DESERT MOBILE MEDICAL, PLLC

PATIENT AGREEMENT

This is an Agreement entered into on ____________, between Desert Mobile Medical, PLLC (Practice, Us or We), and ____ (Patient, Member or You).

Background

The Practice, located at 10255 E. Via Linda Suite 1091 Scottsdale, Arizona 85258, provides ongoing primary care services to its patients/members in a direct primary care practice model (DPC). In exchange for certain periodic fees the Practice agrees to provide the Patient with certain Services under the terms and conditions contained in this Agreement.

State Required Notice

Desert Mobile Medical, PLLC, is not an insurance company, and this Direct Primary Care (DPC) Agreement (Agreement) is not an insurance policy. Your participation in Desert Mobile Medical, PLLC, and your subscription to any of its documents should not be considered to be a health insurance policy. Regardless of your membership in the DPC Practice, You are always responsible for paying any additional health care expenses you may incur. If you have health insurance, it may include, at no additional charge, some of the preventive services which are also included in this Agreement. We may not bill your insurance for services provided to you under this Agreement. Therefore, we will not bill *any* insurance plan or prepare invoices for Patient's to submit for reimbursement.

Definitions

1. **Services**. In this Agreement, "Services" means the collection of medical and non-medical services provided to the Patient by the Practice under this Agreement, and which are described in Appendix A, which is attached and incorporated into this Agreement.

2. **Patient**. In this Agreement, "Patient" "Member" "You" or "Yours" means the person/s for whom the Physician shall provide care; who has signed this Agreement and/or whose name/s appear on the Patient Enrollment form which is attached as Appendix B, and incorporated by reference.

Agreement

3. **Term**. This Agreement will last for one year, starting on the date it is executed by both parties.

4. **Renewal.** The Agreement will automatically renew each year on the anniversary date of the Agreement unless either party cancels the Agreement by giving 30 days written notice of intent to terminate.

5. **Termination.** Either party can end this Agreement by giving 30 days written notice to the other, of intent to terminate. The Practice may not terminate this agreement based on discriminatory factors such as gender, race and religion, nor solely based on the health status of the Patient.

6. **Payment.**
   - **a.** In exchange for the provision of the ongoing Services described in Appendix A, the Patient agrees to pay the Practice a monthly periodic fee in the amount that appears in Appendix C (attached and incorporated by reference). Such periodic fee shall be due and payable on the first day of each month.

   - **b.** In addition, and upon execution of this Agreement, Patient agrees to pay a one-time, non-refundable enrollment fee as described in Exhibit C, as well as the above described periodic fee which shall be prorated to the first of the month.

   - **c.** The Parties agree that the required method of payment shall be electronic payment through a debit or credit card, or automatic bank draft.

   - **d.** The Patient is responsible for all costs/fees associated with procedures, medical imaging (radiology), laboratory testing, specimen analysis, supplies, medications, and any other service not personally provided by the Practice staff and/or not listed in Appendix A. The patient is free to use their health insurance for third party vendor services if applicable and accepted by the third party vendors.

   - **e.** Patient shall be advised in advance of treatment of any additional fees or costs and may choose to obtain such optional services elsewhere. But if patient chooses to receive such services from the Practice, payment of additional fees shall be due at the time of service and billed at the same time as the monthly periodic fee.

7. **Early Termination.**
   - **a.** If the Practice cancels this Agreement before its termination date, We will refund the unused portion of the Patient's monthly fee on a per diem basis.
   - **b.** If the Patient cancels this Agreement before its termination date, the Practice will review and settle the Patient's account as follows:
     - **i.** The Practice will refund the unused portion of Patient's fees on a per diem basis; or
     - **ii.** If the fair market value of the Services received during the term, but before the Patient canceled the Agreement is more than the total amount paid in membership fees during the term, the Patient agrees to reimburse the Practice in the amount of the difference. The Parties agree that the fair market value of Services is equal to the Practice's usual and customary fee-for-service charges for the

