*UTOPIA PRIMARY CARE, PLLC*

**Membership Agreement.**

Dear Patient,

We are pleased that you are joining our exciting new practice for personalized medical services (the “Program”) with Utopia Primary Care, PLLC (the “Practice”). The necessary Membership Form is enclosed with this letter. The purpose of this letter is to summarize the services we will now be able to provide you on a very exclusive basis and what we expect from you in expanding upon our Physician/Patient relationship. If you find the enclosed terms satisfactory, I ask that you sign the copy of this letter on page 4 and return it and the Membership Form with your payment to us. Our receipt of the signed, duplicate copy of this letter, the Membership Form and payment will constitute an agreement between us for the provision of services set forth in this agreement by us to the person or persons set forth in your Membership Form.

# **Services Provided:**

See Exhibit A for complete list of services provided to Patient under Membership Agreement.

# **Annual Membership Fee and Additional Charges:**

Current Patients:

First Family Member: $2,000 per year  
 Second Family Member: $1,500 per year  
 Third & subsequent Family Members: $1,000 per year

New Member Families:

First Family Member: $2,500 per year  
 Second Family Member: $2,000 per year  
 Third & subsequent Family Members: $1,500 per year

Payment of Annual Membership Fee is made upon execution of this Membership Agreement. We reserve the right in future years to adjust the Annual Membership Fee.

Additional office visits above maximum of 10: $50.00 per visit

Additional hospital visits above maximum of 10: $100.00 per visit

# **Patient Agreements:**

# In order for us to offer same day/next day appointment scheduling, it is very important for you to be timely with your appointments, as being late impacts the time availability for you and other scheduled patients.

# Please schedule at least one office visit each year in order for us to properly evaluate you in your wellness and other visits.

# You understand and acknowledge that we are not a contracted provider for any insurance plan, Medicare, AHCCCS, or any other payor. We will not submit any bill for services rendered to you for reimbursement with any insurer or third party payor. You may be entitled to reimbursement from private insurance for out of network coverage; you will be solely responsible for obtaining any such benefits. You should maintain your conventional health insurance which will still be necessary for all expenses outside of the coverage provided by this Agreement.

# **Medical Care Services Excluded from Annual Membership Fee:** Any tests or services not enumerated in this Agreement, such as visits to specialists, hospital charges, or other services provided by the Practice. There will be a customary charge for any services not enumerated in this Agreement.

# **Email and Cell Phone Communications; Privacy:**

If you wish to send e-mail/cell phone communications to and receive e-mail/cell phone responses from you physician and/or staff and representatives, you should be aware that e-mail/cell phone is not a secure medium for sending or receiving potentially sensitive personal health information. Although the Practice will take steps to keep your communications confidential and secure, the confidentiality of e-mail/cell phone communications cannot be assured or guaranteed. You also acknowledge and understand that e-mail/cell phone is not a good medium for urgent communication. In the event a communication is time-sensitive, you must communicate with your physician by phone or in person. You acknowledge and understand that, at the discretion of your physician, your e-mail/cell phone conversation may become part of your permanent medical record.

# **Consent.** You agree to complete and sign the attached Consent portion of this Membership Agreement.

# **Renewals and Termination**

## Membership is automatically renewed yearly. The annual membership fee covers the payment for a period of one (1) year, which may change from time to time, and which such Annual Fee changes shall be made known to the Patient prior to the end of any applicable year. Failure to pay the annual membership fee shall result in termination of your membership from the Program.

## If you wish to withdraw from the Program or are otherwise dissatisfied with our services at any time during the year, then you may terminate this Agreement by giving us at least one month prior written notice of your intent to terminate. Any unused portion of your annual membership fee will be refunded on a prorated basis within thirty days of the effective date of your termination.

## If for any reason we desire to terminate the physician/Patient relationship, then we must provide you with at least thirty days prior written notice of our intent to terminate. We will then refund to you any unused portion of your annual membership fee on a prorated basis within thirty days of the effective date of your termination.

## This Agreement represents the entire agreement between us for the services to be provided under this Agreement. For the purposes of interpreting the provisions of the Agreement or in the event of any dispute between us with respect to this agreement, Arizona law will apply.

If you agree with the terms of this letter as constituting our agreement for our provision of medical services, please date and sign the enclosed copy of this letter where indicated below and return the signed copy with your Membership Form and check in order to initiate our agreement.

We look forward to serving you in the future.

Very truly yours,

Utopia Primary Care, PLLC

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

Jeffery Baird, M.D., Manager

The undersigned hereby approves and accepts the terms of this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient

Date signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXHIBIT A**

**COVERED SERVICES**

# One complete annual wellness physical exam each year.

# Maximum of 10 office visits each year.

# Maximum of 10 hospital visits per year.

# On-line email access for confidential but non-emergency communications.

# Routine immunizations including Tetanus, Measles-Mumps-Rubella, Polio, Yellow Fever, Hepatitis A, Hepatitis B, Influenza, Typhoid, Shingles, Pneumonia, Meningitis and Human Papilloma Virus. (based on manufacturer availability)

# Access to staff for dietary counseling

# Certain simple skin procedures.