Membership Agreement

This Membership Agreement (the "Agreement") specifies the terms and conditions under which you, the undersigned member ("Member"), may participate in the program ("Program") offered by, Bailey Family Medical Care, PC, ("Medical Practice"). This Agreement will become effective on the date of your signature at the end of this Agreement (the "Effective Date").

1. The Program. Any and all Program Services will be provided independently from any services covered by your private or Medicare health insurance plan ("Plan"). No Program Services are offered as an alternative to any Plan covered services, and you will not be billed directly (except for any applicable co-payments, deductibles or office visit fees) for any services covered by Private or Medicare Health Insurance. As such, you acknowledge that any and all Program Services provided for your Membership Fee will be provided for services or amenities that are not covered by any Plan.

According to Medicare, Alternative Therapy, also known as Alternative Medicine or Complimentary Medicine, is currently not covered by Medicare. These therapies include homeopathy, naturopathy, acupuncture, holistic therapies and herbal medicine. Alternative Medicine often incorporates the use of spiritual, metaphysical, and newly-invented approaches to healing, as well as pre-modern medical practices. You are responsible to pay 100% of Alternative Medicine expenses provided as "Services."

Services are amenities that are above, beyond and in addition to any covered medical service as part of the Welcome to Medicare physical, the Annual Wellness Visit covered by Medicare, or any medical office visits or office visits triggered by medical conditions. All members will receive recommendations that they may or may choose to not fully incorporate into their lifestyle, yet still choose to be a member.

Your Physician will provide the following services ("Services") beyond Plan benefits:

- The Membership Fee covers Alternative/Complimentary services as referenced above, integration with a holistic approach of incorporating education and recommendations of natural foods, herbal therapies and study resources for the support of body, soul and spirit with the goal of wholeness and good quality of life for each member and their family.

These Services do not include the cost of any diagnostic or laboratory testing, dietary supplements or books. Additional services may be offered from time to time, and they may be subject to limitations.

2. Medical Care Services Excluded from Membership Fee. The Membership Fee listed above covers only the non-covered and non-emergent Services. You and/or your insurer (your "Healthcare Plan"), as the case may be, will continue to be financially responsible for paying for all covered healthcare and medical care services received by you from the Medical Practice. As necessary, the Medical Practice will bill you and/or your insurer for such Healthcare Plan-covered medical or healthcare services provided to you.

3. Your primary medical care is directed by your doctor. The Doctor(s) of Bailey Family Medical Care, PC is/are not the agent(s), servant(s), or employee(s) of any other employer or business services provider, besides Bailey Family Medical Care ("Medical Practice").

4. Renewals and Termination. The Membership Fee covers a period of one (1) year (the "Term"). At the end of the first one (1) year period (the "**Initial Term**"), this Agreement will renew for successive one (1) year periods (each a "**Renewal Term**") and you will be billed for the next Renewal Term according to your billing preferences, unless this Agreement is earlier terminated according to the terms herein. You may terminate your participation at any time upon ninety (90) days' advance written notice to the Medical Practice. If you terminate this Agreement for any reason, you will be entitled to a prorated refund of any unused portion of your Membership Fee. Such prorated refund will be based on the number of days you have participated in the Program during the period covered by your most recent Membership Fee payment. Upon your doctor's receipt of this Agreement and the Membership Fee, your doctor 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).

5. Annual Membership Fee. Each Member will pay an annual fee ("Annual Fee") of $1,800 (One Thousand Eight Hundred Dollars) to Cypress for all Physician Services described above. Discounts to the Membership Fee (I.E.; reduced Couples or Family discounts, etc.) may be provided and are up to the sole discretion of the physician. Initial payments are processed at the time of enrollment. Subsequent payments are charged quarterly, semi-annually or annually as elected by the Member.

6. Co-Payments and Deductibles. The Membership Fee is for services not covered by your Plan or any other plan, and does not affect the co-payments, co-insurance, or deductibles that you are required to pay pursuant to the terms of your health or other insurance coverage. You will be financially responsible for any co-payments, co-insurance, or deductible amounts required by your Healthcare Plan.

7. HSA/FSA/HRA. If you use a tax-favored vehicle to pay for or to reimburse medical expenses, such as a Health Savings Account (HSA), Medical Savings Account (MSA), Flexible Spending Arrangement (FSA), or Health Reimbursement Arrangement (HRA), please check with your tax advisor regarding the payment or deductibility for Membership Fees.

8. Relationship between Your Physician and Cypress. In exchange for compensation paid by the Medical Practice, Cypress provides administrative, education, marketing and member billing services to the Practice to facilitate the relationship between you and your Physician, and is responsible only for the periodic collection of fees. These services are provided by Cypress to the Medical Practice under a separate and distinct agreement, not incorporated by this reference, and you are not a third-party beneficiary of that agreement. You understand and acknowledge that your Physician is an independent contractor, and not the agent, servant or employee of Cypress. You further agree and understand that Cypress does not, and will not, provide, supervise or control the care that you receive from your Physician. Rather, all Physician Services are furnished and directed solely by your Physician, who exercises his/her own medical judgment in his/her practice of medicine. Cypress is not responsible for the judgment or conduct of any Physician who renders services to you.

