Membership Agreement

This Cypress Affiliated Physician-Member Agreement ("Member Agreement") specifies the terms and conditions under which you, the undersigned member ("Member"), may participate in your Physician's ("Physician") Cypress Concierge Medicine Program ("Program") with the understanding that your Physician will provide the Services listed below but receives administrative, education and marketing services provided by Cypress Concierge Medicine, LLC ("Cypress"). This Agreement will become effective either on the date your Physician commences the Cypress Program or the date of your signature of this Agreement, whichever is later ("Effective Date").

1. Physician Services. Any and all Physician Services will be provided independently from any services covered by your Private or Medicare Health Insurance Plan ("Plan"). No Physician Services are offered as an alternative to any Plan covered services, and you will not be billed directly (except for any applicable co-payments or deductibles) for any services covered by Private or Medicare Health Insurance. As such, you acknowledge that any and all such medical services and/or amenities as described below, that are the subject of a private or additional membership patient fee, will be provided for Physician services or amenities that are not covered by any Private or Medicare Plan.

Your Physician will provide the following services ("Physician Services") beyond Plan benefits:

- After-hours, easy, direct communication with your Physician via his/her personal cell phone, related to health, diet, nutrition and fitness education not covered by your Plan;
- Same day/next day communication response by your Physician and/or his medical staff, but specifically excluding any electronic communication related to office visit scheduling or following-up on an office visit covered by Member's Plan;
- Prime appointment scheduling, unhurried visit times for routine, non-emergent or educational/consultative appointments;
- Education and consultation regarding individualized wellness plan and treatment strategies, not covered by any applicable Plan, compensating your Physician for expending additional time studying records and materials in a manner not covered nor reimbursed by your Plan;
- Consultation and education services regarding specialist referrals, not covered by any applicable Plan; and
- Assistance with data management in the Personal Health Records (PHR) platform (collectively "PHR Support") not covered Plan which can include: Tracking chronic medical conditions, Blood type, Emergency contact information, Results of most recent physical or wellness visit, Dates and results of tests and screenings, and Major illnesses and surgeries.

2. Physician. You understand and acknowledge that physicians participating in this Program may change from time to time and that, from time to time, certain physicians may not be able to accept new members due to patient volume limits. If your Physician is no longer available, either Cypress or your Physician will notify you of such unavailability and will refund your annual fee if you so desire, as explained in paragraph five below.

3. Relationship between Your Physician and Cypress. You understand and acknowledge that your Physician is an independent contractor, and not the agent, servant or employee of Cypress. You further agree and understand that Cypress does not, and will not, provide, supervise or control the care that you receive from your Physician. Rather, all Physician Services are furnished and directed solely by your Physician, who exercises his/her own medical judgment in his/her practice of medicine. Cypress is not responsible for the judgment or conduct of any Physician who renders services to you. In exchange for compensation paid by the Physician, Cypress provides administrative, education and marketing services to the Physician to facilitate the relationship between you and your Physician, and is responsible only for the periodic collection of fees. These services are provided by Cypress to the Physician under a separate and distinct agreement, not incorporated by this reference, and you are not a third-party beneficiary of that agreement.

4. Annual Membership Fee. Each Member will pay an annual fee ("Annual Fee") of $1,650 (One Thousand Six Hundred Fifty Dollars) to Cypress for all Physician Services described above. Discounts to the Membership Fee (I.E.; reduced Couples discount) may be provided and are up to the sole discretion of the physician.

5. Renewals and Termination. The Annual Fee covers a period of one (1) year (the "Term"). Failure to pay the renewal Annual Fee prior to the anniversary of the Effective Date shall result in termination of your membership in the Program (For example, if the Effective Date is January 1, then you must renew on or before December 31 of that same calendar year). Upon the receipt of the Agreement and the Annual Fee, your Physician shall have the option in his/her sole and absolute discretion, not to accept this Agreement and to return your payment to you (e.g. due to limitations in practice size). Unless otherwise terminated, this Agreement shall automatically renew for an additional one-year period upon the expiration of each Term and receipt of payment in accordance with established terms, unless Cypress and/or your Physician have been notified 30 days before your annual term date. Participation in the Program is personal to each individual accepted into the Program, and may not be assigned.

It is possible to terminate this agreement, if done so in writing, for reasons such as job loss, relocation, or deficiency of Physician Services provided as outlined in this agreement. Your termination request will be reviewed by Cypress and/or your Physician. Once approved, you will be entitled to a prorated refund of the Annual Fee. Your Physician also reserves the right to terminate your agreement or adjust annual membership fees at his discretion. If your physician decides to adjust his/her annual membership fee, you will be notified in writing with a minimum of 180 days advanced notice.

