MEMBERSHIP AGREEMENT

The patient membership agreement (the "Agreement") specifies the terms and conditions under which you, our patient (_____)
Name
will participate in our program (☐ Insurance ☐ self pay) offered by White Coat Concierge (the "Practice") and is effective when you sign this Agreement and pay your first fee payment (the "Effective date"). Date_____

PROGRAM OPTIONS

1. Membership with **preferred insurance:**
   This program's monthly fee of $150 per month encompasses the following services ("Services"):
   - Extensive in-home annual wellness examination
   - Telemedicine services
   - In-home urgent care services depending on provider availability
   - In-home follow-up appointments for chronic conditions
   - In-home mobile phlebotomy and specimen handling when indicated and available
   - Maintaining your personal health record
   - Discounts on additional a-la-carte services as they become available
   - Access to providers' cell phones
   - Same day medication refills

2. Membership **WITHOUT** preferred insurance:
   This program's monthly fee of $200 per month encompasses the following services ("Services"):
   - Extensive in-home annual wellness examination
   - Four (4) telemedicine appointments monthly. Additional calls will be billed at $50 per 10 minute call.
   - One (1) in-home follow-up appointment monthly for chronic conditions. Additional visits will be billed at $150 per visit.
   - Maintaining your personal health record
   - Discounts on additional a-la-carte services as they become available
   - Access to a providers' cell phones
   - Same day medication refills

Additional Service Options:

A **monthly** fee of **one hundred dollars ($100)** will be added for one additional qualifying adult over 18 years of age with preferred insurance or **one hundred fifty dollars ($150)** for one additional adult without preferred insurance in the same household.

3. Membership **need based:**
   Patients who require or desire higher than customary in-person visits or telephone communication including provider to provider communication, maintaining a significant health record, extensive specialty referrals or care provider/family communications, will be charged a monthly membership fee of $400/month regardless of insurance status. The implementation of this membership category is to be determined by the Practice at initiation of membership or during the course of membership. A 30-day notice regarding change in membership status will be provided should the need arise.

Explanation of Program Fees

Your concierge fee covers your membership and an annual wellness examination to be completed at your convenience.

Your Provider will be your concierge in the coordination of specialist care.

Members will have secure emailing with the Providers. Members will have access to the Provider's cell phone number for urgencies.

The annual wellness examination will include health screening recommendations, nutrition and wellness counseling, and a comprehensive 90 minute visit with your Provider.

Cancellation and No-show policy

There will be a charge if the patient is a no-show for a scheduled in-home appointment. The Provider will wait no more than 15 minutes after the scheduled appointment time. Patient's will be charged a **$50 (fifty dollar)** fee for in-home no show. This fee must be paid when invoiced and if not paid then no further services will be rendered until the fee is paid; if not paid, membership may be canceled.

Cancellation of an in-home appointment less than 4 (four) hours prior to the appointment time will incur a **$25 (twenty-five dollar)** fee with the same policy as stated above for payment.

There will be a charge of **$25 (twenty-five dollars)** if the patient is a no-show for a telemedicine appointment. The patient will be invoiced, and the same policy as stated above for payment applies.

There will be no fee for a canceled telemedicine appointment when canceled prior to the appointment time. If the patient is more than 10 minutes late for a telemedicine appointment, the appointment will be canceled and will have to be rescheduled by the patient and the no show fee will apply.

MONTHLY PATIENT FEE

The **sign-up fee** will include the first **two months** of the membership to be paid **up front**. The billing cycle starts on the first of every month and must be paid in full by the 1st (first) of the month if you choose monthly billing. The membership fee can also be paid annually if desired. A late fee of **$25** will be accrued on the **5th (fifth) day** of the month. **If the monthly fee has not been paid by the 10th (tenth) day of the month, it will result in termination of your participation in the program unless prior arrangements have been made.**

You or the Practice may terminate this Agreement at any time upon **30 (thirty) days** written notice, (to be received by mail or email) with or without a reason. If you choose to pay for services annually and not monthly, and either You or the Practice terminate the Agreement, you will receive a pro-rated refund of the Annual Fee, less the current month (up to 30 days). If you terminate this Agreement, without giving a 30 (thirty) day notice, a prorated refund for that month will not be issued. Unless otherwise terminated, this Agreement shall automatically renew for additional monthly periods.

Medical Care Services Excluded from Monthly Fee:

The monthly fee specified herein covers only the defined "Services" described in Section 1 above. More details concerning what is included and excluded from the Program as well as Program Fees and other billing are set forth in the Explanation of Program Fees, attached hereto and incorporated herein. Except for your Services, You and/or your insurer, as the case may be, will be financially responsible for paying for all healthcare and medical care services received by you from the Practice and other third parties. The Practice will bill You and /or your insurer, as the case may be, for those healthcare or medical services provided to you, other than those charges paid at the time of your visit.

Entire Agreement

This is the entire, integrated agreement between You and the Practice. There are no promises or representations except as set forth herein.

Governing Law/Jurisdiction:

This Agreement shall be governed by and constructed in accordance with the laws of the State of Nevada and You and the Practice agree to exclusive jurisdiction in Clark County, Nevada.

Billing:

Initial payments are processed at the time of enrollment, which is the effective date. Subsequent payments are charged monthly or annually at your selection. Payments may be made with a credit card or debit card utilizing Quickbooks.

Patient Responsibility

All insurance plans, including Medicare, usually have a deductible/co-pay which will be billed to you after the insurance company sends us an explanation of benefits. A new deductible begins every January 1 and must be billed. The amount may vary based on your current insurance coverage.

Please refer to our financial policy for more information.

It is your responsibility to notify the Practice of any changes to your insurance coverage.

Optional services will be billed to the patient after insurance determines the patient portion. If you do not have insurance, we will work with you regarding pricing.

WHITE COAT CONCIERGE
A mobile service

(mailing address only):
3459 Saint Rose Parkway, Ste #120-461

Henderson, NV 89052

Office: (702) 992-4867 Fax: (833) 795-1957

Membership Agreement

I am requesting enrollment in White Coat Concierge's concierge medical practice. By my signature on this page, I am agreeing to the Membership Agreement attached hereto:

Signature: _____ Date: _____

Name: (please print)_____

Date of birth: _____

Authorized signer: (if applicable) _____

Relationship to patient: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Cell: _____