9. E-mail and other Electronic Communications; Privacy. Under no circumstances email or electronic communications is to be used by members in emergency or time-sensitive situations. By entering into this Agreement, you consent to the Medical Practice communicating with you, for non-emergent communications including sending your protected health information to you electronically via the secured messaging system available through the patient portal provided through the electronic health record, and by telephone, and secure fax pursuant to Schedule 2 and in accordance with the current law. By signing this Agreement Member acknowledges that other forms of communication are not as secure.

In order to keep information secure Member must communicate all personal and health information through the secure patient portal, secure fax and the office voice mail or cell voice telephone communications, and only use other media mentioned above for notification that message has been left on patient portal. By signing this Agreement the Member acknowledges that they have been informed of secure ways of communication and if they choose to use other methods of non-secure communication they do so at their own risk. A copy of privacy policy is available upon request.

10. Entire Agreement. This Agreement, including any exhibits and attachments, constitutes the entire agreement between the parties and no other agreements, oral or written, have been entered into with respect to the subject matter of this Agreement. This Agreement supersedes all prior agreements, negotiations, and communications of whatever type, whether written or oral, between the parties hereto with respect to the subject matter of this Agreement.

11. Notices. Any communication required or permitted to be sent under this Agreement shall be in writing and sent to the party to be so notified via certified mail, return receipt requested, or provided via hand delivery, to the addresses set forth herein. Any change in address shall be communicated in writing to the other party.

12. Governing Law; Venue. This Agreement shall be governed by, construed and enforced under the laws of the State of Arizona, without regard to the conflict-of-law rules of Arizona or any other state. Any and all disputes arising under or related to this Agreement shall be subject exclusively to the jurisdiction of the appropriate federal district courts or the state courts located in Maricopa County, Arizona, and each party hereto hereby waives the claim or defense that such courts constitute an inconvenient or invalid forum.

13. Severability. The provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the parties.

14. Amendment. This Agreement may be amended at any time by mutual agreement of the parties without additional consideration, provided that before any amendment shall become effective, it shall be reduced to writing and signed by all the parties.

15. Captions. Any captions or headings of the articles, sections, subsections, paragraphs, or subparagraphs of this Agreement are solely for the convenience of the parties, are not a part of this Agreement and shall not be used for the interpretation or determination of validity of this Agreement or any provision hereof.

16. Waiver. By signing this Agreement you are indicating that you were informed of the Services which are not covered by your Healthcare Plan and this is signed in acknowledgement that you agree the Services are stated and paid for prior to receiving these services. No delay or omission by either party to exercise any right or remedy under this Agreement shall be construed to be either acquiescence or the waiver of the ability to exercise any right or remedy in the future. Any waiver of any terms and conditions hereof must be in writing, and signed by the parties hereto. A waiver of any term or condition hereof shall not be construed as a future waiver of the same or any other term or condition hereof.

17. Counterparts. This Agreement may be executed in any number of counterparts and transmitted electronically, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument.

18. Confidentiality. The specific terms of this Agreement are to be kept confidential between you and the Medical Practice.

ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

Bailey Family Medical Care ("Medical Practice") and Member enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and other forms of electronic communications (including Skype or FaceTime) may be utilized for communications between Medical Practice and Patient, and these communications may include references to the Patient's Personal Health Information ("PHI"). Patient authorizes Medical Practice to utilize the referenced electronic communication methods despite acknowledging that such electronic communication methods lack any guaranty of privacy. Medical Practice will engage in good faith reasonable efforts to protect Patient's privacy while engaging in such communication methods.

2. Patient agrees to provide accurate mobile telephone number, email address and Skype contact information to Medical Practice, and to immediately inform Medical Practice of any changes to Patient's electronic contact information. Patient authorizes Medical Practice to respond to any and all electronic communications that appear to be from Patient whether or not such communications arrive from the electronic contact information Patient provides Medical Practice.

3. Under no circumstances shall Patient utilize electronic communications to contact Medical Practice regarding an immediate emergency or time-sensitive situation: Patient must call 9-1-1 and/or immediately seek emergency medical attention.

4. Medical Practice values and appreciates Patient's privacy and takes commercially reasonable security measures to protect the Patient's privacy. Medical Practice shall comply with HIPAA/HITECH with respect to all electronic communications.