services received. A copy of these fees is available on request

8. **Medicare.** By placing Your initials at the bottom of this clause in the space provided, You acknowledge that You understand and agree that the Physician has opted out of Medicare and that Medicare cannot be billed for any services personally performed or provided to the You by the Physician or the Practice. *You agree not to directly or indirectly submit charges to Medicare or attempt to obtain Medicare reimbursement for any such services.* If You are eligible for Medicare, or become eligible during the term of this Agreement, You agree to sign the Medicare Opt Out and Waiver Agreement attached as Appendix D. You further agree to sign and renew the Medicare Opt Out and Waiver Agreement every two years, or as required by law. **____________(Initial)**

9. **This Is Not Health Insurance**. Your initials on this clause of the Agreement acknowledge Your understanding that this Agreement is not an insurance plan or a substitute for health insurance nor a replacement for any existing health insurance or health plan coverage that You may carry. This Agreement does not include hospital services, or any services not personally provided by the Practice or its staff. You acknowledge that We have advised You to obtain or continue in full force, health insurance that will cover You for healthcare services not personally delivered by the Practice, including but not limited to specialist care and for hospitalizations and catastrophic medical events. **____________(Initial)**

10. **No Submission of Claims to Third Parties.** Neither the Practice, nor its Staff, participates in any health insurance or HMO plans. Furthermore, as a DPC practice, We may not submit a claim for payment to any third party payor (such as insurance plans), for any services We provide to You. Neither can we provide you with a receipt or invoice reflecting charges for individual services because we are not a fee for service model. It is Your responsibility to ascertain whether any fees paid under this Agreement are reimbursable through an HSA, FSA or other spending account.

11. **Communications**. The Practice endeavors to provide Patients with the convenience of a wide variety of electronic communication options. And although We are careful to comply with patient confidentiality requirements, and make every attempt to protect Your privacy, communications by email, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed to be secure or confidential methods of communications. By placing your initials at the end of this Clause, You understand and acknowledge the above and You agree that by initiating the clause, and participating in the above means of communication, you expressly waive any guarantee of absolute confidentiality with respect to their use. You further understand that participation in the above means of communication is not a condition of membership in this Practice, that you are not required to initial this clause, and that you a have the option to decline any particular means of communication. **____________ (Initial)**

12. **Email and Text Usage.** By providing an e-mail address on the attached Appendix B, the Patient authorizes the Practice and its staff to communicate with him/her by e-mail regarding

the Patient's "protected health information" (PHI).[1] *By providing cell phone number on Appendix B and clicking next to the "YES" on the corresponding consent question, patient consents to text message communication containing PHI through the number provided.* Patient further acknowledges that:

a. Email and text message are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access;
b. Although the Practice and its staff shall make all reasonable efforts to keep email and text communications confidential and secure, We cannot assure or guarantee the absolute confidentiality of these communications;
c. You also understand and agree that email and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information. **In an emergency, or a situation in which could reasonably be expected to develop into an emergency, You understand and agree to call 911 or go to the nearest emergency room, and follow the directions of emergency personnel.**
d. You agree that email and text messaging are not appropriate means of communication in situations requiring a quick response. You further agree that if you use these methods, and do not receive a timely response you will contact the Physician or other staff by telephone. *By placing your initials where indicated at the end of this clause, you verify that you understand and agree to its statements and terms.* ____________ **(Initial)**

13. Technical Failure. Neither the Practice, nor its staff shall be liable for any loss, injury, or expense arising from a delay in responding to Patient when that delay is caused by technical failure. Examples of technical failures:

i. failures caused by an internet or cell phone service provider;
ii. power outages;
iii. failure of electronic messaging software, or e-mail provider;
iv. failure of the Practice's computers or computer network, or faulty telephone or cable data transmission;
v. any interception of e-mail communications by a third party which is unauthorized by the Practice; or
vi. Patient's failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

14. Physician Absence. From time to time, due to vacations, illness, or personal emergency, the Physician may be temporarily unavailable. When times of absences are known in advance, the Practice shall give notice to Patients so that they can schedule non-urgent care accordingly. During unexpected absences, Patients with scheduled appointments shall be rescheduled at the Patient's convenience. In the case of an acute illness requiring immediate attention, Patient should proceed to an urgent care or other suitable facility for care. Charges from Urgent Care and any other outside provider are not included under this agreement and are the Patient's responsibility.

