EVOLVE DIRECT PRIMARY CARE
MEMBERSHIP AGREEMENT

Note: Signing this Membership Agreement may alter your legal rights under Maryland Law. Please read the entire document carefully before signing.

I, the undersigned, wish to receive primary care medical services from Evolve Direct Primary Care ("Evolve") and its practitioners (each, a "Practitioner"). A list of the current Practitioners is included at the end of Attachment B. I understand these medical services are offered subject to the following terms and conditions:

1. Effective/Renewal Date. This Patient Agreement (the "Agreement") shall begin on _____ (the "Effective Date") and continue as long as I continue paying the Membership Fee described below and subject to termination as described below. This Agreement supersedes any prior Patient Agreement(s) I have signed with Evolve.

2. Enrollment Fee. I understand that I must pay a one-time $50 (fifty dollar) enrollment fee upon joining Evolve. I also understand that if I cancel my membership and wish to re-enroll, I will have to pay another enrollment fee of $50.00.

3. Services. I understand that **Evolve is not an insurance plan and DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE**, nor is this a contract of insurance. I understand that Evolve will make available: (a) certain medical services as requested by me or as deemed necessary by the Practitioners in accordance with the established standard of care for primary care practitioners; and (b) certain related services (such medical services and related services are referred to in this Agreement collectively as "Services" and described in further detail in Attachment A).

4. Membership Fee. I understand that I must pay a monthly membership fee (the "Membership Fee") in order to receive Services from Evolve. Certain Services are included in the Membership Fee, but all other Services I receive from Evolve will be charged separately at the time of service according to Evolve's current Member Fee Schedule. Attachment A lists all Services included in the Membership Fee, all other Services available from Evolve, and Evolve's current Member Fee Schedule. Attachment A also lists the current Membership Fee and describes how payment must be made.

5. Private Contract with Medicare Beneficiaries. If I am a Medicare Part B beneficiary, I also agree to the terms listed in Attachment B and will sign Attachment B in addition to this Agreement to confirm my acceptance of those terms.

6. Non-Participation in Medicare and Private Insurance Plans. I understand that Evolve and the Practitioners do not participate or contract with Medicare or any insurance plans, including,

but not limited to, Health Maintenance Organizations (HMOs), Point of Service Plans (POSs), Preferred Provider Organizations (PPOs) and Preferred Provider Networks (PPNs), and that all Practitioners are opted out of the Medicare program. I therefore acknowledge that, if Evolve provides Services to me: (a) Evolve, and not Medicare or my insurance plan, will bill me directly for those Services at its applicable rates; (b) payment for such Services is due at the time the services are rendered; and (c) I, instead of Medicare or my insurance plan, will be fully and personally responsible for paying for those Services. I further acknowledge that it is my responsibility to understand the limitations of my insurance coverage and I will not hold Evolve responsible for any denied payment for services by my insurance plan caused by my entering into this Agreement. I understand that I may, at any point, elect to obtain Services from a health care provider who does participate with my insurance plan rather than getting treatment from Evolve, and that if I obtain Services from such other health care provider, more favorable reimbursement may be available to me.

7. Submission of Insurance Claims. I understand that Evolve will NOT submit any claims for Services to my insurance plan on my behalf, and that I am solely responsible for submitting such claims if I choose to seek reimbursement from my insurance plan for such Services. I also understand that any reimbursement by my insurance plan will be sent directly to me. If Evolve is mistakenly reimbursed by my insurance plan, then Evolve will return the check to my insurance plan. I understand that my insurance plan may not pay at all for some Services provided by Evolve and may only make a partial payment for other Services provided by Evolve. I further understand that Evolve makes no representations or promises regarding the amount of payment to be received for any claim(s) I may submit to my insurance plan. Medicare and HMOs do NOT permit me to submit claims for Services provided by Evolve, and I agree not to submit a claim for any such services to Medicare or any HMO.

8. Termination of this Agreement.

   A. Termination by Patient:

      1. I understand that I may cancel this Agreement at any time by sending Evolve written notice: (a) stating that I wish to cease using Evolve for my medical services, and (b) requesting that a copy of my medical records be sent to either another physician or directly to me. Please note a minimum of 3 business days processing time is necessary to affect the cancellation.

      2. I understand that after cancellation, Evolve will no longer be able to prescribe or continue any prescriptions which I may have been receiving on a long-term basis and it is further understood that PRIOR to canceling my contract, I will establish treatment with, and transfer care to my new primary care provider.

      3. Budget billing is our monthly plan. I understand that if I terminate this Agreement within the first six months of membership after utilizing the Services in any way, I will pay Evolve a total of six months of membership fees in addition to any other Services costs. This is because I understand that Evolve does not place limits on the amount of care that I may receive from it per month. Accordingly, I may, based on the status of my health when joining Evolve, receive a multitude of services in a very short period of time. As a result, I understand and agree that it is only fair for Evolve to receive a total of six months of membership fees despite my terminating the contract earlier than six

months into my membership. Alternatively, I may opt to pay for any services received in the first six months based on the current non-member (urgent care) rate.

