EVOLVE MEDICAL CLINICS
PATIENT AGREEMENT

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

I, the undersigned, wish to receive primary care medical services from Evolve Medical Clinics (the "Practice") 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 the Practice.

2. Services. I understand that the Practice will make available (s) 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).

3. Membership Fee. I understand that I must pay a monthly membership fee (the "Membership Fee") in order to receive Services from the Practice. Certain Services are included in the Membership Fee but all other Services I receive from the Practice will be charged separately at the time of service according to the Practice's current Member Fee Schedule. Attachment A lists all Services included in the Membership Fee, all other Services available from the Practice, and the Practice's current Member Fee Schedule. Attachment A also lists the current Membership Fee and describes how payment must be made. The Practice may change its Member Fee Schedule and the Membership Fee at any time upon ninety (90) days' prior written notice to me.

4. 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.

5. Non-Participation in Medicare and Private Insurance Plans. I understand that the Practice 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 the Practice provides Services to me: (a) the Practice, 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 the Practice 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 the Practice, and that if I obtain Services from such other health care provider, more favorable reimbursement may be available to me.

6. Submission of Insurance Claims. I understand that the Practice 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 the Practice is mistakenly reimbursed by my insurance plan, then the Practice will return the check to my insurance plan. I understand that my insurance plan may not pay at all for some Services provided by the Practice, and may only make a partial payment for other Services provided by the Practice. I further understand that the Practice 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 the Practice, and I agree not to submit a claim for any such services to Medicare or any HMO.***

7. Termination of this Agreement. I understand that I may cancel this Agreement at any time by sending the Practice written notice (a) stating that I wish to cease using the Practice for my medical services and (b) requesting that a copy of my medical records be sent to either another physician or directly to me. The Practice may also terminate this Agreement and 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 and at any other time upon ninety (90) days' prior written notice; in such case, the Practice will provide me with information to assist me in finding another primary care physician to take over my care.

Patient Name: _____ **EVOLVE MEDICAL CLINICS**
(*please print*)

Patient Signature: _____ By: _____

Date: _____ Date: _____

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 or Legal Guardian: _____
(please print)

Signature of Parent or Legal Guardian: _____

EVOLVE MEDICAL CLINICS
PATIENT AGREEMENT

Date: _____

EVOLVE MEDICAL CLINICS
PATIENT AGREEMENT
ATTACHMENT A – SERVICES AND MEMBER FEE SCHEDULE

I. Services Covered Under Membership Fee

• Dedicated representatives and telephone line during normal business hours to make contact easy
• Multiple convenient options for scheduling office visits: on-line; telephone; email; text
• Ability to check on wait times for office visits prior to arrival via text
• Wait times for scheduled visits of 30 minutes (except in cases of unanticipated patient emergency)
• Regular office appointments available same day or next day; urgent visits available within 24 hours
• Email access to nurse practitioners with responses within 24 hours
• Referrals to high quality local and national specialists and facilities, and assistance in making prompt appointments
• Up to 12 text/email/telephone consultations with practitioners per year (for medical problems that can appropriately be handled without an in-person visit, in the professional judgment of the practitioner)

II. Services Billed Separately and Member Fee Schedule (as of July 1, 2014)

SERVICE	MEMBER PRICE
Visits (In-Person and Virtual)	
Primary Care Visit (minor)	$25
Primary Care Visit (more complicated)	$25
Primary Care Visit (complex)	$25
Urgent Care Visit	$25
Procedures	
Skin Biopsy	$100
Ear Wax Removal	$25
Ingrown Toe Nail Removal	$150
Nose Bleed Treatment (packing)	$75
Suture of Skin Cut	$100
Skin Lesion Removal (benign)	$100
(includes Moles, Warts, AKs, SKs)	
Skin Tag Removal	$25
Bladder Catheter	$75
Drain or Inject Joint	$75
(may be small additional fee for medication injected)	
Drain Skin Abscess	$145
Allergy Shots	$10
Comprehensive Yearly Physical	$100
GYN Exam/Well Woman Visit	$100
School Physical Exam	$25
Labs/ Testing	
Breathing Capacity Test	$45
EKG	$25

Hearing Test	$35
PT/INR (Coumadin Monitoring)	$25
Mono Testing	$5

ATTACHMENT A – SERVICES AND FEE SCHEDULE

SERVICE	MEMBER PRICE
Blood Draws	$5
Strep Throat Test	$5
HgA1c (Diabetes 6 week average)	$19
Rapid Flu Test	$15
Urine Analysis	$10
Vaccines	Because the cost of vaccines can vary regularly, we promise to provide all vaccines at OUR cost + 5% (to cover stocking). If you are coming in ONLY for vaccine, the cost of that visit will be $10.

III. Membership Fee and Payment Method (as of July 1, 2014).

- $35.00 per month, payable by automatic deduction from credit card on file.
- Patients must sign credit card authorization when Patient Agreement is signed and before any Services are provided.

EVOLVE MEDICAL CLINICS
PATIENT AGREEMENT

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 the Practice 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 the Practice's and Practitioners' charges for all items and services furnished to me by the Practice.

- Medicare fee limitations do not apply to what the Practice and the Practitioners may charge for the items or services they provide to me.

- I will not submit a claim (or request that the Practice or any Practitioner submit a claim) to the Medicare program for payment for any items or services provided to me by the Practice or any Practitioner, even if the items or services are covered by Medicare Part B.

- Neither the Practice 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 the Practice 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 D, 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.

ATTACHMENT B – MEDICARE OPT-OUT AND LIST OF PRACTITIONERS

- Medigap plans do not provide payment or reimbursement for items and services (such as any Services provided to me by the Practice 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.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

****

PRACTITIONERS

NAME	SERVICES	OPT-OUT EFFECTIVE DATE
Michael R. Freedman, M.D. _____ signature and date	Supervision of Nurse Practitioners	July 1, 2014
Amy M. Ricker, CRNP _____ signature and date	Direct patient care	July 1, 2014

EVOLVE MEDICAL CLINICS
PATIENT AGREEMENT

Kastle Francis Donovan, CRNP _____ signature and date	Direct patient care	July 1, 2014
Hope Anne Pennestri, FNP, CRNP _____ signature and date	Direct patient care	July 1, 2014