

CONCIERGE MEDICINE RETAINER AGREEMENT

CareFirst 360 Concierge Medicine Program

Background

CareFirst 360 Concierge Medicine (the "Practice"), through its physician(s) (the "Physician"), offers enhanced health and wellness services and amenities that are not otherwise covered by commercial insurance, managed care plans, Medicare or other third-party payers. In exchange for the fees paid by you, the undersigned patient ("You" or "Patient"), the Practice agrees to provide the services described in this Retainer Agreement (the "Agreement").

This Agreement is entered into on _____, 20____, and is effective as of _____, 20____ (the "Effective Date"). By voluntarily entering into this Agreement and paying the Annual Retainer Fee, You may participate in the Practice's Concierge Medicine Program (the "Program") for twelve (12) months beginning on the Effective Date.

Physician: _____, M.D./D.O.

1. The Program

The Annual Retainer Fee covers the following services and amenities, described further in Exhibit A:

- Annual Executive Health Assessment, more comprehensive than what is covered by third-party payers (including Medicare)
- Enhanced appointment availability – usually the same business day, and no later than the next business day
- Personal appointment reminders
- No wait or minimal wait for physician appointments
- Extended physician appointment time
- After-hours physician access by cell phone*
- Secure electronic and e-mail communication
- Coordination of specialist care and hospital services

The amenities include both non-healthcare service amenities and healthcare-related services usually not covered by insurance. Other amenities may be offered from time to time and may be subject to limitations.

** With reasonable exceptions, such as limited cell phone reception, dead batteries or electrical outages.*

2. Annual Retainer Fee

Choose one payment option:

Payment Option	Fee	How It Is Paid
☐ Annual	\$2,499 per year	Paid in full at enrollment and at each renewal, by credit/debit card or check payable to CareFirst 360.
☐ Monthly	\$249 per month	Twelve (12) consecutive monthly installments, automatically charged to the card on file on or after the 1st of each month (credit/debit card only).

The first payment is due at enrollment. If You choose the monthly option, You must pre-authorize recurring card charges at enrollment (Exhibit B). The monthly option is a twelve-month commitment; if this Agreement ends early, Section 3 applies. A failed or declined payment not cured within ten (10) days may result in suspension of Program services.

3. Term, Renewal and Termination

(a) Term and renewal. This Agreement lasts one (1) year from the Effective Date and renews automatically for successive one-year periods unless either party gives written notice of non-renewal at least thirty (30) days before the anniversary date. The Practice may change the terms of the Program for any renewal period with written notice to You. Failure to pay the renewal fee by the anniversary date may result in termination of Your membership.

(b) Termination. Either You or the Practice may terminate this Agreement with thirty (30) days' written notice to the other party.

(c) Refunds and balances. If this Agreement is terminated **before** Your Annual Health Assessment, any prepaid Annual Retainer Fee will be refunded on a prorated basis, and monthly installments will stop. If terminated **after** Your Annual Health Assessment has been completed, the Annual Retainer Fee is non-refundable; for monthly members, the remaining balance of the \$2,499 annual fee (less installments already paid) becomes due.

(d) After termination. Ending or not renewing Your membership will be taken as Your decision to establish care with a new physician. The Physician will provide emergency care only for thirty (30) days after termination; You and/or Your insurer will be responsible for charges incurred during that time. To transfer records, You must sign a HIPAA-compliant release; one copy will be sent to Your new physician at no charge, and additional copies are charged at then-current rates.

4. Fees Not Billed to Insurance

Neither the Practice nor the Physician will seek reimbursement for the Annual Retainer Fee from any insurer, Medicare or other third-party payer. You are solely responsible for the Annual Retainer Fee and agree not to submit it to Medicare or Your insurance carrier, except for reimbursement from a health savings account (HSA), medical savings account (MSA) or flexible spending account (FSA) where permitted.

5. Covered Medical Services, Co-Payments and Deductibles

Except for services provided as part of the Annual Health Assessment or as non-medical personal services, You and/or Your insurer remain financially responsible for all other covered services provided by the Practice, which will be billed to You or Your insurer as applicable. You remain responsible for all co-payments, co-insurance and deductibles under Your insurance coverage. Patients without insurance are entitled to up to four (4) additional visits per year (telehealth or in person) in addition to the Annual Health Assessment.

6. Non-Participating Insurance

If You have insurance with which the Practice or Physician does not participate, the Practice will file a claim with Your insurer as a courtesy only for services other than the Annual Health Assessment or personal services, and You will be responsible for the office visit charge.

7. Not Insurance

The Program is not an insurance product and does not replace health insurance. You are advised to maintain Your own health insurance coverage, including for specialist care, hospitalization, emergencies, imaging and prescriptions.

8. E-Mail and Electronic Communications

You acknowledge that standard e-mail is not a secure way to send or receive personal health information. If You choose to send health information by non-secure e-mail, You authorize the Practice to reply with protected health information. The Physician has sole discretion whether to reply to any e-mail or open attachments, and e-mails may become part of Your medical record.

You will not use e-mail or messaging for urgent or time-sensitive issues; for those, contact the Practice by telephone or in person, and in an emergency call 911. If You do not receive a reply within one (1) business day, You agree to use another method to reach the Physician. Neither the Practice nor the Physician is liable for any loss, injury or expense resulting from a delayed response caused by technical failures, including (i) internet service provider failures; (ii) power outages, messaging software failure or incorrectly addressed messages; (iii) failure of the Practice's computers, network, telephone or data transmission; (iv) interception of communications by a third party; or (v) Your failure to follow these guidelines.