B. Termination by Practice:

I understand that Evolve may also terminate this Agreement, as well as the physician-patient relationship with me, upon thirty (30) days' prior written notice if any Membership Fee payment is more than fifteen (15) days late. In such case, Evolve will provide me with information to assist me in finding another primary care physician to take over my care.

9. Membership Fee(s) and Fee Schedule. I understand the current amount of the fee for my monthly Membership will be calculated according to the following age brackets:

Member Fee Schedule

Ages:	18-49	$59.00
	50-64	$69.00
	65-79	$79.00
	80 +	$99.00

Children of members

Ages:	6-17	$19.00
	18-25	$29.00

I also understand Evolve may change its Member Fee Schedule and the Membership Fee at any time upon ninety (90) days' prior written notice to me.

10. Payment. I understand that payment of my Membership will be automatically deducted from my bank account using the information on file or may be automatically charged to my credit card on file. I agree to sign a credit card authorization (see Attachment C) as part of my enrollment into the Evolve Membership Program, which I understand is required prior to any Services being provided to me. If I decide not to authorize Evolve to debit my bank account or charge my credit card for monthly payments, I agree that I will provide payment for at least six months of Services in advance and prior to any Services being rendered to me. I also agree to continue, throughout my Membership, to pay for Services on the same date each month.

    a. Services automatically renew for your convenience unless termination has been requested.

11. Patient Rights and Responsibilities.

    A. I understand that pre-existing medical conditions do not disqualify me from enrolling into Evolve and that I have a right to know my treatment options and actively participate in my health care decisions.

B. I understand that I have the right to a fair, expedient and objective review of any complaint I may have against Evolve and a Practitioner and that I will submit my concerns, suggestions, and patient feedback to info@emc4me.com.

C. I understand that in the event of a life-threatening medical condition, I should always call 911 or proceed to the nearest emergency department. I also understand that the costs of urgent care services not rendered by Evolve are not included in Evolve's monthly membership fees or otherwise.

D. I understand that Practitioners are available for telephone consultations in the event of an urgent medical matter, but I will call 911 or proceed to the nearest emergency department if immediate medical attention and/or treatment is required.

Evolve Member:

Patient Name: _____
(Please Print)

Patient Signature: _____Date: _____

Evolve Direct Primary Care:

Signature: _____Date: _____
Michael R. Freedman, MD

If the Patient is a minor, the Patient's parent or legal guardian must sign below indicating the parent or guardian's acceptance of the above terms and agreement to pay the Membership Fee on behalf of the Patient:

Name of Parent/Guardian: _____
(Please Print)

Signature of Parent/Guardian: _____Date: _____

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ATTACHMENT A

Services Included Under Membership

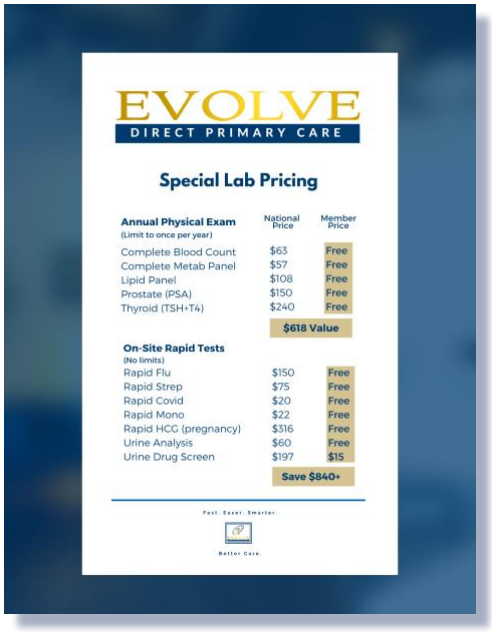
Please note: Evolve makes every effort to minimize lab costs for our members! Covid PCR lab billing is done by the lab processing your sample and it is not within our ability to control this cost.

Our member cost for lab processing of PAP smears is also steeply discounted. PAP alone is $30 for our members (average national price is $88) and PAP with HPV is $87 for our members (average national price is $129).

Women's health can be very expensive if paying out-of-pocket. In addition to the fee for the lab (PAP+HPV=$129), you can expect to pay $65 to $125 for the visit PLUS $90 to $360 for the Pelvic Exam.

Annual physical labs covered include the following screening labs once per year:

- CBC (complete blood count)
- CMP (comprehensive metabolic panel)
- Lipid analysis
- TSH/T4 (thyroid stimulating hormone and thyroid hormone)
- PSA (prostate specific antigen) for men only