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[1] As that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations.

15. **Dispute Resolution**. Each Party agrees not to make any inaccurate, or untrue and disparaging statements, oral, written, or electronic, about the other. We strive to deliver only the best of personalized patient care to every Member, but occasionally misunderstandings arise. We welcome sincere and open dialogue with our Members, especially if we fail to meet expectations and We are committed to resolving all Patient concerns.

    Therefore, in the event that a Member is dissatisfied with or has concerns about any staff member, service, treatment, or experience arising from their membership in this Practice, the Member and the Practice agree to refrain from making, posting or causing to be posted on the internet or any social media, any untrue, unconfirmed, inaccurate, disparaging comments about the other. Rather, the Parties agree to engage in the following process:

    - **a.** Member shall first discuss any complaints concerns or issues with their respective Physician;
    - **b.** Their respective Physician shall respond to each of Member's issues and complaints;
    - **c.** If, after such response, Member remains dissatisfied, the Patient and Dr. Paresh Goel, M.D., the President of Desert Mobile Medical, shall enter into discussion and attempt to reach a mutually acceptable solution.
    - **d.** If no resolution is found, a mutually accepted third party will be invited to arbitrate on behalf of both parties, and both parties accept the decision of arbitrator as being in good faith and final.

16. **Fee Adjustments.** In the event that the Practice finds it necessary to increase or adjust monthly fees before the termination of the Agreement, Practice shall give Patients 30 days' written notice of any adjustment and if Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled monthly payment. Practice and Patient my give notice through first class US mail or by Email to the address as provided by the Party to be notified.

17. **Change of Law.** If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

18. **Severability**. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable, and the remainder of the Agreement will stay in force as originally written.

19. **Amendment.** Accept as provided within, No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties.

20. **Assignment**. The Patient may not assign this agreement or any rights provided within to any third party.

21. **Legal Significance**. The Patient understands and agrees that this Agreement is a legal document and gives the parties certain rights and responsibilities. The Patient further attests that

a. s/he is suffering no medical emergency.
b. s/he has had reasonable time to seek legal advice regarding this Agreement and has either chosen not to do so or has done so and is satisfied with the terms and conditions of the Agreement.

22. **Miscellaneous.** This Agreement shall be construed without regard to any rules requiring that it be construed against the party who drafted the Agreement. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

23. **Entire Agreement.** This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

24. **No Waiver.** Either party may choose to delay, excuse, or not to enforce a duty or responsibility (under this Agreement) of the other Party. Doing so will not constitute a waiver of the right to enforce such duty or responsibility in the future. The party will have the right to enforce their rights under this Agreement again at any time.

25. **Jurisdiction.** This Agreement shall be governed and construed under the laws of the State of Arizona without regard to rules of conflicts of laws. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice in Scottsdale, Arizona.

26. **Notice**. All written notices, except those required under paragraph 17, shall be sent by first class U.S. mail to the Practice, at the address first written above and to Patient, at the address appearing in Appendix B.

The Parties may have signed duplicate counterparts of this Agreement on the date first written above.

____________________	____________________	____________
Name of Patient	**Signature of Patient**	**Date**
____________________	____________________	____________
Name of Patient	**Signature of Patient**	**Date**

____	____________
Signature of President of Desert Mobile Medical, PLLC	**Date**
____	____________
Signature of Paresh Goel, MD (Physician)	**Date**

APPENDIX A

SERVICES

The Physician does not store, carry, or dispense scheduled opioid medications.

1. **Medical Services.** Medical Services provided in this Agreement are those Services that are consistent with Physician's training and experience, and as deemed appropriate at the sole discretion of the Physician. The Patient is responsible for all costs associated with any medications, laboratory testing, durable medical equipment, and specimen analysis associated with these Services. The Medical Services provided under this Agreement include the following:

- Acute and Non-acute Visits – one per month. Additional visits available for an added charge of $50 per visit.*
- Chronic Condition Management (e.g. diabetes, high blood pressure, high cholesterol, etc.)
- Comprehensive Annual Exams
- Preventive and Wellness Exams
- Sports Medicine
- Medical Weight Loss and Weight Management
- Body Fat analysis
- Hospital follow up care
- Preoperative evaluations
- Sports physicals
- EKG
- Smoking cessation
- Spirometry
- Nebulizer treatments
- Removal of benign skin lesions/warts (excluding pathology fee)
- Ingrown toenail removal
- Skin biopsies (excluding pathology fee)
- Simple wound repair and sutures
- Simple aspiration/injection of joint (excluding any pathology fee)
- Abscess Incision and Drainage (excluding any pathology fee)
- Removal of Cerumen (ear wax)
- IV Nutritional therapy
- Medical esthetics (additional fee for cost of products / medications)
- Hormone replacement therapy (additional fee for cost of hormones)
- Administration of Injectables (additional fee for cost of products / medications)
- Access to imaging and lab testing at significantly reduced rates through select vendors as negotiated through the Practice.
- Access to a variety of prescription medications at wholesale or close to wholesale price and dispensed directly by physician.

*** In the event that Patient schedules a home visit and fails to appear for the visit when the Physician arrives, or cancels within 24 hours of said appointment, it shall be count as one visit against the patient's account.**

2. **Non-Medical, Personalized Services**. The Practice shall also provide Patient with the following non-medical services, which are complementary to our members in the course of care:

- **After Hours Access.** The Practice's hours are 8 AM through 6 PM, Monday through Friday. The Practice shall endeavor to provide direct telephone access to the Physician after office hours for guidance in regard to urgent concerns that arise unexpectedly. Video chat and text messaging may be used when the Physician and Patient agree that it is appropriate. The Physician may arrange an in person visit if appropriate and necessary at the sole discretion of the Physician.

- **E-Mail Access.** Patient shall be given the Physician's e-mail address to which non-urgent communications can be addressed. Such communications shall be dealt with by the Physician or staff member in a timely manner. *Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that could reasonably develop into an emergency***.** Patient agrees that in this situation, when s/he cannot speak to the Physician immediately in person or by telephone, to call 911 or go to the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

- **No Wait or Minimal Wait Appointments.** Reasonable effort shall be made to assure that Patient is seen by the Physician at the scheduled time. If Physician foresees more than a minimal delay, Patient shall be contacted and advised of Physician's projected arrival time. Patient will then have the option to keep the appointment or reschedule the visit at Patient's convenience.

- **Same or Next Day Appointments.** Reasonable effort shall be made to accommodate Patient for same or next day appointments, but cannot guarantee availability, and cannot guarantee that the patient will not need to seek treatment in an urgent care or emergency department setting.

- **Specialists Coordination.** Physician shall coordinate with Patient's medical specialists to assure continuity of care, and if necessary, shall assist in obtaining a referral for specialty care. *Patient understands that monthly fees paid under this Agreement do not include specialist's fees or fees due to any outside medical professional. These are the patient's responsibility but Patient may submit such charges to insurance.*

APPENDIX B

PATIENT ENROLLMENT

*** Click box for YES where indicated only if you agree to text message communication and provide email address only if you agree to Email communication.**

The fees as set out in the attached Appendix C, shall apply to the following Patient(s), who by signing below, (or) as Parent or Legal Guardian certify that they have read and agree to the terms and conditions of this Agreement:

Primary Patient Name Date of Birth

Street Address City, State, Zip

Home Phone Cell Phone Email

Do you agree to text message communication? YES NO

Signature of Patient / Guardian: _____________________________ Date: ______________

Secondary Patient Name (If applicable) Date of Birth

Street Address City, State, Zip

Home Phone Cell Phone Email

Do you agree to text message communication? YES NO

Signature of Patient / Guardian: _____________________________ Date: ______________

Child (1) Print Name (If applicable) Date of Birth

Child (2) Print Name (If applicable) Date of Birth

Child (3) Print Name (If applicable) Date of Birth

Signature of Parent / Guardian: _____________________________ Date: ______________

APPENDIX C

FEE ITEMIZATION

Two or more Members	$ 129.00 per month per individual
One-time Non-refundable Enrollment Fee	$ 100.00 per individual

Should Patient's membership lapse or be terminated, and Patient later wishes to re-enroll, Patient will be accepted on a space available basis only, subject to a $250.00 re-activation fee.

Patient 1 $______________
Patient 2 $______________
Patient 3 $______________
Patient 4 $______________
Patient 5 $______________
Enrollment Fees $______________
Total Amount Due $______________

Total Monthly Amount Due $______________

Appendix D

Medicare Opt Out and Waiver Agreement

This agreement (Agreement) is entered into by and between Mobile Medicine, PLLC, and Paresh Goel, MD (Provider), whose principal address is, 10255 E. Via Linda Suite 1091 Scottsdale, Arizona 85258, and ______________________, a beneficiary enrolled in Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997 ("Beneficiary"), who resides at ____.

The Practice and Provider have informed Patient that Provider has opted out of the Medicare program and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Introduction

The Balanced Budget Act of 1997 allows providers to "opt out" of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, provider 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 providers not opted out of Medicare). In essence, the provider must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years.

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

Provider Responsibilities

(1) Provider agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.

(2) Provider agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.

(3) Provider agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.

(4) Provider agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Provider also agrees to retain a copy of this document for the duration of the opt-out period.

(5) Provider 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 Provider, and understands that no reimbursement will be provided under the Medicare program for such items or services.

(2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Provider for such items or services.
(3) Beneficiary agrees that s/he is not currently in an emergency or urgent health care situation.
(4) Beneficiary agrees not to submit a claim to Medicare and not to ask Provider to submit a claim to Medicare.
(5) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Provider that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
(6) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered items and services from providers 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 providers or practitioners who have not opted out of Medicare.
(7) 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.
(8) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.
(9) Beneficiary acknowledges that a copy of this contract has been made available to him/her.

Medicare Exclusion Status of Provider

Beneficiary understands that Provider 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 ___________________, and will continue in effect for 365 days from the above date. Either party may terminate treatment with reasonable notice to the other party, as provided in the agreement. Notwithstanding this right to terminate treatment, both Provider 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.

Provider and Beneficiary intend to be legally bound by signing this agreement on the date set forth below:

______________________	____________________________	______________
Name of Beneficiary	**Signature of Beneficiary**	**Date**

Signature of President of Desert Mobile Medical, PLLC	Date
Signature of Paresh Goel, MD (Physician)	Date

DESERT MOBILE MEDICAL, PLLC

Patient Name ______________________________ **DOB:**_________________

Health Information and Portability & Accountability Act

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Conduct normal healthcare operations, such as quality assessments and provider certifications.

I have been informed by you or your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization at any time to obtain a current copy of the Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry our treatment or obtain payment of health care operations. I also understand you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

Signed:___________________________________ Date ______________

Relationship to patient ____

DESERT MOBILE MEDICAL, PLLC

Patient Name ______________________________ DOB:________________

PATIENT AUTHORIZATIONS

Please write the name of the person to whom you wish us to disclose your health information:

___Spouse:________________________________

___Parents:________________________________

___Children:_______________________________

___Other:_________________________________

___May leave on answering machine/voicemail

___May correspond by electronic means, i.e. text, email, video, Skype, and other means of electronic communication. You also are Opting-In for our newsletter which will contain information on the practice, as well as, news on Health & Wellness.

___DO NOT release any medical information to anyone

Signed:___________________________________ Date _____________

Relationship to patient ____

This authorization will expire one year from the signed date or may be changed by the responsible party at any time.

DESERT MOBILE MEDICAL, PLLC

LIVING WILL & DURABLE MEDICAL POWER OF ATTORNEY

Your answers to the following questions will assist Desert Mobile Medical, PLLC to respect your wishes regarding your medical care. This information will become part of your medical record.

Do you have a living will? Yes No

If yes please provide us with a copy for your medical record.

Do you have a durable power of attorney for health care? Yes No

If yes please provide us with a copy for your medical record.

____
Name of Patient (please print)

____
Signature of Patient

DESERT MOBILE MEDICAL, PLLC

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

PATIENT INFORMATION (please print)

Name: ____DOB: ______________

Address: ___________________________City/State/Zip: __________________

Telephone Number: ________________________

RELEASE MY MEDICAL RECORDS TO:

Desert Mobile Medical, PLLC
10255 E. Via Linda, Suite 1091
Scottsdale, AZ 85258
Tel: 833-366-3721
Fax: 480-462-4966

FROM:

I hereby give____ permission to transfer my complete medical records, including but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests to be housed permanently at Desert Mobile Medical, PLLC. Any further transfer of records can be made by written request.

BY MY SIGNATURE I AUTHORIZE THE TRANSFER OF MEDICAL RECORDS

PATIENT: ____ DATE: ________________

DESERT MOBILE MEDICAL, PLLC

Credit/Debit Card or Bank Savings/Checking Account Payment Authorization Form

Patient Name: ____________________________

Date of Birth: ____________________________

Street Address: ___________________________

City, State, Zip Code: ______________________

Phone Number: ____________________________

Schedule your payment to be automatically deducted from your bank savings/checking account, debited from your banks debit card, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Please complete the information below:

I, _____________________, hereby authorize Desert Mobile Medical, PLLC to charge my debit/credit card or bank savings/checking account immediately for $100.00 for the enrollment fee.

I, _____________________, hereby authorize Desert Mobile Medical, PLLC to charge my debit/credit card or bank savings/checking account immediately for:

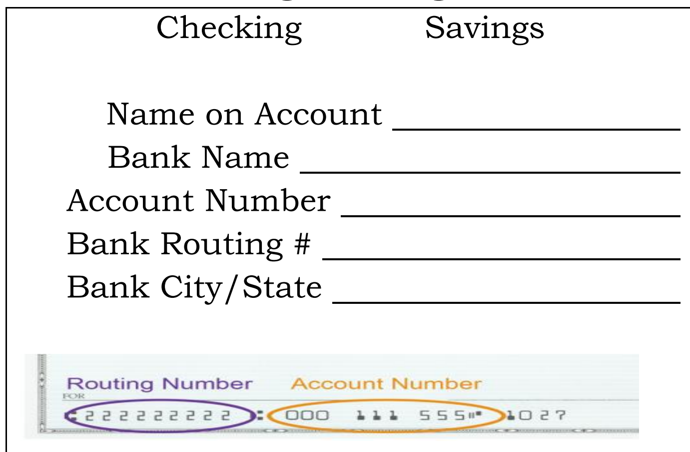
> $129.00, for the first months' installment for myself, and each of my dependents. This is for my on-going monthly membership.
>
> $387.00, for the first 3 months' installment for myself, and each of my dependents. This is for my on-going quarterly membership.

I, _____________________, hereby also authorize Desert Mobile Medical, PLLC to charge my debit/credit card or bank savings/checking account on subsequent billing periods of monthly or quarterly, for whichever has been selected above and the same amounts listed above.

