Concierge Medical Care, LLC

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PATIENT APPLICATION

Patient Name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name _____ Middle Initial _____

Last Name _____ I prefer to be called _____

Date of Birth _____

Marital Status ☐ S ☐ M ☐ W ☐ D

Street Address _____

City _____ State _____ Zip _____

Phone: Home (____)_____ Work (____)_____ Cell (____)_____

Please circle the phone number you prefer we call for contact or messages.

E-mail Address _____

Emergency Contact _____

Relationship to Patient _____ Phone (____)_____

Please list other members of your immediate family who will be joining the practice:

Name/DOB _____ Name/DOB _____

Name/DOB _____ Name/DOB _____

EMPLOYER & INSURANCE:

This will help us when ordering labs or diagnostic tests for you.

Employer or Retired from _____

Insurance (please present card to be copied) _____

Subscriber Name (if other than patient) _____ DOB _____

Relationship to Patient (if other than self) _____

BILLING:

☐ Check ☐ Electronic Funds Transfer from checking account (preferred)

☐ VISA ☐ MasterCard

☐ Annual Payment $4200 ($3360 with family discount)

☐ Quarterly Payment $1050 ($840 with family discount)

☐ Monthly Payment $350 ($280 with family discount)

Name as it appears on card _____

_____ _____

Credit Card Number 3 digit code

Expiration Date _____ Billing Zip Code _____

I authorize Concierge Medical Care to apply charges to this credit card.
Credit card information will not be stored in your medical records.

_____

Patient Signature (or Responsible Party/Guarantor Signature) Date

Concierge Medical Care, LLC

PARTICIPANT RETAINER AGREEMENT

This Participant Agreement describes the terms and conditions of your participation as a patient of Concierge Medical Care, LLC. (the "Practice"). Please read this Agreement carefully before you sign it and contact the office by email (info@ConciergeMedicalCare.com) or phone (303-454-2266) if you have any questions.

About the Practice

The Practice provides Internal Medicine services to patients. This Agreement creates a retainer relationship under which you, the Participant, will obtain personalized medical care in exchange for a yearly fee, payable by the month, quarter or year. The Supplement to this Agreement lists the specific services the Practice will provide you.

Participant's Rights and Responsibilities

Voluntary Participation Your decision to be a patient of the Practice under this Agreement is voluntary. If you decide not to be a patient of the Practice or start with us and later cancel your participation, Dr. Lutz and Dr. Griffith will make reasonable efforts to help you transfer your medical care to another physician or practice.

Covered Services Some of the Services that are medical, clinical, diagnostic or therapeutic may be partially or fully covered by your private health insurance or other third-party payment program. You have the right to seek reimbursement for Services covered by your private health insurance or other third party payment program, and we encourage you to maintain adequate insurance coverage for this purpose. The Practice will make reasonable efforts to assist you in determining whether any Services may be covered by such programs.

Services or Amenities Not Covered by Insurance or Deductible Your private health insurance or other third-party payment program may not cover your Participation Fee or some of the Services or Amenities, even if medical, clinical, diagnostic or therapeutic. Your Participation Fee pays the Practice for providing these non-covered Services, and you agree not to seek third party reimbursement for them unless your private health insurance or other third party payment program requires it for purposes of obtaining a non-coverage determination. All or part of the Participation Fee may not be considered deductible for IRS or state tax purposes or reimbursable by private health insurance, Flex plans, Health Savings or Health Reimbursement Accounts. Check with your benefits administrator with any questions about coverage and with your accountant or financial specialist with any question related to taxes.

Governmental or Non-Governmental Health Care Please notify us if you are a recipient or beneficiary of Medicare/Medicaid or any other government sponsored health care payment program.

Fees, Renewal and Cancellation

Participation Your medical care begins the day you make your first payment. Your billing cycle begins the first day of the calendar month after you sign and date this Agreement and runs for one calendar year unless canceled as provided below.

