PATIENT SERVICES AGREEMENT

This Patient Services Agreement ("Agreement") is between the undersigned patient ("Patient" or "you") and Donna Sue Dolle, M.D., P.A. ("Practice") and sets forth the terms and conditions under which the Patient may participate in the Membership Practice ("Program"). By completing the information below, signing as indicated, and paying the Annual Membership Fee, you agree to participate in the Program and to accept the terms and conditions specified in this Agreement.

Patient Name_____

_____

Street Address City State Zip

Effective starting date of participation in the Program: _____

This Annual Membership Fee is based on the table below and may be paid in one payment or in equal monthly installments. Should you terminate this Agreement for any reason, you will be charged a minimum of 6 months of the Annual Membership Fee ("Non-Refundable Fee"), and the balance of your refund shall be prorated per Section 2 below.

ANNUAL MEMBERSHIP FEE SCHEDULE FOR PRACTICE

AGE	COST IF PAID MONTHLY	COST IF PAID ANNUALLY
15-34	$110	$1250
35-44	$125	$1450
45-54	$140	$1650
55-64	$160	$1850
65 and over	$175	$2050
Nursing Home	$215	$2500

1. **Services**. You, the Patient, engage the Practice in a retainer relationship for which the Practice will commit to leave multiple office appointment times un-booked on a daily basis and be available to see you on short notice, thereby forfeiting traditional revenue for the Practice. As a Program participant you will benefit from a variety of additional amenities to enhance your comfort and convenience as a patient of the Practice. The amenities may change from time to time. Any changes will be updated by written notice of the changes to be sent to the Patient's address. If the amenities are substantially reduced or eliminated, you have the right to cancel the Agreement in accordance with the terms and conditions set forth in Article 3 below. By payment of the Annual Membership Fee, the Patient can access the services available through the Program ("Services") to be provided by the Practice. The Services are defined as an annual comprehensive wellness assessment and ongoing medical care provided only by this Practice which are non-covered by Medicare, an online or transportable electronic medical record, and an online patient portal.

2. **Membership Fees and Payment Options**. Patient shall pay an annual membership fee to Practice in the amount specified in the schedule above ("Annual Membership Fee"). The Annual Membership Fee serves a period of one (1) year starting on the Effective Date. In lieu of paying the full Annual Membership Fee in a lump sum, Patient may authorize Practice to deduct monthly pro rata installments from Patient's credit or debit card, but Patient agrees Practice shall be entitled to receive not less than fifty percent (50%) of the Annual Membership Fee (i.e., six months of installments) should Patient terminate this Agreement, and such amount shall be non- refundable ("Non-Refundable Fee"). Practice will notify you of the renewal fee at least 30 days prior to the one (1) year anniversary of the Effective Date (the "Anniversary Date") only if it is different from the current Membership Fee schedule. Unless either party notifies the other party at least 30 days prior to the expiration of the applicable term of non-renewal of this Agreement or unless this Agreement is earlier terminated as set forth in paragraph 3 below, this Agreement shall automatically renew for successive one-year periods, and the payment schedule will remain. Any failure to pay the annual fee by the Anniversary Date, or if paying in monthly installments, any monthly installment by the 5th day of any month, shall result in automatic termination of this Agreement and your membership in the Program. However, such termination for failure to pay will not release you of the obligation to pay the Non-Refundable Fee.

3. **Termination**. You or Practice may terminate this Agreement by giving thirty (30) days prior written notice to the other, at any time and for any reason. If this Agreement is terminated, you will be entitled to a prorated refund of your pre-paid membership fee. However, you will still be obligated to pay the Non-Refundable Fee.

4. **Electronic Communications/Privacy**. If you wish to communicate by email, text or other electronic communication (collectively, "email") with the Practice, you acknowledge that email is not a secure medium for sending or receiving potentially sensitive personal health information. Although Practice will take steps to keep your communications with Practice and/or their respective employees, agents and representatives, confidential and secure, the confidentiality of email communications cannot be assured or guaranteed.

5. **Application of Fee**. The Annual Membership Fee covers only the defined Services described in Section 1 above. The defined Services are not covered (in whole or in part) by private health insurance or third party payment programs providing health related benefits (including Medicare or any other government payor) (collectively "Payor" or "Payors"). Patient acknowledges and agrees that the membership fee does not constitute payment (in whole or in part) for any medical, clinical, diagnostic, or therapeutic services or for any items that are covered (in whole or in part) by any Payors providing any benefits to Member. You should consult your accountant or tax consultant in regard to the tax deductible status of the Annual Membership Fee.

6. **Patient Responsibilities**. The Program is not intended as a replacement of any health insurance or similar benefits program maintained by any third party Payor, such as Medicare, Aetna, Cigna, BlueCross/BlueShield or United Healthcare, and does not effect any applicable co-payments, co-insurance, or deductible thereunder (which you must continue to pay under the terms of such insurance or such program). This Agreement is a service contract, and not a contract of insurance. Please note that the Practice currently does not participate in the Medicare program or accept assignment of benefits, nor does the Practice participate with many other health care insurance plans.

7. **Notices**. Any communication required or permitted to be sent under this Agreement shall be in writing sent via facsimile or via certified mail, return-receipt requested, to the addresses set forth in this Agreement. Any change in address shall be communicated in accordance with this Section.

8. **Non-Assignment**. You may not assign this Agreement or any of the rights and benefits in this Agreement, without Practice's prior written consent. Any attempt to assign this Agreement without such consent shall be null, void, and of no legal effect.

9. **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 may not be modified or amended without the express written consent of Practice. The Agreement is entered into and entirely performable in Harris County, Texas.

10. **Effective Date**. This Agreement shall be effective on the date signed by Practice below; provided that payment has been received ("Effective Date"). Practice is not obligated to accept this Agreement or payment, and may, in its sole discretion, elect not to do so, based on limitations on the number of members and other restrictions.

By: _____
Donna Sue Dolle, M.D., President

Date: _____

I agree to all of the terms of the Program described above.

Patient Signature: _____

Patient Name: _____

Date _____