BEYOND CONCIERGE MEDICAL CARE LLC

Dear Patient:

Welcome to Beyond Concierge Medical Care. We appreciate your choosing to become a member of our Concierge Program. By having a limited number of patients in my Concierge Program I will be better able to manage my patient's individual health and wellness issues.

My goal is to provide service BEYOND concierge.

Services. The Concierge Program will provide the following services ("Services"): but not limited to these services.

- Yearly 1 hour physical
- 1 hour appointment blocks
- Patient Portal
- Priority scheduling for consultants and testing
- Guaranteed 24-hour scheduling
- Email response within 24 hours
- No wait appointments
- 24/7 access for emergencies
- Courtesy calls for family
- Availability via telephone
- Coordination for specialist
- Accelerated hospital admission
- Arrangement of transfers
- Telemedicine visits wherever you are worldwide
- Customized doctor-patient interaction
- At home visits when necessary
- Telephone and text access
- In hospital visits
- Weight loss counseling and treatment

1. **Membership Fee**. The annual membership fee for each member is listed below. The Membership Fee is due in advance of your participation in the Concierge Program. You will have the right not to renew if you provide written notice to the Practice 30 days prior to the renewal date.

The Membership Fee covers the cost of physician access and does not cover the cost of any health care services. You, or your insurance company will be financially responsible for any health care services not included in the list of membership services.

MEMBER UNDERSTANDS THAT THIS AGREEMENT IS A SERVICE CONTRACT AND NOT A CONTRACT FOR INSURANCE.

The amount of the Annual Membership Fee is:

- Regular Membership: $6,000.00 or $416.66 per month
- Regular Spouse/Partner Membership $10,000.00 or $850 per month
- Seasonal Membership $4,500.00 or $1,125 quarterly
- Seasonal Spouse/Partner Membership $8,500.00 or $2,125 quarterly
- Add on 3rd member of same household
    - Regular Membership $3,000.00

Medical Care, LLC.

1. **Term**. The term of this Membership Agreement is one (1) year, commencing on ____________, 202__, and the Agreement will renew automatically at the then-current annual membership rate for an additional period of one (1) year unless you or I give the other party at least thirty (30) days' advance written notice of non-renewal. Either party may voluntarily terminate this Agreement by giving the other party at least thirty (30) days advance written notice of such termination. This Agreement will automatically terminate if you cease to be a patient of the Medical Practice. If this Agreement is terminated prior to your next annual renewal date, you will not be refunded any portion of the Membership Fee that you have paid up to the date of termination.

2. **Healthcare Services Excluded from the Membership Fee**. You understand and agree that the Membership Fee covers only the Services described in Section 1 above. Any medical services provided to you at or by the Medical Practice are excluded from this Agreement, and you (and/or your medical insurance, as applicable) will be responsible to pay for any such medical services. You understand that this Agreement is a membership contract for the Concierge Program only and is not a contract for insurance or the provision of medical services and is not a substitute for insurance or other health plan coverage. You acknowledge that you are not entitled to receive any medical services from the Concierge Program because of your execution of this Agreement. You acknowledge that the services arranged by the Concierge Program are not covered by insurance and are not reimbursable by your insurer or other health plan. You agree to bear the financial responsibility for the Membership Fee and agree to not submit to your insurer or other health plan any bill, invoice, or claim for payment or reimbursement of such Membership Fee.

3. **Email Communication**. You understand that although you will be provided with your physician's email address, email is not a secure medium for sending and/or receiving sensitive protected health information, and that we, therefore, strongly advise against using email for the purpose of directing questions to the physician regarding your health condition, treatment, etc. This means that we cannot protect your protected health information sent by email in the manner we would protect, for instance, your medical records. If you send email communications to and receive email responses from your physician or his or her staff or representatives, you must be aware that the confidentiality of such email communications cannot be assured or guaranteed. Once received by the Concierge Program, email communications that your physician deems appropriate may become part of your medical record. You should also remember that email is not a suitable medium for urgent or time-sensitive communications. In the event a communication is time-sensitive, you must communicate with the Concierge Program by telephone or in person. By signing this Membership Agreement, you acknowledge that you understand these important issues.

4. **Miscellaneous**. Any notice between you and the Concierge Program with respect to the terms of this Membership Agreement (such as renewal or cancellation notices) must be in writing and sent by mail or fax or hand-delivery. This Agreement may not be modified except in a written document executed by both parties. Any previous agreements or understandings (whether written or oral) between the parties regarding the subject matter hereof are merged into and superseded by this Agreement. You may not assign this Membership Agreement to anyone. If any of the provisions of this Membership Agreement are held to be invalid or unenforceable for any reason by any court, the remaining provisions hereof will not be affected thereby, and the provisions found invalid or unenforceable will be revised or interpreted to the extent permitted by law to uphold the

validity and enforceability of this Agreement and the intent of the parties expressed herein. This Membership Agreement shall be governed by and construed in accordance with the laws of the State of Florida. If there is a change of any state or federal law, regulation, or rule that 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 Membership Agreement. If the parties are unable to reach an agreement concerning the modification of this Membership Agreement within the earlier of forty-five (45) days after the date of the notice seeking renegotiation or the effective date of the change, or if the change is effective immediately, then either party may immediately terminate this Membership Agreement by written notice to the other party.

PHYSICIAN Dr Linda Lucombe MD is the designated Member's primary treating physician. Members understand that I may not be available due to illness or vacation or for other reasons and may designate a physician or licensed practitioner to attend the Member's medical needs from time to time.

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Please contact us with any questions or concerns that you may have regarding this Agreement. If you wish to become a member of our Concierge Program, please sign below, and complete and sign the attached Member Information and Signature Sheet. Please return this signed

Membership Agreement, the completed Member Information and Signature Sheet.

Sincerely,

Linda P Lucombe MD

AGREED TO AND ACCEPTED
THIS ____DAY OF ____________, 202__.

____
Patient Signature

____
Print Patient Name

MEMBER INFORMATION AND SIGNATURE SHEET

MEMBER INFORMATION:

Member Name: ____

SS#: ________________________________Date of Birth: ___________________

Address: ____

City: ________________________State: ________________Zip: _______________

Phone: Home (____)_____________________Cell (___)_______________________

Work (____)__________________ E-Mail: __________________________________

BILLING INFORMATION:

Annual membership fee will be paid: _____Annually ____Every 6 mos. ____Every 3 mos. (quarterly only available for recurring credit card charge) or monthly.

Please make checks payable to: Beyond Concierge Medical Care LLC

Credit card: VISA ___ MasterCard ______ AmEx _____ Discover_____
Do you wish to use this card for future renewals, payment installations? (required if choosing quarterly payment option) YES_______NO________

Card number: ____________________________

Expiration date: ___________________________

Billing zip code: __________________________

Name on card: ____________________________

Approval signature: ____________________________________
(by signing, you are approving the above-listed charges to be made to your credit card)