CONCIERGE PRACTICE MEMBERSHIP AGREEMENT

This Concierge Practice Membership Agreement (the "Concierge Agreement") is made as of September 1, 2020 ("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 Concierge 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 allergy care needs as described in this Concierge Agreement. In general, the Practice will not accept patients other than those who have entered into Concierge 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. Patient can send two (2) messages to Practice per calendar month.

The Practice will also provide one (1) thirty (30) minute telephone or real time video medical consultations to Patient, annually.

In general, the Practice will respond to Patient (via patient portal or telephone, as applicable) within the next three (3) business days after Patient sends a message or requests their annual telephone consultation. 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 assist Patient in scheduling the annual telephone consultation and accessing the Online Portal.

The Practice's staff will be available to assist Patient and provide the services described in this section during the hours of 9:00 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 Concierge Membership Fee of Nine Hundred Dollars ($900) (the "Concierge Membership Fee") in monthly installments of Seventy-Five Dollars ($75) per month unless Patient selects semi annual or annual payment on the Application and Payment Form attached at Appendix A.

This Concierge 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 nonrenewal prior to the annual anniversary of the Effective Date. Patient understands that the Practice may change the Concierge Membership Fee at any time on notice to Patient and that the revised Concierge Membership Fee will be applied at Patient's next annual renewal date.

In addition to the Concierge Membership Fee, the payment of which permits the Patient to participate in the Program, the Patient can pay the following for additional Online Portal messages with the Practice:

Thirty-Five Dollars ($35) per one (1) Online Portal message

Additional Online Portal messages shall be payable by Patient to Practice within thirty (30) days of Patient's receipt of an invoice from the Practice in consideration for the additional Online Portal message communication.

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 Concierge 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 Concierge Agreement at any time by notifying the Practice in writing of termination at least thirty (30) 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 Concierge Agreement, the right to terminate will be Patient's only remedy at law or in equity.

The Practice may terminate this Concierge Agreement on thirty (30) days' written notice to Patient for any reason or no reason. If the Concierge 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 Concierge 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 Concierge 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 Concierge Agreement will be governed by the laws of the State of New York.

This Concierge 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 Concierge 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. Only for Annual and Semi-Annual Payments.

☐ Payment authorization to use credit card.

Please accept this as my authorization to pay the annual Concierge 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: _____

_____

☐ Monthly Payment ($75.00) ☐ Semi-Annual Payment ($450.00) ☐ Annual Payment ($900.00)
Credit card only. No checks

I understand and agree that this Concierge 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 _____