Participation Fee Schedule The Participation Fee is $4200 yearly, which may be paid in full, $1050 quarterly or $350 monthly. Additional adult members of your immediate family pay the reduced rate of $3360 yearly, $840 quarterly or $280 monthly. Your dependents ages 16 - 21 are treated at no additional charge.

Payment Terms The Participation Fee is payable *in advance* by check, ACH, Visa or Master Card. Participation Fees are subject to change 30 days after written notice from the Practice and at the time of renewal. The Participation Fee is payable each month whether or not you receive Services during the month. A late fee of $75, or the highest rate permitted by law, will apply to any payment not made within ten days after the due date.

How to Renew We will renew your Participation automatically each year. At least 30 days before the end of your Participation Year, we will send you a renewal notice outlining any changes to the Practice or the Participation Fee for the upcoming Participation Year. If we do not receive written notice from you cancelling your Participation at least **30 days** before the end of the current Participation Year, we will assume that you are renewing your Participation and will invoice you according to the payment terms set out in the renewal notice.

How to Cancel Your Participation We want every Participant to be satisfied with the Services we provide. However, if you choose to cancel your Participation before the end of a Participation Year, you must notify us in writing **30 days** in advance. The cancellation will be effective the last day of the calendar month following our receipt of your cancellation notice. If you have paid less than $2500 when you cancel but received a comprehensive physical during the Participation Year, the balance of $2500 will be charged to your account. We will refund any remaining Participation Fees we may be holding for future periods. If you do not give us a cancellation notice and fail to pay the Participation Fee when required under this Agreement within 30 days after any due date, we will assume that you have chosen to cancel your Participation.

X_____

Changes in the Practice and the Practice's Obligations

Practice Service Changes If it becomes necessary or desirable for us to change the Practice or Services substantially, we will notify you in writing at your most recent address provided. You may cancel your Participation within 30 days after the date of our notice of such a change and receive a refund of any unused Participation Fees as provided above.

Discontinuation We may discontinue the Practice at any time by notifying you in advance at your most recent address provided. If the Practice is discontinued, you will have no further obligation to pay the Participation Fee, and we will refund any unused Participation Fee in a prorated manner.

This Agreement is Not Insurance

Participation is not Health Insurance The Practice is not health insurance, a health benefit plan or a health insurance provider. You, your private health insurance or other third-party payment program will continue to be financially responsible for all Services and Amenities you receive that the Practice is not specifically agreeing to provide in this Agreement. The Practice only provides preventive & routine medical care and other Services to assist your wellness and health care program. **The Practice is not intended as, and is not a substitute for, emergency medical services. In the event of a medical emergency, call 9-1-1.**

Communications

Confidentiality You acknowledge that communications with the Practice using e-mail and cell phone are not guaranteed to be secure or confidential methods of communications. As such, you expressly waive the Practice's obligation to ensure confidentiality with respect to those means of communication. Under Colorado law, all such communications will become part of your medical records.

Email Communications You authorize the Practice to communicate with you by e-mail regarding your "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations) using any email address you provide. By providing your e-mail address, you acknowledge that: 1) E-mail is not a secure medium for sending or receiving PHI and, in particular, if you send or receive e-mail through your employer's e-mail system, the employer may have the right to review it; 2) Although the Practice will make reasonable efforts to keep e-mail communications confidential and secure, the Practice cannot guarantee their confidentiality; 3) E-mail is not an appropriate means of communication regarding emergency or other time-sensitive issues. If you do not receive a response to an e-mail message within two days, you agree to use another means of communication to contact the Practice. The Practice will not be liable to you for any damages caused by a delay in responding to you as a result of technical failures.

Miscellaneous

No Assignment No Participant may assign any participant right in this Agreement.

Faxed or Emailed Signatures Your signature the Practice receives by fax or email will have the same effect as an original signature.

