PATIENT DIRECT PRIMARY CARE CONTRACT

By signing below you are agreeing to participate in the Direct Primary Care Practice Program at Max Health Maine Family Practice LLC. This Contract defines both your obligations as well as those of the Practice.

What the Practice Provides:

1. As an enrollee in the Program, the Practice will provide you with the following services:

(a) Annual Physicals;

(b) Well and sick care office visits of up to 10 per year (additional visits at the posted fee rate);

(c) Urgent care during office hours;

(d) Some basic Lab tests which can be performed in the office or a small number of basic laboratory results from another contracted laboratory (a list will be provided upon request);

(e) Yearly Flu Vaccine;

(f) Availability of a Practice Physician on call 24/7 subject to the limitation below;

(g) Patient advocacy and care coordination with specialists and hospital physicians should you require either of these, subject to limitation below.

2. Limitations. The Practice can only provide those services which are within its physician's training and capabilities. For example, the Practice will not cover hospital care nor specialty services such as surgery. Lab work which must be completed outside of the office is not included. There may be problems for which the Practice physician determines that consultation or treatment by outside providers is appropriate and you will be responsible to for any associated costs. There may be times when the Practices' physician(s) are not available due to vacations, illness, etc. or equipment is unavailable and during those times, you may need to seek urgent care elsewhere and you will be responsible for the costs associated with such urgent care services. Opiate addiction treatment with or without buprenorphine is not included. Prenatal and obstetrical care is not included. Cost of vaccines is not included, except one influenza vaccine (non egg-free) annually. Yellow fever vaccination is not included. Assistance with legal proceedings is not included but can be negotiated separately with your attorney.

(a) Costs. Your total costs for the above services and your payment obligations are as follows:

An Initial Medical Assessment fee of ninety to one-hundred and twenty dollars, payable in advance of, or on the date of initial service, and a monthly/annual membership fee as set forth in the fee schedule: (Appendix 1)., due at the end of each membership month

(b) You hereby authorize the Practice to charge the monthly/quarterly/annual membership fee through on the first day of membership each month/year.

(c) The first three monthly membership payments must be paid in their entirety and are non-refundable. If you have chosen the prepaid annual

membership plan the same required three month minimum membership payment applies to and will be deducted from any refund made if membership is cancelled.

(d) You agree to provide either a working bank pre-authorized bank debit arrangement (ACH) with this office, (or a secure on-line debit service, eg. Hint.com, or equivalent secure service); OR a valid credit card for the payment of membership fees, and scheduling fees.

(e) In addition, you agree to pay for any non-covered services provided by this office which shall be charged to that same account you have provided, and you agree to allow such incidental charges to be applied to your account without additional approval. Receipt for those additional charges will be provided upon request.

(f) If you fail to update an expired or invalid credit card or keep ACH bank transfer arrangements open and funded within the 14 days of the payment due date, your participation in the Program will terminate. This failure to update your financial information with the Practice, will be considered notice by you of immediate termination of the patient-physician relationship, as well as this care plan. You will have 30 days from that date to establish care from another provider, during which time we will continue to provide essential and usual medical care available at the office. Max Health Maine will not be responsible for your medical care beyond that period unless Max Health Maine agrees to provide such services and you either re-enroll in the Program, or sign the contract for the cash for services plan at this office. Charges as allowed by Maine law will be incurred for copies of your medical records.

(g) A re-enrollment fee of $180 if you drop out of the Program (or don't pay the monthly/quarterly/annual membership fee within 14 days of payment due date), and then wish to re- enroll.

(h) Late payments: Late payments, invalid credit cards, or bounced ACH auto-payments will incur a $30 charge per incident.

3. Term, Termination. Though this Agreement is for an initial term of one year, either you or the Practice can terminate your participation in the Program at any time by giving at least 60 (sixty) days' written notice. If you terminate your participation in the Program within the first three months of membership, no funds will be returned to you. Any amount prepaid by you beyond the initial three months of your enrollment, and beyond the 60 days of notice, will be refunded, (minus any discounts extended to you, for multiple family members, annual membership or other discounts).

4. Program is Not Insurance. You recognize that membership in the Program is not insurance and is not intended to replace any existing or future health insurance or health plan coverage that you may carry. It simply gives you access to some medical care for a small scheduling fee. It is not intended to cover all medical care you may ever need. The Practice will not be submitting any of the services to your insurance company for reimbursement. If you need a receipt for services rendered in order to submit your own claim for insurance, the Practice will provide you with one. The Practice in no way can assure that you will receive reimbursement from you insurer for such claims.

5. Not Participating in Insurance. You acknowledge that the Practice may not participate in your health insurance or HMO plans or panels, and that the Practice does not make any representations whatsoever that any amounts paid under this Contract are covered by your health insurance or other third party payment plans. You retain full and complete responsibility for any such submissions and acknowledge that you may not by law or regulation be allowed to submit such claims for reimbursement.

6. . Not Covered by Insurance. You acknowledge that though the Practice does participate with certain health insurance programs, the fees paid for the Program are entirely for services and scheduling that are **not** covered by your insurance. If you have Medicare, then the Program fees and services are entirely for services not covered by Medicare. If you submit any claims for reimbursement for such fees, you retain full and complete responsibility for any such submissions and acknowledge that you may not by law or regulation be allowed to submit such claims for reimbursement.

7. Health Savings Accounts. The Practice does not make any representation about your ability to pay Program fees from your Health Savings Account, if you have one. The IRS regulations about the use of such accounts are complicated and you should seek the advice of a tax professional before using your HSA to pay the Program fees.

8. [*Required if you opt out of Medicare for your Medicare patients*] Medicare Agreement. You report and verify that you are not enrolled in Medicare. This contract is automatically and immediately null and void if you have Medicare or if you subsequently may enroll in Medicare. You recognize the Practice may opt out of participating in Medicare. You are signing this Contract to evidence your understanding and agreement regarding payment for any services to be provided by the Practice. The Practice certifies that neither it nor any of its physicians have been excluded from participation in the Medicare program under Sections 1128, 1156, 1892 or other applicable sections of the Social Security Act. The Practice will certify to you, the effective date of opt-out from Medicare when determined and the estimated date of expiration of the opt-out period, provided that the Practice may extend the opt-out period further. By executing this Contract, you acknowledge and agree as follows with respect to all items after that opt-out date:

(a) You accept full responsibility for payment of the Practices charges for all services furnished by the Practice;

(b) You understand that Medicare limits do not apply to what the Practice may charge for items or services furnished by the Practice ;

(c) You agree not to submit a claim to Medicare or to ask the Practice to submit a claim to Medicare;

(d) You understand that Medicare payment will not be made for any items or services furnished by the Practice that would have otherwise been covered by

Medicare if there was no private contract and a proper Medicare claim had been submitted;

(e) You enter into this Contract with the knowledge that you have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that you are not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out;

(f) You understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;

(g) You do not currently require emergency care services or urgent care services; and

(h) You acknowledge that you have been provided a copy of this Contract.

(i) If you are a Medicare Patient, you understand that you will be contributing an annual fee of _____($780) for non-covered services that this practice provides to all patients

9. Miscellaneous.

(a) This agreement is governed by the laws of the State of Maine.

(b) Any notice that the Practice gives to you can be sent to the address you provide below. Any notice to the Practice shall be sent to 1226 Shore Road, Cape Elizabeth, Maine 04107

YOU ACKNOWLEDGE THAT YOU HAVE READ THIS CONTRACT AND UNDERSTAND WHAT THE PRACTICE INTENDS TO PROVIDE TO YOU AND WHAT IT WILL NOT PROVIDE. YOU ALSO ACKNOWLEDGE THAT YOU HAVE HAD AN OPPORTUNITY TO ASK ANY QUESTIONS YOU MAY HAVE ABOUT THIS CONTRACT AND THEY HAVE BEEN ANSWERED TO YOUR SATISFACTION.

_____ _____

Signature Date

_____ _____

Name (printed) Address

APPENDIX 1

_____ *initials*

MONTHLY MEMBERSHIP Cost: $_(see attached fee schedule) _____/month/year

Plus the one time initial medical evaluation fee at membership initiation fee of $_____($120.00)

(1)) Annual Physicals;

(2)) Well and sick care office visits of up to 12 per year (additional visits at the posted fee rate);

(3)) Urgent care during office hours;

(4)) Lab tests which can be performed in the office (a list will be provided upon request);

(5)) Availability of a Practice Physician on call 24/7 subject to the limitations listed above ;

_____ *initials*

ANNUAL PREPAID MEMBERSHIP Cost: $_____/year

(1)) All of the services in Plan 1

Plus the one time membership initiation fee of $_____

_____ *initials*

ADDITIONAL FAMILY MEMBER(S) Cost: $_____/month/year

(1)) All of the services in Plan 1

Plus the one time membership initiation fee of $_____/per member

See APPENDIX 2 Fee Schedule (TABLE FORM)