PRACTICE SERVICES AGREEMENT

This Practice Agreement (the "Agreement") is made as of _____, ___ ("Effective Date"), by and between Comprehensive Allergy and Asthma Care, PLLC (the "Practice") and the individual identified on the signature page ("Patient"). When signing as a legal representative of the actual patient (*i.e.*, you are the parent or guardian of the patient), the term "Patient" will be read to include you and/or the actual patient, as applicable.

I. The Parties and Their Roles

The purpose of this Agreement is to set forth the terms on which Patient will participate in the program for certain consultative services designed by the Practice related to mast cell activation disorder, respiratory system dysfunction, connective tissue issues, and homeostasis which are not covered services under Patient's health plan (the "Program").

II. The Practice's Responsibilities

- **Clinical Responsibilities**

The Practice agrees to arrange its practice so as to be able to afford Patient the care and attention relating to Patient's care needs as described in this Agreement. In general, the Practice will not accept patients other than those who have entered into Agreements to be part of the Program.

The Practice (or a covering physician) will be available to Patient through the Comprehensive Allergy and Asthma Care ("Online Portal") via electronic message.

In general, the Practice will respond to Patient (via text or telephone, as applicable) within the next three (3) business days or the earliest practicable time after Patient sends a message. In the case of a true medical emergency, 911 should be called before calling the Practice.

- **Administrative Responsibilities**

The Practice agrees to provide the non-clinical services described in this section with the objective of making Patient's experience with the Practice as convenient and effective as possible.

The Practice's staff will be available to assist Patient and provide the services described in this section during the hours of 10:00 a.m. to 5:00 p.m. each business day, practice schedule subject to change without prior notice.

Patient's Responsibilities

Patient agrees to pay the Fee of Nine Hundred Dollars ($900) or if patient selects semi annual payment of Four Hundred and Fifty Dollars ($450) on the Application and Payment Form attached at Appendix A.

This Agreement will renew automatically for additional one-year terms unless Patient or Patient's legally designated caregiver provides the Practice with advance written notice of non-renewal 45 days prior to the annual anniversary of the Effective Date. Patient understands that the Practice may change the Fee at any time on notice to Patient and that the revised Fee will be applied at Patient's next annual renewal date. Without limiting anything contained herein, the Practice may change its fee schedule upon at least thirty (30) days' prior written notice by sending Patient a notice enclosing a revised fee schedule.

Patient acknowledges and agrees that this Agreement only provides coverage for services provided by the Practice (i.e., allergy consultations) and does not provide the Patient with any coverage for services required or provided by any other provider. For instance, hospitalization, durable medical equipment, prescription medicine, etc. are not provided by the Practice, and therefore, if the Patient receives these services, the Patient acknowledges and agrees that he/she is responsible for payment with respect to the same.

Termination

Patient may terminate this Agreement at any time by notifying the Practice in writing of termination at least forty five (45) days prior to the date on which Patient's termination is to be effective. Patient understands that, if Patient is dissatisfied with any of the non-clinical services provided by the Practice under this Agreement, the right to terminate will be Patient's only remedy at law or in equity.

The Practice may terminate this Agreement on thirty (30) days' written notice to Patient for any reason or no reason. If the Agreement is terminated by the practice for any reason during the first 60 days of the term or any subsequent renewal term and Patient has not had the annual telephone consult, Patient will be entitled to a refund of 75% of Membership Fee, terminations by patient or enrolled member are not covered under the refund policy.

Additional Provisions

For the avoidance of any doubt, the arrangement contemplated hereby will not constitute a risk-sharing arrangement nor is it a contract of insurance.

By entering into this Agreement, Patient acknowledges and agrees that the Program services included hereunder are NOT covered services under any government or commercial health plan in which Patient is enrolled, and that neither Patient nor the Practice will submit a claim to Patient's health plan for services provided under the Program.

This Agreement will be governed by the laws of the State of New York.

This Agreement sets forth the entire agreement of the parties with respect to the subject matter hereof, and may not be amended except by a written instrument signed by Patient and the Practice.

[Signature page to follow]

Accept Agreement ☐

Patient/Personal Representative:

_____ (Signature)

_____ (Print Name)

If signed by other than Patient, Relationship to Patient:

_____

If signed by other than Patient, Print Name of Patient:

_____

_____ (Date)

Comprehensive Allergy and Asthma Care, PLLC

_____ (Signature)

_____ (Print)

(Date)

[Signature page]

APPLICATION AND PAYMENT

PATIENT NAME

First Name _____ Middle Initial _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Phone: Home _____Office _____ Cell _____

Date of Birth _____ Email Address _____

Method of payment:

☐ Check payable to ***Comprehensive Allergy and Asthma Care, PLLC*** enclosed.

☐ Payment authorization to use credit card.

Please accept this as my authorization to pay the annual Membership Fee using the following credit card**:**

Amount: $_____

MasterCard/Visa No: _____

American Express No: _____

Exp. Date: _____ Sec. Code: _____

Signature: _____

Name Printed On Card: _____

Address On Card: _____

_____

Zip Code: _____

_____

☐ Semi-Annual Payment ($450.00) ☐ Annual Payment ($900.00)

I understand and agree that this Services Agreement will be automatically renewed and the credit card used to join this Program will be charged per billing cycle selected above. I agree to notify the Practice if my credit card expires, or if I wish to change credit cards, and I will provide the new credit card information if I want to continue in the Program.

Signature _____ Date _____