Carolina Preventive Medicine Physicians, Inc.
Membership Agreement

This Membership Agreement specifies the terms and conditions under which you, the undersigned Member, may participate in the **Carolina Preventive Medicine Physicians** Program. This Agreement will become effective as of the date set forth by **Carolina Preventive Medicine Physicians** at the end of this Agreement (the "Effective Date").

1. **Carolina Preventive Medicine Physicians Program**
   The Program's annual fee encompasses the following services:
   - ♦ Annual Preventive Care History & Physical Examination
   - ♦ Comprehensive Wellness Plan
   - ♦ All Office Visits During the Year
   - ♦ Electrocardiogram
   - ♦ Laboratory Assessment (at the time of physical exam)
     - Comprehensive Metabolic Panel
     - Complete Blood Count
     - Prostate Specific Antigen (for men)
     - Thyroid Stimulating Hormone
     - Lipid Profile
     - Urinalysis

2. **Annual Membership Fee**
   Each member will pay an annual fee of $3,000 to **Carolina Preventive Medicine Physicians.**

3. **Financial Procedures for Services**
   Carolina Preventive Medicine Physicians is an out-of-network provider for insurance and does not participate with or file Medicare. As a courtesy we will print out billing statement for **all non-Medicare members** so that they may receive reimbursement from their insurance carrier for their office care.

4. **Additional Services and Benefits**
   A variety of additional services and benefits are offered under this Program. These services are subject to insurance filing if applicable. The Member's financial responsibility is capped at a particular dollar amount depending upon the service. Examples of these services are flu or pneumonia vaccinations, Berkeley Heart Lab tests, etc. The fee schedule is subject to change without notification.

5. **Medical Care Services Excluded from Annual Membership Fee**
   The annual membership fee specified herein covers only the defined services.
   All other services are excluded from this Agreement, such as diagnostic imaging, specialist visits, additional laboratory services, hospitalization, etc. All other services may be filed to your insurance if applicable, and you will ultimately be responsible for any additional balances, not medically necessary services, non-covered services, deductibles, coinsurance, and co-payments.

6. **Renewals and Termination**
   The annual membership fee covers a period of one (1) year. In order to renew membership the annual fee must be paid prior to the anniversary of the Effective Date. (For example, if the anniversary Date is September 15 then you must renew on or before September 14 the following year). If the annual renewal fee is not received by the anniversary date, the membership will be terminated. You or **Carolina Preventive Medicine Physicians** may terminate this Agreement at any time upon 30-days prior written notice. If you or **Carolina Preventive Medicine Physicians** terminate this Agreement for any reason, you will be entitled to a prorated refund of any unused portion of your annual membership fee. Such prorated refund will be based on the number of months you have participated in the Program, and whether you received your Annual Preventive Care Physical Examination, Comprehensive Wellness Plan, and Services. The amount of any such refund will be determined by the Program. Upon **Carolina Preventive Medicine Physicians** receipt of this Agreement and the membership fee, **Carolina Preventive Medicine Physicians** shall have the option, in its sole and absolute discretion, not to accept this Agreement and to return your payment to you (e.g., due to limitations on the number of Members). The annual membership fee is subject to change on an annual basis.

7. **Entire Agreement**
   Each of the undersigned agrees to the terms of this Membership Agreement, all of which are expressed herein. There are no promises or representations except as set forth herein.

8. **Notices**
   Any communication required or permitted to be sent under this Agreement shall be in writing and sent via certified mail, return receipt requested, to the addresses set forth below. Any change in address shall be communicated in accordance with the provisions of this section.

9. **Governing Law**
   This Agreement shall be governed by and construed in accordance with the laws of the State of South Carolina.

10. **Member Billing**
    You may pay for your membership and additional fees with cash, check or credit card. We accept Visa, MasterCard, and American Express. Please make your checks payable to **Carolina Preventive Medicine Physicians.**

I understand that I am responsible for payment of deductibles, co-payments, coinsurance, medically unnecessary services, and /or non-covered services that are not included in the Services provided by the **Carolina Preventive Medicine Physicians** Program.

I hereby authorize the physician to release all medical information necessary for continuity of care, and payment of balances.

I certify that I have read, understand and agree to the terms and conditions of this Agreement:

Name Member 1 (Print) **Member 2 (Print)**

Address

City, State, and Zip Code

Signature of Member 1 Date

Signature of Member 2 Date

Carolina Preventive Medicine Physicians, Inc.
238 Mathis Ferry Road, Suite 103
Mt. Pleasant, SC 29464
Phone: 843-388-2400 Fax: 843-388-2444

effective date

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Mt. Pleasant, SC 29464
Phone: 843-388-2400 Fax: 843-388-2444

Check Enclosed _____ **Payment Amount _____**

If paying by Credit Card please complete the following:

I authorize **Carolina Preventive Medicine Physicians** to keep my signature on file to charge my:

VISA **MASTERCARD** **AMERICAN EXPRESS**

For the annual membership fee in the amount of $_____ due for membership in the **Carolina Preventive Medicine Physicians** program.

ACCOUNT NUMBER _____ EXPIRATION DATE _____

Cardholder Billing Zip Code _____ Code # on back of card or front _____

Signature _____

I understand that this form is valid unless I cancel the authorization through written notice to Carolina Preventive Medicine Physicians.

SIGNATURE FOR MEMBERSHIP _____