6. Medical Care Services Excluded from Annual Membership Fee. All Physician Services are offered beyond coverage of any Plan. All communications offered as part of the Physician Services do not include communications related to office visit scheduling or following-up on an office visit covered by Plan or for emergent medical needs. The Annual Fee specified herein covers only the defined Physician Services. Neither Cypress nor your Physician or his/her staff will seek reimbursement from any Plan or other third-party payer for the private pay Physician Services covered under this Agreement. Except for the Physician Services described above, you and/or your Plan as the case may be, will be financially responsible for paying for all healthcare and medical care services received by you from your Physician and his or her staff. Medicare, and any private Plan under which Physician is a network provider pursuant to a written Plan agreement, may be billed for services that are covered by such Plans.

7. Co-Payments/Deductibles. The Annual Fee does not affect the co-payments, co-insurance or deductibles that you may be required to pay for services that are covered by a Plan and that will be billed to a Plan You will continue to be financially responsible for any co-payments, co-insurance or deductible amounts required by your Plan. If you are Medicare-eligible, Medicare will be billed for Medicare covered services and you may be responsible for any applicable co-payments or deductibles triggered by billing Medicare.

8. Vacations and Illness for Your Physician. Your Physician will provide you with notice as soon as reasonably possible of his or her absence exceeding two (2) business days. Should your Physician be on vacation, or ill and unable to see you in a timely manner, you will be referred to another physician or facility. Related costs will be assessed separately from your Physician and are your sole responsibility.

9. Entire Agreement. The undersigned agrees to the terms of this Agreement, all of which are expressed herein. There are no promises or representations except as set forth herein.

10. Notices. Any communication required or permitted to be sent under this Agreement shall be in writing and sent via U.S. mail to the addresses set forth in this Agreement. Any change in address shall be communicated in accordance with the provisions of this section.

11. Billing. Initial payments are processed at the time of enrollment. Subsequent payments are charged quarterly, semi-annually or annually as elected by the Member.

12. Electronic Communications. You should be aware that sending email and/or text messages to your Physician through traditional messaging (personal email and cell phone) is generally an unsecure medium for sending or receiving potentially sensitive personal health information.

13. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State in which your Physician practices medicine.

Membership Application

Physician Name _____ ❑ **Single** ❑ **Couple** ❑ **Family**

First Name _____(M/F) Spouse First Name _____ (M/F)

Last Name_____ Spouse Last Name _ _____

Date of Birth _____ Spouse Date of Birth _ _____

Phone: Primary (_____) _____(h/c/w) Spouse Primary (_____) _____(h/c/w)

Phone: Alternate (_____) _____(h/c/w) Spouse Alternate (_____) _____(h/c/w)

E-mail Address _____

Street Address _____

City, State, Zip Code _____

Primary Insurance_____ **Secondary**_____

Dependent _____(M/F) Date of Birth _____

Dependent _____(M/F) Date of Birth _____

Dependent _____(M/F) Date of Birth _____

**Add'l Adult Member _____(M/F) Date of Birth _____

**Add'l Adult Member _____(M/F) Date of Birth _____

Primary Insurance _____ **Secondary**_____

Notes to Membership Services:

Referral Source:

This program may be eligible for reimbursement through some HSA's/FSA's, etc. It is the responsibility of the member to receive approval from their benefits coordinator as to the amount that may be reimbursable.

I agree to the terms and conditions set forth in and acknowledge receipt of a copy of the Cypress Affiliated Physician – Member Agreement. With the signature below I acknowledge that I am authorized to sign for all members listed above.

AUTHORIZED MEMBER'S SIGNATURE _____ Date _____

PAYMENT

❑ Annual Payment _____ ❑ Semi-Annual Payment _____ ❑ Quarterly Payment _____

After initial payment, the payment schedule will begin on _____ based on your payment of choice.

❑ Credit Card Payment (Please circle: Visa/MasterCard/Discover/AmEx)

Cardholder Name:	
Billing Address:	
Credit Card Number:	
Expiration Date:	Security Code:

I acknowledge receipt of a copy of this agreement and agree to the terms of the payment plan listed above. I further authorize Cypress Management Group to charge my credit card for the balance of the fees not paid and in accordance with the payment schedule selected.

AUTHORIZED MEMBER'S SIGNATURE _____ Date _____

CYPRESS' SIGNATURE _____ Date _____