Membership Contract

Dear Patient:

Personalized Primary Care Atlanta, LLC ("PPC Atlanta") is committed to delivering high quality healthcare services to each and every patient. PPC Atlanta treats 70% to 90% fewer patients per doctor than the average primary care practice. This lower patient to doctor ratio allows us to be more responsive to your healthcare needs both during and between office visits.

PPC Atlanta appreciates that patients may desire to purchase service amenities above and beyond what is covered by health insurance and managed care programs. In response to this need we are pleased to provide you care to complement your healthcare services. If you would like to join our practice please review our Program Agreement ("Agreement") outlined below and provide your signature in the space provided.

Sincerely,

Juliet K. Mavromatis, MD FACP
Director

Patient Name: _____ **Date:** _____

I am requesting services by Personalized Primary Care Atlanta and agree to the following terms and conditions:

Personalized Primary Care Atlanta

The Program's Annual Fee includes these enhanced service amenities that complement traditional healthcare services:

- Annual Comprehensive Health Assessment with Extended Laboratory Preventive Screening.
- Extended office visits (20-50 minutes)
- Improved care coordination of subspecialty care, chronic illness care and inpatient (hospital) to outpatient (office-based) care
- Direct cell phone access to your physician
- E-mail access to your physician

- Easy appointment scheduling--usually same or next business day
- Reduced office wait times
- Use of up-to-date technology to support high quality care delivery

Annual Comprehensive Health Assessment[1]

An annual comprehensive health assessment allows us to review your medical history, family history, lifestyle factors, and physical exam findings that contribute to your health profile and make recommendations for health promotion and the prevention of future illness. At this visit we will review current prevention and disease management guidelines as they relate to you personally, and make recommendations.

Extended Laboratory Preventive Screening

- Complete lipid profile
- CBC
- Electrolytes
- Liver Function
- Kidney Function
- Glucose
- Hemoglobin A1C (blood sugar testing)
- Ferritin
- Vitamin B12
- Vitamin D
- Uric Acid
- PSA (as guided by risk and individual counseling)
- Thyroid function test
- Hs-CRP test (test of "inflammation")
- EKG (baseline at 40 and then as guided by health risk)
- Urinalysis

Should you require hospital admission, hospital care will be delivered by a designated hospital medicine specialist, with involvement and help with transition care coordination by Dr. Mavromatis. During Dr. Mavromatis' periodic time off from work for professional meetings or vacation, she will carefully arrange coverage for you to be seen by one of several excellent local physicians.

Annual Membership Fee[2]:

I understand and agree to pay the Annual Fee selected below for membership in Personalized Primary Care Atlanta medical practice.

Individual Membership

☐ $1,000 per year per individual

☐ $1,100 per year per individual (Quarterly Plan)

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[1] PPC Atlanta is committed to remaining in compliance with Medicare. Should Medicare coverage change in the future years to include services covered in our annual fee, PPC Atlanta will deduct the cost of the covered service at the contractual rate.

[2] Annual fee payment is due on enrollment and may be made by credit card or check made payable to Personalized Primary Care LLC. Quarterly payments are by credit card . You must pre-authorize a credit card charge for the second payment at time of enrollment in Program.

Family Membership (2 or more first degree family members)[3]
□$900 per year per member
□$990 per year per member (Quarterly Plan)

Payment Options:
Annual payment in full at the time of enrollment with annual renewal is our preference.

A quarterly payment plan is available for those who prefer this option at $275 per quarter. A minimum commitment of one quarter (excluding the Annual Comprehensive Health Assessment) or two quarters (including the Annual Comprehensive Health Assessment) is required. Quarterly payments are by credit card only.

Refunds
Refunds will be prorated at a rate of $83.33 per month (or $91.67 per month under the quarterly plan) to the nearest month of enrollment with minimum commitments as noted: three month minimum ($275) before your Comprehensive Annual Health Assessment and six month minimum ($550) after your Comprehensive Annual Health Assessment.

