

## **PremierMED PRIME Membership Agreement Premium Plan**

This Membership Agreement (the “Agreement”) specifies the terms and conditions under which you, the undersigned member (“Member”), or if the signature page of this Agreement indicates that the Member means a couple or a family (parents and children), then any reference in this Agreement to “You” or “Member” refers to each such member of your family, may participate in the PREMIER FAMILY AND SPORTS MEDICINE, LLC (“PremierMED”) program called PremierMED PRIME, (the “Program”).

### **I. Program Benefits and Services.**

PremierMED agrees to provide the following “Program Benefits and Services” in exchange for the Membership Fee:

- o Same business day appointments
- o Direct physician visits
  - At many doctor’s offices the patient meets with a nurse practitioner or a physician assistant, and not a doctor. PremierMED PRIME members meet with a doctor during all office visits.
- o Convenient dedicated membership appointment slots
  - Certain high demand appointment times are blocked off for PremierMED PRIME members.
- o 24/7 phone access
  - PremierMED PRIME members have a phone number they may call to speak directly with a physician. A PremierMED physician will endeavor to return calls received between 8:00 am and 9:00 pm within an hour, and calls between 9:00 pm and 8:00 am by 9:00 am the following day. If you are experiencing a medical emergency, you must call 911 before calling your physician.
- o Physician e-mail correspondence
  - PremierMED PRIME members have direct email access to our physicians.
- o Video conference appointments (when appropriate)
- o Minimal or no wait times
- o After hours office visits available when appropriate
- o Home visits available; 3 per Member per year included
- o Annual Health Summary written report

### **II. Non-discrimination**

For both members and non-member patients alike, PremierMED will provide the same level of timely diagnostic and therapeutic services in line with the standard of care in the community. The Program Benefits and Services included above are non-healthcare services that are not covered by insurance.

### **III. Membership Fee**

By executing and entering into this Agreement you agree to pay a membership fee “Membership Fee” to PremierMED, as set forth in Appendix A.

**IV. Term, Renewal, and Termination.**

The term of this Agreement is one (1) year commencing on the Effective Date. This Agreement will automatically renew each year on the anniversary of the Effective Date, unless otherwise terminated pursuant to the terms hereunder. The Membership Fee for each successive renewal term shall be 5% greater than the preceding term.

Either party may terminate this Agreement at any time by providing thirty days written notice to the other. The Agreement will terminate 30 days after the date written notice is delivered to PremierMED. In the event of a termination, the Membership Fee shall be pro-rated as of the termination date. The Member will pay the Membership Fee up to the termination date and if any portion of the Membership Fee has been paid in advance, any unused portion of the Membership Fee, if any, will be refunded to the Member within 30 days following the termination date.

**V. Scope of Work Covered by Membership Fee.**

The Membership Fee covers the cost of Program Benefits and Services. The Membership Fee does not cover the cost of other healthcare services provided by PremierMED, such as, but not limited to, the cost of office visits, co-pays, treatments, medication, supplies, procedures, and other medical services ("Other Services"). Neither the Physicians nor their staff will seek reimbursement from any insurer or other third-party payer for the Program Benefits and Services. If You are entitled to benefits under or enrolled in Part B of Medicare, You agree not to submit a claim (or request that PremierMED submit a claim) under the Medicare Program, Medigap plan, or to any intermediary or carrier of the Medicare Program for any portion of the Membership Fee. You further acknowledge the limits Medicare places on physician charges do not apply to the Membership Fee. You and/or your insurer, as the case may be, will be financially responsible for paying for all Other Services received by You from PremierMED. If Other Services are not covered by your health insurance, you may incur additional expenses.

**VI. Co-Payments and Deductibles.**

The membership fee does not impact any co-payments, co-insurance or deductibles that you are required to pay for a routine visit pursuant to the terms of your health or other insurance coverage, if applicable. You will continue to be financially responsible for any co-payments, co-insurance or deductible amounts required by your insurer.

**VII. E-mail/Text Communications; Privacy.**

PremierMED does not warrant or represent that emails and/or text messages sent to PremierMED are secure. Although PremierMED will take steps to keep your communications with PremierMED and its physicians, staff, employees, agents and representatives, confidential and secure, the confidentiality of e-mail cannot be assured or guaranteed. By entering this Agreement, you acknowledge that e-mail is not a good medium for urgent or time-sensitive communications. In the event a communication is time-sensitive, you must communicate with PremierMED PRIME's physicians by telephone or in person, and, as always in the event of a medical emergency always dial 911 before contacting PremierMED. You agree that, at the discretion of PremierMED and/or as required by law, your e-mail or text communications may become part of your medical record.