5. Patient acknowledges that electronic communications and related portable data communication and storage devices are prone to technical failures, are not 100% guaranteed to protect privacy, and can be hacked or the subject of theft or other events that may result in the loss of Patient's information or data (including PHI). Patient nevertheless authorizes Medical Practice to communicate with the Patient utilizing electronic communication solutions as requested and authorized by Patient. Patient shall hold harmless Medical Practice and its owners, officers, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or caused by electronic communication (whether encrypted or not) losses or disclosures caused by technical failures, privacy leaks, hacks, thefts, or other events not directly caused by Medical Practice.

6. Medical Practice will obtain the Patient's express written or electronic consent if Medical Practice is required or requested to forward Patient's identifiable PHI to any third party, other than as authorized and specified in the Medical Practice's Notice of Privacy Practices, or as authorized or mandated by applicable law. Patient hereby consents to the communication of such information as necessary to coordinate care and achieve scheduling with the Patient and all parties responsible for providing or overseeing care. Patient identifies the following individuals or entities as authorized to receive Patient PHI from Medical Practice in connection with authorized consulting, education, and all other aspects of supporting the Patient's care, and Medical Practice may share Patient PHI with such parties without additional written or electronic consent from Patient.

7. Patient acknowledges that Patient's failure to comply with the terms of this PHI Agreement may result in Medical Practice terminating the use of electronic communication methods with Patient, and may result in the termination of Patient's agreement for Medical Practice services.

8. Patient hereby consents to engaging in electronic and after-hours communications referenced above with reference to and communicating Patient's PHI, including communication with the parties identified in paragraph 6 above.

9. Patient understands that all electronic communication methods and platforms, while convenient and useful in expediting communication, are prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. Patient nevertheless authorizes the Medical Practice to communicate with the Patient regarding PHI via electronic communication methods and platforms referenced in this PHI Agreement, and with those parties designated by Patient as authorized to receive PHI. The Medical Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of Patient's PHI and HIPAA/HITECH compliance. Patient has received a Notice of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgement.

10. Patient has the right to request from Medical Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by Medical Practice shall not be the subject of additional charges to Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronic information. However, Patient's Medical Practice fees may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning and burning PHI to media and distributing the media with media costs charged to Patient; and Medical Practice administrative staff time spent preparing additional explanations or summaries of PHI. If Patient requests that Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive), Medical Practice's actual supply costs for such equipment may be charged to Patient and Patient agrees to pay Medical Practice such costs.

11. This PHI Agreement will remain in effect until either Patient or Medical Practice provides written notice to the other party revoking this PHI Agreement or otherwise revoking consent to electronic communications between the parties. Such revocation will occur thirty (30) calendar days after written notice of such revocation. Revocation of this Agreement will preclude Medical Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law or by Patient. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Medical Practice for all present and future purposes.

Membership Application

Physician Name: ___**Bailey Family Medical Care**_____ ❑ **Single** ❑ **Couple** ❑ **Family**

First Name _____(M/F) 2nd Member First Name _____ (M/F)

Last Name_____ 2nd Member Last Name _____

Date of Birth _____ 2nd Member Date of Birth _____

Phone: Primary (_____) _____(h/c/w) 2nd Member Primary (_____) _____(h/c/w)

Phone: Alternate (_____) _____(h/c/w) 2nd Member Alternate (_____) _____(h/c/w)

E-mail Address _____

Street Address _____

City, State, Zip Code _____

Primary Insurance_____ **Secondary**_____

Dependent _____(M/F) Date of Birth _____

Dependent _____(M/F) Date of Birth _____

Dependent _____(M/F) Date of Birth _____

**Add'l Adult Member _____(M/F) Date of Birth _____

**Add'l Adult Member _____(M/F) Date of Birth _____

Primary Insurance _____ **Secondary**_____

Referral Source:

Notes to Membership Services:

This program may be eligible for reimbursement through some HSA's/FSA's, etc. It is the responsibility of the member to receive approval from their benefits coordinator as to the amount that may be reimbursable.

I agree to the terms and conditions set forth in and acknowledge receipt of a copy of the Member Agreement and Electronic Communications Agreement for Personal Health Information. With the signature below I acknowledge that I am authorized to sign for all members listed above.

AUTHORIZED MEMBER'S SIGNATURE _____ Date _____

MEDICAL PRACTICE SIGNATURE _____ Date _____

PAYMENT

❑ Annual Payment _____ ❑ Semi-Annual Payment _____ ❑ Quarterly Payment _____

After initial payment, the payment schedule will begin on _____ based on your payment of choice.

❑ Credit Card Payment (Please circle: Visa/MasterCard/Discover) **OR** ❑ Check (made payable to Bailey Family Medical Care)

Cardholder Name:	
Billing Address:	
Credit Card Number:	
Expiration Date:	Security Code:

I acknowledge receipt of a copy of this agreement and agree to the terms of the payment plan listed above. I further authorize Cypress Management Group to charge my credit card for the balance of the fees not paid and in accordance with the payment schedule selected.

AUTHORIZED MEMBER'S SIGNATURE _____ Date _____