following administrative tasks:

- Verify patient medical insurance coverage, active policy status, copayments, deductibles, and co-insurance requirements.
- Identify commercial and federal payer prior authorization (PA) and pre-certification requirements for specified procedures or treatments.
- Document insurance payer representative interactions, call reference numbers, and coverage guidelines into a standardized summary report provided to Client within two (2) business days.

3. FEES & PAYMENT TERMS

3.1 Transactional Service Fee

Client shall pay Service Provider a fixed fee of **$20.00 USD per completed Benefit Investigation** ("BI Fee"). A Benefit Investigation is deemed complete upon transmission of the verified coverage summary report to Client.

3.2 Regulatory Compliance & Anti-Kickback Compliance

The parties expressly acknowledge that the BI Fee represents Fair Market Value (FMV) for administrative labor and overhead. Fees are strictly transaction-based and are in no way dependent upon, tied to, or contingent upon:

- The financial volume or value of referrals between the parties;
- Whether insurance coverage is approved or denied by the payer; or
- Whether the patient ultimately undergoes medical treatment with Client.

3.3 Invoicing & Direct Billing Prohibitions

Service Provider shall invoice Client on a monthly basis. Payment is due within thirty (30) days of invoice date. Under no circumstances shall Service Provider bill, collect fees from, or assess surcharges to patients directly for services rendered under this Agreement.

4. HIPAA COMPLIANCE & BUSINESS ASSOCIATE AGREEMENT

In performing Services, Service Provider may receive, create, or maintain Protected Health Information ("PHI") on behalf of Client. Service Provider agrees to comply fully with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and HITECH Act standards. The parties shall simultaneously execute the Business Associate Agreement ("BAA") attached hereto as **Exhibit A**, which is incorporated by reference.

5. TERM & TERMINATION

This Agreement commences on the Effective Date and continues for a period of one (1) year, automatically renewing for successive one-year terms unless either party provides thirty (30) days' written notice of termination. Either party may terminate immediately upon material breach of HIPAA regulations or failure to cure payment default within fifteen (15) days.

6. LIMITATION OF LIABILITY & NON-CLINICAL STATUS

Service Provider is an administrative services entity and does not provide medical advice, diagnosis, treatment, or clinical determinations. Final treatment decisions, billing selections, and clinical authorizations remain the sole legal responsibility of Client and its attending healthcare providers.

IN WITNESS WHEREOF, the parties have executed this Master Services Agreement as of the Effective Date.

TRUE USA SENIOR CONCIERGE LLC
(Service Provider)

_____

By: Authorized Representative
Title: Founder / Managing Director
Date: _____

MEDICAL PRACTICE NAME:
_____

_____

By: Authorized Physician / Executive
Title: _____
Date: _____

EXHIBIT A: BUSINESS ASSOCIATE AGREEMENT (BAA)

Compliant with HIPAA Privacy, Security, and Breach Notification Rules

This Business Associate Agreement ("BAA") is entered into by and between **True USA Senior Concierge LLC** ("Business Associate") and _____ ("Covered Entity") to ensure compliance with HIPAA, HITECH, and the Omnibus Rule.

1. DEFINITIONS

Terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in 45 CFR Parts 160 and 164 (Privacy, Security, Breach Notification, and Enforcement Rules).

2. OBLIGATIONS & ACTIVITIES OF BUSINESS ASSOCIATE

Business Associate agrees to:

- **Permitted Use:** Not use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement, the MSA, or as required by law.
- **Safeguards:** Implement appropriate administrative, physical, and technical safeguards (including encryption in transit and at rest) to prevent unauthorized use or disclosure of PHI.
- **Breach Reporting:** Report to Covered Entity any acquisition, access, use, or disclosure of PHI not provided for by this BAA, including security incidents and breaches of unsecured PHI, within five (5) business days of discovery.
- **Subcontractors:** Ensure that any agents or subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate.
- **Access to Books & Records:** Make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services (HHS) for purposes of determining compliance.

3. PERMITTED USES & DISCLOSURES BY BUSINESS ASSOCIATE

Except as otherwise limited in this BAA, Business Associate may use or disclose PHI to perform Benefit Investigations, coverage determinations, and administrative support functions for Covered Entity under the MSA, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity.

4. TERM & TERMINATION

4.1 Term

The Term of this BAA shall be effective as of the Effective Date of the MSA and shall terminate when all PHI provided by Covered Entity is destroyed or returned.

4.2 Effect of Termination

Upon termination, Business Associate shall return or destroy all PHI received from Covered Entity. If return or destruction is infeasible, Business Associate shall extend all protections, limitations, and restrictions of this BAA to such information.

TRUE USA SENIOR CONCIERGE LLC
(Business Associate)

_____
By: Authorized Representative
Date: _____

COVERED ENTITY (MEDICAL PRACTICE)

_____
By: Authorized Officer
Date: _____

PATIENT HIPAA AUTHORIZATION & CONSENT FORM

Authorization for Disclosure of Health Information for Benefit Verification

Patient Name: _____ **DOB:** _____

Medical Record / ID Number: _____

1. AUTHORIZATION & PURPOSE

I hereby authorize my healthcare provider, _____ ("Practice"), and its designated administrative vendor, **True USA Senior Concierge LLC** (trueusasenior.com), to use, request, obtain, and disclose my Protected Health Information (PHI) for the specific purpose of conducting health insurance benefit investigations, verifying coverage eligibility, evaluating prior authorization requirements, and facilitating insurance claims administration.

2. SCOPE OF INFORMATION AUTHORIZED FOR RELEASE

This authorization permits insurance carriers, health plans, pharmacy benefit managers (PBMs), and medical billing clearinghouses to release the following information to True USA Senior Concierge LLC and the Practice:

- Demographic information, health insurance policy ID, group numbers, and claim history.
- Benefit coverage details, deductibles, copayments, coinsurance balances, and benefit maximums.
- Prior authorization criteria, pre-certification approvals, and medical necessity guidelines related to recommended treatments or procedures.

3. PATIENT RIGHTS & IMPORTANT DISCLOSURES

- **Voluntary Authorization:** Signing this authorization is voluntary. Refusing to sign will not affect my ability to receive standard medical treatment from the Practice.
- **Revocation Right:** I have the right to revoke this authorization at any time by delivering written notice to the Practice. Revocation will not apply to information already released in reliance on this authorization.
- **Redisclosure Warning:** Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy rules.
- **No Financial Fee to Patient:** I understand that True USA Senior Concierge LLC provides administrative support to my physician and that **I am not being charged any fee** for this benefit verification service.

4. EXPIRATION

This authorization shall remain valid for one (1) year from the date of signature below unless explicitly revoked earlier in writing.

Patient Signature: _____ **Date:** _____

Personal Representative Signature (if applicable): _____

Relationship / Legal Authority: _____