INTEGRATIVE CARE PROGRAM

Annual Enrollment Agreement

This Patient Agreement ("Agreement") is made and entered into as of the date set forth below ("Commencement Date"), by and between the patient(s) signing below ("Patient"), and William F. Corell, M.D. ("Physician").

The Patient identified below desires unique services and benefits (the "Integrative Care Program") to be provided by Physician that are not covered or otherwise not reimbursable under a private health insurance policy, private health plan, or government program in which Patient is enrolled.

Patient and Physician agree, as of the Commencement Date and upon payment for such services by the Patient, to enter into a contractual relationship for the following services and benefits under the following terms and conditions:

BENEFITS AND SERVICES

In addition to items covered by insurance and expected of any physician, Physician agrees to provide to Patient:

35 years' expertise in Integrative, Holistic, and Functional Medicine; Board Certified in Longevity Medicine

- Access to cutting edge diagnostic and treatment modalities not available through conventional medical offices
- Specialty alternative laboratory test kits on site
- Professional quality nutritional supplements available for purchase in the office and online
- Commitment to personalized care with an emphasis on wellness, healthy aging, disease prevention, and early detection of disease
- In-depth consultations, with enough time available to explore the underlying *causes* of health problems rather than simply treating the symptoms
- Direct communication with the office including telephone and email access during office hours, with emergency on-call phone service as needed
- Timely appointments with our health care providers
- Co-ordination of specialty referrals
- Telephone, skype, and email consultations available with patients and family members (an additional fee may apply)

FEE

Patient has financial responsibility to pay for medical services that are provided at regular office visits that are not part of the Integrative Care Program. The Practice will assist Patient in billing Patient's insurance for services performed, but Patient shall remain financially responsible for all charges incurred, including applicable deductibles, co-payments, and coinsurance.

In consideration of the applicable Integrative Care Program Benefits and Services, Patient agrees to pay to Physician a nonrefundable annual fee, payable in advance, according to the following schedule:

- Individuals pay $240/year (an average of $20/month) for services not covered by your insurance or co-pay/coinsurance; alternatively, you may prepay $70 per quarter when set up on a pre-approved quarterly payment program
- Families (e.g. 1-2 adults and their child or children) pay $456/year (an average of $38/month), or $125 per quarter
- You save 10 to 16% discount when paying on a yearly basis
- For Patients/families receiving 3 or more IV Therapy treatments per patient per quarter, their fee will be waived
- Medicare patients' fee will be 50% of the above
- Your Annual Fee does not cover your co-pay, coinsurance, or deductible that you will owe

PATIENT ACKNOWLEDGMENTS AND CONDITIONS OF PARTICIPATION

Patient acknowledges and understands that Integrative Care Program Benefits and Services are unique and are provided with certain specific limitations and conditions, as follows:

The applicable Integrative Care Program Benefits and Services are not covered and otherwise not reimbursable under any private health insurance policy, private health plan or government program in which Patient is enrolled. Accordingly, Patient understands and acknowledges that Integrative Care Program Benefits and Services convey value and benefits that Patient does not already receive under any private health insurance policy, private health plan or government program in which Patient is enrolled. To the extent any one or more Services listed above are considered covered and reimbursable benefits, the Annual Enrollment Fee is in consideration for the remaining items, which shall be deemed the applicable Integrative Care Program Benefits and Services. The list of Integrative Care Program Benefits and Services may be amended or modified to the extent necessary to reflect any change in interpretation or terms of coverage and benefits of any private health insurance policy, private health plan or government program.

Physician may also provide service(s) to Patient that are covered or reimbursable from a private health insurance policy, private health plan or government program in which Patient is enrolled. In such case, Physician may assist in billing and seek reimbursement from patient's private health insurance policy or private health plan under the terms and conditions of Patient's enrollment agreement with such payor(s). Physician may also seek reimbursement from Patient as permitted under Patient's enrollment agreement with such payor(s) *(e.g.*, deductible, coinsurance or co-pays). Patient understands and acknowledges that any covered and reimbursable services are separate and distinct from and independent of the applicable Integrative Care Program Benefits and Services provided herein.

TERM

This Agreement shall automatically expire at the end of the existing Term unless Patient renews the Agreement and pays the Annual Fee for the next Term. Upon expiration of this Agreement, Practice will transfer Patient's medical records and continuing care to any physician requested by Patient with written notice. If Patient chooses not to accept or renew the Agreement, Physician will continue Patient care for 30 days for emergency purposes.

By signing below, Patient and Physician represent that they fully understand and freely covenant to accept the rights and obligations under this Patient Enrollment Agreement.

Commencement Date _____

End of Term _____

(Please complete and sign page 4 if you request a quarterly payment plan.)

PATIENT

Signature: _____ Date: _____

Printed Name: _____

For family enrollment, please list family members: _____

_____

NOTICE OF ACCEPTANCE:

Physician acknowledges receipt of this agreement and application to become an Integrative Care Patient.

_____

William F. Corell, MD

QUARTERLY PAYMENT AGREEMENT

I have reviewed and signed the Annual Enrollment Agreement for the Integrative Care Program offered by Integrative Medicine Associates. I understand that this is an annual agreement and that I will be personally responsible for the entire annual enrollment fee. I have requested to pay this fee on a quarterly basis and I agree to make four payments as scheduled below. I understand that each payment is due by the date indicated, and that my continued participation in the Integrative Care Program is dependent upon receipt of payment by due date. I understand that I will no longer be able to receive care at Integrative Medicine Associates if payment is not received. In that case, I will be assisted in transferring to another physician and patient records will be provided at a nominal charge.

1st Quarter:	Payment due _____
2nd Quarter:	Payment due _____
3rd Quarter:	Payment due _____
4th Quarter:	Payment due _____

I have reviewed and agree to all of the above.

Name:_____

Signature:_____

Date:_____