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 date entered below (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.

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: