FLATIRON FAMILY MEDICAL | An Integrative Health & Healing Partnership

PROGRAM AGREEMENT

This Program Agreement (this "Agreement") is entered into and effective as of the ___ day of _____, 20__ (the "Effective Date"), between you, the undersigned Patient ("You"), and Flatiron Family Medical, P.C. (the "Practice"), under which the Practice will make certain health and wellness services, amenities and enhanced services available to you which are not otherwise covered by commercial insurance, managed care, Medicare and/or other third party payers. By voluntarily entering into this Agreement and remitting the Annual Program Fee (as set forth below), you may participate in the Practice's Concierge Medical Services Program (the "Program") for a period of twelve (12) months beginning on the Effective Date.

1. **The Program**. The Program's Annual Program Fee covers the following services and amenities provided by the Practice:

   - Communication access and physician availability after hours by telephone, cell phone and e-mail service [1]
   - Travel medical advice
   - Completion of school and work disability forms
   - Videoconferencing
   - Periodic health podcasts
   - Access to discounts on supplements through the Practice's website
   - Enhanced appointment availability (usually the same business day, but no later than the next business day)
   - Personal appointment reminder

   Other service amenities may be offered from time to time in the sole discretion of the Practice and these may be subject to limitations.

2. **Annual Program Fee**.[2]

   Individual: $900 per year.

   First Family Member or Registered Domestic Partner: $900 per year.

   Second Family Member or Registered Domestic Partner: $900 per year.

   Third and Fourth Family Members: $300 per person.

   Fifth Family Member and beyond is free.

You may elect to pay the Annual Program Fee on an annual or on a monthly basis in advance of each month. If you elect to pay on a monthly basis, each fee installment will be paid on the first day of each month as set forth in footnote 2 at the end of this Agreement.

3. **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 nonrenewal at least thirty (30) days prior to the anniversary date of the Agreement. The terms and conditions of this Agreement may be changed with written notification to You. The Practice reserves the right to change the Annual Program Fee at any renewal date of this Agreement, by giving you at least thirty (30) days' advance written notice. Failure to pay the Annual Program Fee (or any monthly installment if You are paying monthly) in a timely manner may result in termination of this Agreement and your membership in the Program.[3] Either You or the Practice may terminate this Agreement with thirty (30) days written notice to the other party. If this Agreement is terminated after you have paid the Annual Program Fee in full, the Annual Program Fee is refundable on a prorated basis.[4]

4. **Medical Care Services Excluded From Annual Program Fee**. Neither the Practice nor any of its physicians will seek reimbursement for the Annual Program Fee from any insurer, Medicare or other third-party payer for services provided that are included in the Annual Program Fee. You are solely financially responsible for payment of the Annual Program Fee and agree not to submit the Annual Program Fee to Medicare or your private insurance carrier, except for reimbursement from your health savings account ("HSA"), medical savings account ("MSA") or Flexible Benefits Account ("FBA") to the extent any such programs provide for reimbursement for the Program. The Practice makes no representation that reimbursement for the Program is allowed under an HSA, MSA or FBA. You shall be responsible for payment of the full Annual Program Fee if You pay by a credit card that is linked to an HSA, MSA or FBA and the payment is disallowed. You and/or your insurer shall be financially liable for all covered services provided by the Practice, its physicians and/or its physician assistants and You or your insurer, as the case may be, will be billed for these covered services.

5. **Co-Payments**. You remain financially responsible for all co-payments, coinsurance and/or deductibles as defined by the terms of your insurance coverage for provision of covered services.

6. **Non-Participating Provider**. If You have insurance with which the Practice and/or its physicians do not participate, the Practice will file a claim with your insurance company as a courtesy only with respect to covered services that are provided. Under such circumstances, You will be responsible for an office visit charge.

7. **E-Mail Communications/Privacy**. You acknowledge that traditional e-mail is not a secure way for sending or receiving personal health information. If You choose to send confidential personal health information by non-secure e-mail, You specifically authorize the Practice and/or its physicians to reply with personally identifiable protected health information. The Practice's physicians 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. E-mails may become part of your medical record. You also acknowledge You will not use e-mail regarding emergencies, to seek an urgent appointment or ask questions about an urgent issue, or for any other time sensitive issue. If You have an emergency, an urgent issue or other time sensitive issue, You must contact the Practice by telephone or in person at the Practice's office. If You do not receive a response to your e-mail within two (2) business days, You will use another means of communication to contact the Practice or your physician. Neither the Practice nor your physician shall be liable to you for any loss, cost, injury, or expense caused by, or resulting from: (a) a delay in responding to You as a result of technical failures, including, but not limited to, technical failures attributable to any internet service provider, power outages, failure of any electronic messaging software, failure to properly address e-mail messages, failure of the Practice's computers or computer network, or faulty telephone or cable data transmission; (b) any interception of e-mail communications by a third party; or (c) Your failure to comply with the guidelines regarding use of e-mail communications set forth in this Section. The Practice may, but is not obligated to, keep copies of e-mail messages that You send to your physician or your physician send to You.

8. **Change of Law**. If there is a change of any law, regulation, rule, or third party payor policy which affects this Agreement or the activities of either party under this Agreement, or any change in the judicial or administrative interpretation of any such law, regulation, or rule, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights or obligations under this Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of this Agreement. If the parties are unable to reach an agreement concerning the modification of this Agreement within the earlier of thirty (30) days after the date of the notice seeking renegotiation or the effective date of the change, or if the change is effective immediately, then, notwithstanding anything contained in this Agreement to the contrary, either party may immediately terminate this Agreement by written notice to the other party.

9. **Amendments and Waivers**. Except as otherwise set forth in this Agreement, this Agreement may only be revoked, altered, amended or modified by the written agreement of both parties hereto. No waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any provision of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach of the same provision.

10. **Section Headings**. Any section, section title or caption contained in this Agreement is for convenience only and in no way defines, limits or describes the scope or intent of this Agreement or any of the provisions hereof.

11. **Invalid Provisions**. The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

12. **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.

13. **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.

14. **Governing Law**. This Agreement shall be governed by and construed in accordance with the laws of the State of New York.

[SIGNATURE PAGE FOLLOWS]

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SIGNATURE PAGE TO PROGRAM AGREEMENT

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

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

_____ _____
Patient Signature Date
Address:
Patient Email Address:
Patient Home Phone Number:
Patient Work Phone Number:
Patient Cell Phone Number:

Acknowledged and accepted by the Practice:

FLATIRON FAMIILY MEDICAL, P.C.

_____ _____
By: Date

[1] With reasonable exceptions, i.e., limited cell phone coverage/reception, low or dead batteries, electrical outages, physician availability due to vacation or other reasons, etc.

[2]Annual Program Fee payment is due on enrollment and may be made by credit card or check made payable to Flatiron Family Medical, P.C. If you pay the Annual Program Fee in full at the time of enrollment, or at the time of any automatic renewal of this Agreement, the Practice will discount the Annual Program Fee by an amount equal to one-twelfth (1/12) of the then applicable Annual Program Fee at the time of enrollment or any renewal). Monthly payments are by credit card, automatic bill payment or check. If you are paying the monthly payments by credit card or automatic bill payment, you must pre-authorize a credit card charge or an automatic bill payment from your bank account for the monthly payment at time of enrollment in the Program. The current monthly installment of the Annual Program Fee during the first (1st) year of your enrollment in the Program is $75 for individuals, and for first and second family members or registered domestic partners, and $25 for third and fourth family members.

[3] 1f 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.

[4]Your failure to renew in the Program will be taken as your decision to immediately establish yourself with a new physician.