

PRESERVE HEALTH MD
PATIENT MEMBERSHIP AGREEMENT

This is an Agreement entered into and to be effective the ___ day of _____ 20__ (the “**Effective Date**”), by and between the person signing below (the “**Member**” or “**You**”) and **ISPMD, LLC**, doing business as **PRESERVE HEALTH MD**, a Florida limited liability company (the “**Practice**”).

Recital

The Practice provides family medical services to patients, and employs Dr. Ira Pearlstine (the “**Physician**”) for the purpose of providing the services defined in this Agreement. You desire to receive, in exchange for a set, periodic fee, certain medical (“**Medical Services**”) and non-medical services (“**Non-Medical Services**”) (collectively the “**Services**”) from the Practice as part of and by virtue of this membership agreement. The purpose of this Agreement is to set forth the terms and conditions of how the Services will be furnished to you by the Practice. You and the Practice therefore agree as follows.

1. Payment. In exchange for the services provided for in this Agreement, you agree to pay the Practice the fee set forth on the attached Schedule A. Your election with respect to the payment of the periodic fee and the person(s) to whom this Agreement applies, are set forth on the attached Schedule A.

2. Medical Services. The Practice will provide you with the Medical Services described in this paragraph 2. As used in this Agreement, the term “Medical Services” means those medical services that the Physician himself is permitted to perform under the laws of the State of Florida and that are consistent with his training and experience as a family physician. The Medical Services will include minor office procedures, joint and trigger point injections, EKGs, and diagnostic and wellness exams. Medical Services shall specifically **EXCLUDE** obstetrical care, diagnostic tests not normally administered by the Physician, and other services not typically rendered by family physicians in their offices.

3. Non-Medical Services. The Practice will provide you with the following Non-Medical Services:

(a) 24/7 Access; After Hours Care. You will have direct telephone access to the Physician on a twenty-four hour per day, seven day per week basis. You will be given a phone number where you may reach the Physician directly around the clock. During the Physician’s absence for vacations, continuing medical education, illness, emergencies, or days off, the Practice will provide the services of a substitute physician, and you will be given instructions as to how to contact the substitute physician. The substitute physician will be available to you to the same extent as the Physician, although the substitute physician may be contacted through an answering service rather than directly.

Note: If you experience an emergency medical situation that is life-threatening or of a serious nature, you should NOT call the Physician but instead you should CALL 911 IMMEDIATELY.

(b) Facsimile, E-Mail, and Text Access. You will be given the Physician’s facsimile number, e-mail address, and cell phone number to which non-urgent

communications can be addressed. Such communications will be dealt with by the Physician or staff member of the Practice in a timely manner, including a reasonably prompt response to you by the Physician or by the staff member.

(c) Same Day/Next Day Appointments. If you call, fax, e-mail, or text the Physician prior to noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort will be made to schedule an appointment with the Physician on the same day. If you call, fax, e-mail, or text the Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort will be made to schedule an appointment with the Physician on the following normal office day. In any event, however, the Practice will make every reasonable effort to schedule an appointment for you on the same day that the request is made.

(d) No-Wait Appointments. You will be seen by the Physician immediately upon arriving for a scheduled office visit or after only a minimal wait in the Practice's lobby or waiting area.

(e) Home Visit. The Physician will visit you in your home, nursing or rehab facility, or Adult Congregate Living Facility in medically appropriate situations.

(f) Video Conferencing. At your request, the Physician will arrange video conferences to communicate and consult with you.

(g) Health Record Access; Appointments. The Practice maintains an on-line medical record system that will allow you to access your records and lab results around the clock, at your convenience. The on-line system will also allow you to schedule appointments with the Physician.

(h) Hospital Visits. When you are hospitalized, the Physician will make courtesy visits to hospitals where he has privileges.

The Physician may from time to time, due to emergency situations, like medical emergencies and natural disasters, not be available at the times referred to above, and you acknowledge such possibilities.

4. Effective Date, Term and Termination. This Agreement will commence on the Effective Date and will extend for one year thereafter, except that you or the Practice may terminate this Agreement upon thirty (30) days' written notice to the other party. Such notice of termination will not, however, in and of itself, be deemed a termination of the physician-patient relationship between the Practice and you. Upon termination of this Agreement, any fees paid in advance by you will be refunded on a prorated basis as of the effective date of the termination, subject to the provisions of Exhibit A, attached. Unless previously terminated as set forth above, at the expiration of the initial one year term (and each succeeding one year term), the Agreement will automatically renew for successive one year terms upon your payment of the required annual fee (or upon the payment of the first installment of the annual fee).