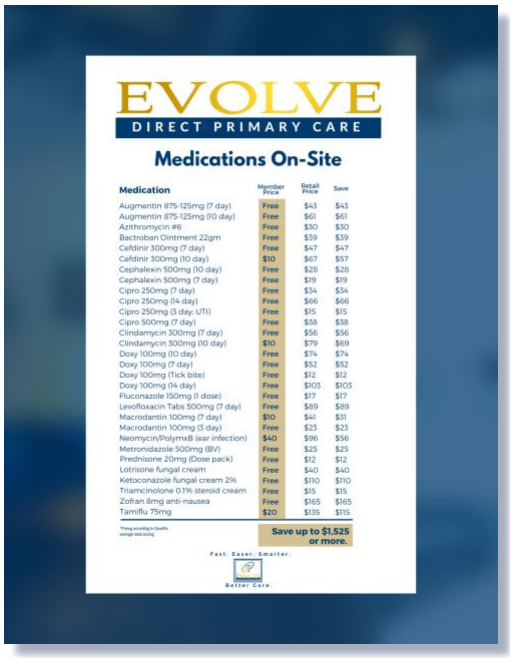


Discounted Services Under Membership

Evolve makes every effort to provide any additional services at a highly discounted rate compared with other doctor's offices, which we hope will minimize your out-of-pocket spending.

On-Site Medications

The following medications are available on-site and based on availability, will be provided to you at the time of your visit.



ATTACHMENT B

MEDICARE OPT-OUT
AND LIST OF PRACTITIONERS

I AGREE, UNDERSTAND AND EXPRESSLY ACKNOWLEDGE THE FOLLOWING:

- The Practitioners listed below (the "Practitioners") have all opted out of the Medicare program effective on dates indicated after their names for a period of at least two years.
- Neither Evolve nor any Practitioner is involuntarily excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.
- I accept full responsibility for payment of Evolve's and Practitioners' charges for all items and services furnished to me by Evolve.
- Medicare fee limitations do not apply to what Evolve and the Practitioners may charge for the items or services they provide to me.
- I will not submit a claim (or request that Evolve or any Practitioner submit a claim) to the Medicare program for payment for any items or services provided to me by Evolve or any Practitioner, even if the items or services are covered by Medicare Part B.
- Neither Evolve nor any Practitioner will submit a Medicare claim for items or services they furnish to me, and no Medicare reimbursement will be provided for such items or services.
- Medicare payment will not be made for any items or services provided to me by Evolve or any Practitioner even if those items or services would have otherwise been covered by Medicare if I had not signed this Patient Agreement and this Attachment B, and a proper Medicare claim had been submitted.
- I enter into this Patient Agreement with the knowledge that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other physicians or practitioners who have not opted out of Medicare.
- Medigap plans do not provide payment or reimbursement for items and services (such as any Services provided to me by Evolve or the Practitioners) not paid for by Medicare, and other supplemental plans may likewise deny payment or reimbursement for such items and services.
- I am not currently in an emergency or urgent health care situation, and do not currently require emergency care or urgent health care services.
- A copy of this Patient Agreement with this Attachment B has been provided to me.

Member Name:

_____

(Please Print)

Member Signature:

_____ Date: _____

PRACTIONER NAME	SERVICES	OPT-OUT DATE
Michael Freedman, M.D.	**Primary Care**	**July 1, 2014**
Loren Nedelman, DNP	**Primary Care**	**July 1, 2022**
Kerri Jones, CRNP	**Primary Care**	**January 1, 2022**
Kevin Barnes, CRNP	**Primary Care**	**January 1, 2022**

ATTACHMENT C

AUTHORIZATION AGREEMENT FOR RECURRING PAYMENTS

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to EITHER your bank or credit card (such as Visa, MasterCard, American Express or Discover card).

You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided for the recurring monthly payment.

Choose either banking or credit card form below.

EVOLVE
DIRECT PRIMARY CARE

AUTHORIZATION FOR
AUTOMATIC DEBIT PAYMENTS (ACH DEBIT)

I, the undersigned, hereby authorizes Evolve Direct Primary Care, to initiate debit entries to its bank account at the depository institution named below, ("Depository"), every month for each monthly service payment due under the Evolve Direct Primary Care Agreement, ("Agreement"), in the amount reflected on each month's invoice (based upon current enrollment and enrollment fees, if applicable).

Once the bank account information has been entered into Evolve's system, I understand I will receive an email with a link to create a profile in Hint to access invoices and related details of charges.

Failure for any reason of final credit or a reversal of any credit to the monthly service amount will constitute a breach/default under the terms of the Agreement that may result in the immediate termination of the Evolve Direct Primary Care Medical Services being provided under this Agreement.

The Agreement is supplemented by this ACH Agreement and all terms of the Agreement are in full force and effect.

Depository Name (Name on check/Checking Account):		Account Type ☐ Personal ☐ Business
Bank City:	Bank State:	Bank Zip Code:
Bank Transit/ABA number/Routing Number:	Bank Account Number:	

This authorization will remain in full force until Evolve receives written notification from me of its termination.

Signature:_____ Date:_____

Name (Print): _____

I authorize Evolve DPC to debit my bank indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this bank and that I will not dispute the scheduled payments with my bank provided the transactions correspond to the terms indicated in this authorization form.

EVOLVE
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AUTHORIZATION FOR CREDIT CARD

Please complete the information below:

I _____ authorize Evolve Direct Primary Care to charge my credit card indicated below on a monthly basis, for payment of my membership.

Billing Address_____Phone#_____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____DATE _____

I authorize Evolve DPC to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.