Entire Agreement; Amendment; Severance & Enforceability This Agreement is the only agreement between you and the Practice concerning its subject matter and there are no other promises, representations or agreements between us concerning such subject matter. Except as otherwise provided above, this Agreement may be modified or amended only in a written document you and the Practice sign. Any unenforceable provision of this Agreement will be modified to the extent necessary to make it enforceable or, if that is not possible, will be severed from this Agreement, and the remainder of this Agreement will be enforced to the fullest extent possible.

Jurisdiction and Choice of Law This Agreement will be interpreted and enforced under Colorado law. The forum for any litigation arising from this Agreement will be in the State courts in Denver, Colorado.

Mediation-Arbitration Provision You and the Practice each has the option to submit any dispute arising under this Agreement, including about any of the Services, to mediation under the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation. If any dispute is not resolved by mediation within 90 days after mediation begins, either party may submit the dispute to arbitration in Denver, Colorado, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration. The same person may not serve both as the mediator and the arbitrator.

Other Dispute Resolution The Practice may assign over any amounts owed under this Agreement to a collection agency and/or hire legal counsel to pursue a collection action. The Participant shall be liable for all expenses and costs arising from the collection process, including but not limited to attorneys' fees and other costs, which shall be added to any final judgment or award received from the collection action.

Participant's Acknowledgments By signing this Agreement, you acknowledge that neither Dr. Lutz nor Dr. Griffith has used coercion or exercised undue influence to induce you to participate in the Practice, you have had ample time to consider your options, and you are not suffering from any urgent or emergency medical condition that might cause you to sign this Agreement against your better judgment. THE PARTICIPANT SPECIFICALLY ACKNOWLEDGES THAT THE PARTICIPANT HAS READ THIS AGREEMENT, THAT THE PARTICIPANT HAS BEEN ADVISED TO CONSULT WITH AN ATTORNEY BEFORE SIGNING THIS AGREEMENT, AND THAT THE PARTICIPANT UNDERSTANDS ALL OF ITS TERMS AND EXECUTES IT VOLUNTARILY WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE AND THE CONSEQUENCES THEREOF.

_____

Participant's Printed Name

_____

Signature

_____

Date

Concierge Medical Care, LLC

SUPPLEMENT TO PARTICIPANT AGREEMENT

As a Participant in the Practice, in return for the Participation Fee and your other obligations under the Participant Agreement, you will be entitled to receive the following medical services and nonmedical amenities from Concierge Medical Care, LLC, subject to the limitations detailed below:

Medical Services

- Annual comprehensive physical including risk-factor assessment and wellness planning
- Thorough office visits
- Care coordination with other doctors
- Disease prevention counseling
- Diagnosis and management of acute and chronic medical problems
- Routine vaccinations
- Diagnostic tests performed in the office (e.g. EKG, spirometry)

Non-Medical Amenities

- Exceptional, individualized care in an unhurried, patient-centered practice
- Same day or next day appointments: Monday – Friday usually within 24 hours of the patient's call
- Minimal time in waiting room
- E-mail and cell phone access to Dr. Lutz & Dr. Griffith

Services NOT Covered by the Participation Fee

- Non-routine inoculations, vaccinations or other injections
- Surgeries
- Obstetrical care
- Treatment of broken bones
- Treatment of cuts requiring stitches
- Diagnostic test not normally administered by Dr. Lutz or Dr. Griffith
- Services not typically rendered by Internal Medicine specialists
- Prescription medications
- Treatment by providers other than Dr. Lutz, Dr. Griffith or employees of the Practice

Direct Access to Dr. Lutz and Dr. Griffith

Direct access to the doctors via office or cell phone 24 hours per day/7 days per week, except when a doctor is on vacation, personal leave or attending continuing medical education courses. During those times, a suitable substitute will cover the Practice. Direct e-mail access to the doctors is for **non-emergency** purposes. The Practice will attempt to answer all such e-mails within 2 days.