5. Non-Participation in Insurance and Medicare. You acknowledge that the Practice and the Physician do not participate in any health insurance or HMO plans or panels and have **opted out of Medicare**. Neither the Practice nor the Physician makes any representations

whatsoever that the fees paid under this Agreement are or are not covered by your health insurance or by other third party payment plans applicable to you or your family. You will have the full and complete responsibility for any such determination. **If you are eligible for Medicare, or during the term of this Agreement become eligible for Medicare, then you agree to sign the agreement attached as Schedule B.**

6. Arbitration of Disputes. You agree that any dispute or disagreement under this Agreement will be resolved as you and the Practice (or the Physician) may amicably agree, and if we cannot agree then in accordance with the rules and procedures of the American Arbitration Association then in effect in the State of Florida. The decision of the arbitrator will be binding on you and the Practice and may be reduced to judgment in the State of Florida.

7. Communications. You acknowledge that communications with the Physician using facsimile, e-mail, text, and cell phone are not guaranteed to be secure or confidential methods of communications. As such, you expressly waive the Physician's obligation to ensure confidentiality with respect to correspondence using such means of communication. You acknowledge that all such communications may become a part of your medical records.

You authorize the Physician to communicate with you by e-mail and text 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 your e-mail address and cell phone number shown on the attached Schedule A. By inserting your e-mail address, you acknowledge that:

(a) E-mail and text are not secure mediums for sending or receiving PHI and, in particular, if you send or receive e-mail through your employer's e-mail or cell phone system, the employer may have the right to review it;

(b) Although the Practice and the Physician will make reasonable efforts to keep e-mail and text communications confidential and secure, neither the Practice nor the Physician can assure or guarantee the confidentiality of e-mail and text communications;

(c) In the discretion of the Physician, e-mail and text communications may be made a part of your permanent medical record; and

(d) E-mail and text are not appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information.

If you do not receive a response to your e-mail message or text within two days, you agree to use another means of communication to contact the Physician. Neither the Practice nor the Physician will be liable to you for any loss, cost, injury or expense caused by, or resulting from a delay in responding to you as a result of technical failures, including, but not limited to, (i) technical failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, failure to properly address e-mail messages or texts, (iii) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail or text communications by a third party; or (v) your failure to comply with the guidelines regarding use of e-mail or text communications set forth in this paragraph.

8. Dependant Members. If you are signing for and on behalf of dependant Members, such dependant Members will be responsible under this Agreement as if they were adults on the date of this Agreement and had signed this Agreement. You, as the signing Member, agree to hold harmless and indemnify the Practice and the Physician for, from, and against any claims of the dependant Members based on or allowed by the fact that the dependant Members were minors on the date of this Agreement and/or did not sign this Agreement.

9. Insurance or Other Medical Coverage. This Agreement is not a substitute for health insurance or other health plan coverage. You acknowledge that the Physician has advised you to keep in full force your health insurance policy(ies) or plans in order to cover you and your family members for healthcare costs not within the definition of Medical Services under this Agreement and to prevent gaps in health coverage. You therefore agree to keep your current health insurance policy in force and effect throughout the term of this Agreement, or, if you do not currently have health insurance, you agree to obtain such insurance and keep the policy in force and effect throughout the term of this Agreement.

10. Amendment. No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all parties hereto. Notwithstanding the foregoing, the Physician may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation ("**Applicable Law**") by sending you 30 days' advance written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by the Physician, except that you shall initial any such change at the Physician's request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

11. Severability; Payment. If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

If for any reason this Agreement is held to be invalid for any reason, and if the Physician is therefore required to refund all or any portion of the fees paid by you, you shall pay to the Physician an amount equal to the reasonable value of the Services actually rendered to you and your family members during the period of time for which the refunded fees were paid.

12. Assignment. You may not assign this Agreement or any rights you may have under it.

13. Relationship of Parties. The Practice and you intend and agree that the Physician, in performing his duties under this Agreement, is an independent contractor, as defined by the guidelines promulgated by the United States Internal Revenue Service and/or the United States Department of Labor, and the Physician shall have exclusive control of his work and the manner in which it is performed.

14. Legal Significance. You acknowledge that this Agreement is a legal document and creates certain rights and responsibilities. You also acknowledge that you have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

15. Miscellaneous. This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted. Captions in this Agreement are used for convenience only and shall not limit, broaden, or qualify the text. This Agreement contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement. This Agreement shall be governed and construed under the laws of the State of Florida. The parties expressly waive their right to trial in any court. All written notices are deemed served if sent to the address of the party written above or appearing in Schedule A by first class U.S. mail.