I, ____________________, hereby authorize Desert Mobile Medical, PLLC to charge my debit/credit card or bank savings/checking account for any incidentals (Ancillary Services) that may occur that are not part of my membership including, but not limited to:

Medications, including Hormone Replacement Therapy
Laboratory blood work
Radiological Imaging
IV Nutritional Therapy
Medical Aesthetics
Physical & Occupational Therapy
Massage Therapy

Bank Checking / Savings Account



Checking Savings

Name on Account ________________

Bank Name ____________________

Account Number ________________

Bank Routing # ________________

Bank City/State ________________

Debit / Credit Card

Visa MasterCard

Amex Discover

Card holder Name ________________

Account Number ________________

Exp. Date ________________

CVV (3 digit number on back of card) _____

SIGNATURE: ______________________________ DATE: ____________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Desert Mobile Medical, PLLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates occur. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Desert Mobile Medical, PLLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this debit/credit card/bank account and will not dispute these scheduled transactions with my bank or debit/credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.

Appendix D

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

Provider Responsibilities

(1) Provider agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.

(2) Provider agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.

(3) Provider agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.

(4) Provider agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Provider also agrees to retain a copy of this document for the duration of the opt-out period.

(5) Provider 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 Provider, and understands that no reimbursement will be provided under the Medicare program for such items or services.

(2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Provider for such items or services.
(3) Beneficiary agrees that s/he is not currently in an emergency or urgent health care situation.
(4) Beneficiary agrees not to submit a claim to Medicare and not to ask Provider to submit a claim to Medicare.
(5) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Provider that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
(6) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered items and services from providers 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 providers or practitioners who have not opted out of Medicare.
(7) 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.
(8) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.
(9) Beneficiary acknowledges that a copy of this contract has been made available to him/her.

Medicare Exclusion Status of Provider

Beneficiary understands that Provider 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 ___________________, and will continue in effect for 365 days from the above date. Either party may terminate treatment with reasonable notice to the other party, as provided in the agreement. Notwithstanding this right to terminate treatment, both Provider 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.

Provider and Beneficiary intend to be legally bound by signing this agreement on the date set forth below:

______________________	____________________________	_____________
Name of Beneficiary	**Signature of Beneficiary**	**Date**

____ __________
Signature of President of Desert Mobile Medical, PLLC **Date**

____ __________
Signature of Paresh Goel, MD (Physician) **Date**

DESERT MOBILE MEDICAL, PLLC

Patient Name ______________________________ **DOB:**_________________

Health Information and Portability & Accountability Act

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Conduct normal healthcare operations, such as quality assessments and provider certifications.

I have been informed by you or your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization at any time to obtain a current copy of the Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry our treatment or obtain payment of health care operations. I also understand you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

Signed:___________________________________ Date ______________

Relationship to patient ____

DESERT MOBILE MEDICAL, PLLC

Patient Name ______________________________ DOB:________________

PATIENT AUTHORIZATIONS

Please write the name of the person to whom you wish us to disclose your health information:

___Spouse:________________________________

___Parents:________________________________

___Children:_______________________________

___Other:_________________________________

___May leave on answering machine/voicemail

___May correspond by electronic means, i.e. text, email, video, Skype, and other means of electronic communication. You also are Opting-In for our newsletter which will contain information on the practice, as well as, news on Health & Wellness.

___DO NOT release any medical information to anyone

Signed:___________________________________ Date _____________

Relationship to patient ____

This authorization will expire one year from the signed date or may be changed by the responsible party at any time.

DESERT MOBILE MEDICAL, PLLC

LIVING WILL & DURABLE MEDICAL POWER OF ATTORNEY

Your answers to the following questions will assist Desert Mobile Medical, PLLC to respect your wishes regarding your medical care. This information will become part of your medical record.

Do you have a living will? Yes No

If yes please provide us with a copy for your medical record.

Do you have a durable power of attorney for health care? Yes No

If yes please provide us with a copy for your medical record.