9. General Provisions

(a) Amendments and waivers. This Agreement may be changed only by written agreement signed by both parties, except that the Practice may amend it as required by federal, state or local law ("Applicable Law") with thirty (30) days' written notice, and You agree to initial any such change on request. Provisions required by Applicable Law are incorporated by reference. No waiver is valid unless in writing and signed by the party against whom it is sought, and a waiver of one breach is not a waiver of any other.

(b) Severability. If any provision is found invalid or unenforceable, the rest of this Agreement remains in effect and that provision will be modified to the minimum extent needed to comply with law.

(c) Entire agreement. This Agreement, including its Exhibits, is the entire understanding of the parties on this subject. There are no promises or representations other than those stated here.

(d) Notices. Notices must be in writing and are effective when delivered in person or sent by U.S. mail to the addresses on file.

(e) Governing law; change in law. This Agreement is governed by the laws of the State of Texas. If a change in law, regulation or its interpretation would substantially and adversely affect either party's rights or obligations under this Agreement, that party may require good-faith renegotiation by written notice. If no agreement is reached within forty-five (45) days after the change takes effect, either party may terminate this Agreement immediately by written notice.

(f) Assignment. You may not assign or transfer this Agreement or any rights under it.

(g) Relationship of parties. The Physician acts as an independent professional and has exclusive control over the manner in which medical care is provided.

(h) Legal significance; construction. You acknowledge that this is a legal document creating rights and responsibilities and that You have had reasonable time to seek legal advice. This Agreement will be interpreted without any presumption against the party that drafted it, and section headings are for convenience only.

Patient Acknowledgement and Signatures

I, _____, agree to the terms and conditions of this Agreement. I understand the Program, that it is not an insurance product, and that I should continue my own health insurance. I have read and agree to the Practice's payment policies.

Patient Signature

Date

Printed Name

Date of Birth

Accepted by CareFirst 360 Concierge Medicine

By: Physician / Authorized Representative – Name & Title

Date

Patient Initials: _____

EXHIBIT A

Program Services

1. Medical Services

“Medical Services” means the services the Physician is permitted to perform under Texas law consistent with the Physician’s training and experience in internal medicine. Patient is also entitled to an annual in-depth wellness examination and evaluation performed by the Physician, including:

- Executive annual physical exam, typically lasting over one hour
- Health risk assessment, vision and hearing screening, and EKG (age 40 and over)
- Comprehensive, age-appropriate laboratory screening
- Coronary calcium score (age 50 and over)
- Psychosocial screening
- Advance care planning
- Custom wellness plan, including exercise and dietary plan

When the Physician is unavailable due to vacation, illness, continuing education or similar reasons, calls will be directed to a covering physician. The Practice will make every effort to arrange coverage but cannot guarantee it.

2. Non-Medical, Personalized Services

(a) 24/7 access. Patient will receive a direct number to reach the Physician by phone around the clock, and may also use secure messaging and video visits. During the Physician’s absence, an appropriately licensed provider will be available through an answering service, and Patient will be told how to reach that provider.

(b) E-mail access. Patient will receive the Physician’s e-mail address for non-urgent communications, which will be handled by the Physician or Practice staff in a timely manner. E-mail and the internet must never be used for an emergency or a situation that could become one; if Patient cannot reach the Physician immediately by phone or in person, Patient will call 911 or go to the nearest emergency facility.

(c) No-wait or minimal-wait appointments. Every effort will be made to see Patient promptly on arrival. If a wait is expected, Patient will be contacted and told the projected wait time.

(d) Same-day / next-day appointments. Requests made before noon on a regular office day (Monday–Friday) will be scheduled the same day whenever reasonably possible; requests after noon will be scheduled the next office day whenever reasonably possible.

(e) Home or office visits. Patient may request a visit at home or work; where the Physician considers it reasonably necessary and appropriate, the Physician will make every reasonable effort to accommodate the request.

(f) Visiting family. Family members visiting Patient from out of town may use the services in (a), (c) and (d) for up to three (3) weeks. Medical services for visitors are billed on a fee-for-service basis.

(g) Specialist coordination. The Physician will coordinate with specialists to whom Patient is referred. Fees under this Agreement do not cover specialist fees or fees of any provider other than the Practice’s Physician.

EXHIBIT B*Payment Election and Card Authorization*

Select one payment option:

- ☐ Annual – \$2,499 paid in full at enrollment and at each renewal
- ☐ Monthly – \$249 per month for 12 months, charged automatically on or after the 1st of each month

Payment method: ☐ Credit/Debit Card ☐ Check (annual option only)

Cardholder Name

Card Type

Card Number

Expiration (MM/YY)

Security Code

Billing Address

Billing Zip Code

I authorize CareFirst 360 Concierge Medicine to charge the card above for the Annual Retainer Fee under the option selected, including recurring monthly charges if I selected the monthly option, and at each renewal unless I give written notice of non-renewal as described in the Agreement. I will notify the Practice in writing of any change to my card. This authorization remains in effect until revoked in writing, which does not relieve me of any balance owed under Section 3 of the Agreement.

Cardholder Signature

Date

Patient Name (if different from cardholder)

Phone

EXHIBIT C

Controlled Substances Acknowledgement

Your Physician may prescribe certain controlled substances from time to time as medically appropriate. However, the Physician does not treat chronic pain or provide chronic pain management, so any controlled substances will be prescribed only on a limited, short-term basis. If You require long-term pain management, the Physician will refer You to an appropriate provider and/or help transfer Your care to the provider of Your choice.

By signing below, You acknowledge that neither the Physician nor the Practice provides long-term pain management and that You will not be prescribed controlled substances on a long-term basis. You agree to inform the Physician of all controlled substances prescribed to You by any other provider, and You understand this is an ongoing obligation.

Patient / Legal Representative Signature

Date

Printed Patient Name

Printed Legal Representative Name (if applicable)

Relationship to Patient