The parties have signed duplicates of this Agreement on the date first written above.

ISPMD, LLC
d/b/a PRESERVE HEALTH MD

Member
_____, 20__

By _____
Ira Pearlstine, MD, President

Member
_____, 20__

Schedule A

Individual Membership:

-Adult: \$1,800 per year

-Age 17-26 and child of member: \$900 per year

Member's Name: _____ E-Mail Address: _____

Address: _____

Home Phone Number: _____ Fax Number: _____

Cell Phone: _____ Work Phone: _____

Member's Name: _____ E-Mail Address: _____

Address: _____

Home Phone Number: _____ Fax Number: _____

Cell Phone: _____ Work Phone: _____

Child Member #1: _____

Child Member #2: _____

Child Member #3: _____

Parent or guardian signature if child is under 18 years: _____

Payment Election:

____ I elect to pay annually. The entire payment is due in full at the signing of this Agreement.

____ I elect to pay semi-annually. The first six-month payment is due in full at the signing of this Agreement, and the second six-month payment is due six months later.

____ I elect to pay quarterly. The first quarter's payment is due in full upon signing the Agreement, with additional payments due every 90 days.

____ I elect to pay monthly, however, the first payment shall be equal to three months. At the end of three months, monthly payments shall then begin.

Upon termination of the Agreement under paragraph 4, any refund shall be based upon the difference between payments made for the contract year and the unused months of the contract year, less \$450 as a retainer fee.

Schedule B

Medicare Opt Out Agreement

This agreement (“**Agreement**”) is entered into by and between **ISPMD, LLC**, d/b/a **PRESERVE HEALTH MD**, a Florida limited liability company, and **IRA PEARLSTINE, MD** (the “**Physician**”), whose principal medical office is located at 561 Lake Whitney Place, Suite 104, Port St. Lucie, Florida 34986 and _____ a beneficiary enrolled in Medicare Part B (“**Beneficiary**”), who resides at _____, _____.

Introduction

The Balanced Budget Act of 1997 allows physicians to “opt out” of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, physicians are required to file an affidavit with each Medicare carrier that has jurisdiction over claims that they have filed (or that would have jurisdiction over claims had the physicians not opted out of Medicare). In essence, the physician must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided by the Physician to any Medicare beneficiary for two years.

This Agreement between Beneficiary and Physician is intended to be the contract physicians are required to have with Medicare beneficiaries when physicians opt-out of Medicare. This Agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

Physician Responsibilities

- (1) Physician agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.
- (2) Physician agrees not to submit any claims under the Medicare program for any items or services provided or furnished by him or her, even if such items or services are otherwise covered by Medicare.
- (3) Physician agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.
- (4) Physician agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Physician also agrees to retain a copy of this document for the duration of the opt-out period.
- (5) Physician agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS) upon the request of CMS.

Beneficiary Responsibilities

- (1) Beneficiary agrees to pay for all items or services furnished by Physician and understands that no reimbursement will be provided under the Medicare program for the items or services provided or furnished by the Physician.
- (2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Physician for such items or services.
- (3) Beneficiary agrees not to submit a claim to Medicare and not to ask Physician to submit a claim to Medicare for any items or services provided or furnished by the Physician.
- (4) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Physician that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
- (5) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other physicians or practitioners who have not opted out of Medicare.
- (6) Beneficiary understands that Medigap plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare.
- (7) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

Note: This Agreement covers items and services furnished by the Physician and does not affect other rights the Beneficiary may have under Medicare.

Medicare Exclusion Status of Physician

Beneficiary understands that Physician has not been excluded from participation under the Medicare program under section 1128, 1156, 1892, or any other sections of the Social Security Act.

Duration of the Contract

This contract becomes effective on _____, 20__ and will continue in effect until _____, 20__. Either party may terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

Successors and Assigns

The parties agree that this Agreement will be fully binding on their heirs, successors, and assigns.

Physician and Beneficiary intend to be legally bound by signing this Agreement on the date set forth below.

ISPMD, LLC, d/b/a PRESERVE HEALTH MD

By _____
Ira Pearlstine, MD

Ira Pearlstine, MD

Date Signed

Name of Beneficiary (printed)

Signature of Beneficiary

Date Signed



Acknowledgment of Notice of Privacy Practice

Preserve Health MD will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed *Notice of Privacy Practice* to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our office and have copies available for distribution.

I acknowledge that I have received a copy of the *Notice of Privacy Practice*.

Patient Signature _____ Date _____

Patient Name _____