Renewals and Termination: The term of this Agreement shall be one (1) year from the Effective Date and shall automatically renew for every one (1) year period thereafter unless either party gives written notice of termination of the agreement 30 days prior to the anniversary date of the Agreement. I understand that failure to pay renewal of the annual membership fee prior to the anniversary of the Effective Date may result in termination of my membership in PPC Atlanta.[4] I understand that failure to make timely quarterly payment of my membership fee may result in termination of my membership in PPC Atlanta.[5]

Terms and Exclusions:
I understand that the Annual Membership Fee payable to PPC Atlanta strictly covers healthcare services that are not consistently reimbursed or offered through the Medicare, Medicaid and third-party payors (health insurance) programs. As such, PPC Atlanta will not seek reimbursement for services provided as part of my Annual Membership Fee from Medicare, Medicaid, or any other third-party payer. I understand that I am solely financially responsible for payment of my Annual Membership Fee and that this fee is not reimbursable by my private insurance carrier, Medicare or Medicaid. However, the fees for my annual membership fee may be submitted to my health savings account

[3] First degree family members include spouse or domestic partner, parent, sibling or child
[4] If terminating from the program you must sign a HIPAA compliant request to have your records transferred to your new physician. One copy of your records will be provided to your physician at no charge. Any additional copies of your records will be charged for at then current rates.
[5] Failure to renew or to make quarterly payment in a timely fashion will be taken as your decision to immediately establish yourself with a new physician. Dr. Mavromatis will provide emergency care only for 30 days after your termination from the program. After this time Dr. Mavromatis will no longer be responsible for any aspect of your medical care and you should see your new physician for all medical issues. You and/or your insurance company as the case may be, will be responsible for any charges incurred for emergency care provided during this time.

(HSA), medical savings account (MSA) or flexible benefits account (FBA) for reimbursement.

I understand that I, or my insurance company, am responsible for all healthcare services that are traditionally covered by a health insurance program. These services exclude the services that are provided under my Annual Membership Fee. Regardless of health coverage, I understand that all co-payment, co-insurance and/or deductibles will apply as defined by my insurance policy. PPC Atlanta will bill my Payor for those services. In the event that the services are not covered by my Payor I understand that I am responsible for payment.

Non-Participating Provider: Our practice is pleased to work with you as you navigate the complexity of health insurance. We will do our best to answer your questions and are available to help you sort through health insurance plans as you evaluate what works best for you and your family. However, if your health insurance does not participate with PPC Atlanta we will be unable to file your insurance claims using these carriers. Under such circumstance you will be responsible for an office visit charge and may submit on your own for out-of-network reimbursement. PPC Atlanta will make our list of office visit charges and laboratory fees transparent and competitive for consumers.

A list of health plans that PPC Atlanta participates with will be available on our website. However, patients are encouraged to confirm participation prior to enrollment.

E-mail Communications/Privacy: I acknowledge that traditional e-mail is not a secure way for sending or receiving personal health information. If I choose to send confidential personal health information by non-secure e-mail, I authorize Dr. Mavromatis or the Practice to reply with personally identifiable protected health information. Dr. Mavromatis will have sole discretion as to whether or not to reply to any e-mail communication and whether or not to open e-mail attachments. I understand that e-mails may become part of my medical record. I will not use e-mail to: seek an urgent appointment, ask questions about an urgent issue, or for any other time sensitive issue. If I have time sensitive issues I will contact Dr. Mavromatis or the Practice directly by telephone or in person in the office. **Patient's initials_____**

Entire Agreement: This Agreement constitutes the entire understanding of the parties with respect to the subject matter outlined in this Agreement. The undersigned agrees to the terms and conditions of this agreement and acknowledges there are no promises or representations except as specifically listed in this Agreement.

Notices: Notice from one party to the other shall be in writing and shall be deemed to have been duly given when delivered in person or sent via U. S. mail to the addresses listed in this Agreement.

Governing Law: This Agreement shall be governed by and constructed in accordance with the laws of the State of Georgia.

This Membership Contract is entered into as of the _____ day of _____, and is effective as of the _____ day of _____ between you, the undersigned Patient ("You"), and Personalized Primary Care Atlanta LLC (the "Practice") under

which the Practice will make certain medical and supportive services available to you which are not otherwise covered by commercial insurance, managed care, Medicare and other third party payers. By voluntarily entering into this Agreement and remitting the Annual Retainer Fee (as set forth below), you may participate in the Practice's Personalized Primary Care Program (the "Program") for a period of twelve (12) months beginning on the Effective Date.

I, _____, agree to the terms and conditions herein.
Patient Printed Name

I, further, acknowledge I understand the "Program," that this is not an insurance product, and that I have been advised I will need to continue my own health insurance. I have read and agree to the terms of the Practice's payment policies.

_____ _____
Patient Signature Date

_____ _____
Juliet Mavromatis, MD Date