**VIII. Limitation of Liability.**

In the event You are dissatisfied with any of the Program Benefits and Services, Your right to

terminate this Agreement will be Your only remedy at law or in equity (subject to any rights that are non-waivable by law).

**IX. Entire Agreement.**

Each of 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. This Agreement constitutes the entire agreement between the parties related to the subject matter hereof and supersedes all prior agreements, understandings, and correspondence or communications relating to the subject matter hereof.

**X. Notices.**

Any communication required or permitted to be sent under this Agreement shall be in writing and sent to the party to be so notified via certified mail, return receipt requested, to the addresses set forth herein; PremierMED, 2658 Maguire Rd. Ocoee, FL 34761. Any change in address shall be communicated in accordance with this section.

**XI. Governing Law.**

The laws of the State of Florida shall govern the validity, interpretation and performance of this Agreement without giving effect to the principles of comity or conflicts of laws thereof. Each party hereto agrees to submit to the personal jurisdiction and venue of the state and federal courts having jurisdiction over Orange County, Florida for the resolution of all disputes arising in connection with the interpretation, construction and enforcement of this Agreement, and hereby waives the claim or defense therein that such courts constitute an inconvenient or invalid forum.

**XII. Amendments and Waivers.**

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 both parties. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach or of other covenants or conditions.

**XIII. 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.

**XIV. 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.

**XV. Counterparts.**

This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which shall constitute a single Agreement.

**XVI. Signatories.**

This Agreement shall be signed by one of the Managing Member's on behalf of PremierMED and by the Member(s) in an individual capacity. You acknowledge that You are currently not facing an emergency, urgent or terminal health care situation, and You have voluntarily elected to enter into the agreement. This Agreement is effective as of the date written below.

Member: \_\_\_\_\_  
(Signature)

Member: \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print)

\_\_\_\_\_  
(Print)

Effective Date of Agreement: \_\_\_\_\_

List Names of Additional Children (up to age 21) Members (if applicable):

Members: \_\_\_\_\_  
\_\_\_\_\_

PREMIER FAMILY AND SPORTS MEDICINE, LLC

By: \_\_\_\_\_

\_\_\_\_\_  
(Print)

As its: Managing Member

**MEMBER INFORMATION**

**Please Provide a Copy of a Photo ID**

Each of the undersigned Members acknowledges that he or she freely and voluntarily executed this Membership Agreement

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Email Address: \_\_\_\_\_

Patient Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

**FOR INTERNAL USE**

DATE ACCEPTED BY PREMIERMED PRIME: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Policy Information (as printed on your I.D. card)

**Please Provide a Copy of your Insurance Card Front and Back**

Person Responsible for Account: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

Address (if different from member's) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Person Responsible Employed by: \_\_\_\_\_

Occupation: \_\_\_\_\_

Business Address: Business Phone : (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Insurance Company: \_\_\_\_\_

Contact #: \_\_\_\_\_ Group #: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

**APPENDIX A**

**Premium Membership Fee.**

Please check the appropriate box for your desired membership status:

You must provide a valid credit card or account information on file with PremierMED to select the monthly or quarterly membership status options.

Monthly (includes a 5% administrative fee)

Monthly memberships will process in advance, on the first day of every month to the payment method provided below.

\$302 Individual Membership  \$460 Couple Membership  \$46 Child, from age 6 up to 21

Quarterly

Quarterly memberships will process in advance, on the first day of each quarter to the payment method provided below.

\$789 Individual Membership  \$1313 Couple Membership  \$132 Child, from age 6 up to 21

Annually

Annual memberships will process in advance on the payment method upon execution of this Agreement.

\$3150 Individual Membership  \$5250 Couple Membership  \$525 Child, from age 6 up to 21

**MEMBER BILLING -- INCLUDE YOUR PAYMENT ALONG WITH THE SIGNED MEMBERSHIP AGREEMENT.**

Bank Account Auto Debit (ACH) /  Check /  Cash

Name on Account: \_\_\_\_\_

ABA Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Type:  Checking  Savings  Business Checking

Bank Name: \_\_\_\_\_

Check # (if applicable): \_\_\_\_\_

VISA  MasterCard  American Express  Discover

Name on Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Verification Code: \_\_\_\_\_

**Signature:** \_\_\_\_\_