____

Name of Patient (please print)

____

Signature of Patient

DESERT MOBILE MEDICAL, PLLC

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

PATIENT INFORMATION (please print)

Name: ____DOB: _______________

Address: ______________________________City/State/Zip: ____________________

Telephone Number: __________________________

RELEASE MY MEDICAL RECORDS TO:

Desert Mobile Medical, PLLC
10255 E. Via Linda, Suite 1091
Scottsdale, AZ 85258
Tel: 833-366-3721
Fax: 480-462-4966

FROM:

I hereby give____ permission to transfer my complete medical records, including but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests to be housed permanently at Desert Mobile Medical, PLLC. Any further transfer of records can be made by written request.

BY MY SIGNATURE I AUTHORIZE THE TRANSFER OF MEDICAL RECORDS

PATIENT: ____ DATE: _________________

DESERT MOBILE MEDICAL, PLLC

Credit/Debit Card or Bank Savings/Checking Account Payment Authorization Form

Patient Name: ____________________________

Date of Birth: ____________________________

Street Address: ___________________________

City, State, Zip Code: ______________________

Phone Number: ____________________________

Schedule your payment to be automatically deducted from your bank savings/checking account, debited from your banks debit card, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Please complete the information below:

I, _____________________, hereby authorize Desert Mobile Medical, PLLC to charge my debit/credit card or bank savings/checking account immediately for $100.00 for the enrollment fee.

I, _____________________, hereby authorize Desert Mobile Medical, PLLC to charge my debit/credit card or bank savings/checking account immediately for:

$129.00, for the first months' installment. This is for my on-going monthly membership.

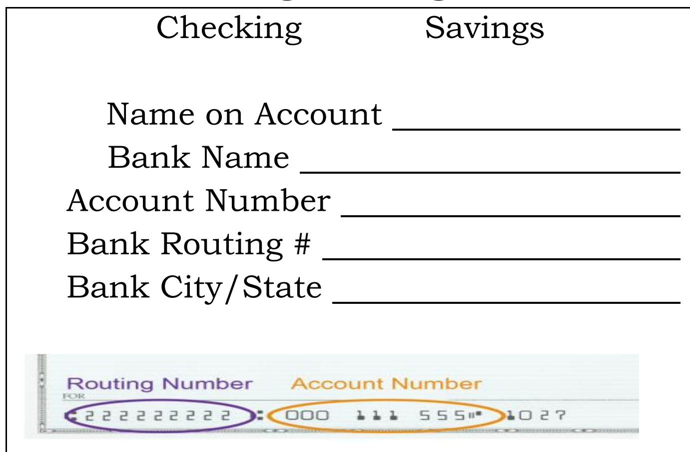
$387.00, for the first 3 months' installment. This is for my on-going quarterly membership.

I, _____________________, hereby also authorize Desert Mobile Medical, PLLC to charge my debit/credit card or bank savings/checking account on subsequent billing periods of monthly or quarterly, for whichever has been selected above and the same amounts listed above.

I, ______________________, hereby authorize Desert Mobile Medical, PLLC to charge my debit/credit card or bank savings/checking account for any incidentals (Ancillary Services) that may occur that are not part of my membership including, but not limited to:

- Medications, including Hormone Replacement Therapy
- Laboratory blood work
- Radiological Imaging
- IV Nutritional Therapy
- Medical Aesthetics
- Physical & Occupational Therapy
- Massage Therapy

Bank Checking / Savings Account



Checking Savings

Name on Account ________________

Bank Name ______________________

Account Number __________________

Bank Routing # ___________________

Bank City/State __________________

Debit / Credit Card

Visa MasterCard

Amex Discover

Card holder Name ________________

Account Number _________________

Exp. Date _________________

CVV (3 digit number on back of card) _____

SIGNATURE: _________________________________ DATE: ______________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Desert Mobile Medical, PLLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates occur. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Desert Mobile Medical, PLLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this debit/credit card/bank account and will not dispute these scheduled transactions with my bank or debit/credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.