**AMY H. GORDON, M.D., LLC**

**PHYSICIAN/PATIENT AGREEMENT**

I, the undersigned, wish to receive my primary care medical services from Amy H. Gordon, M.D., LLC (the "Practice") and Amy H. Gordon, M.D. ("Dr. Gordon"). I understand that these medical services are offered subject to the following terms and conditions:

**1. Effective Date**. This Physician/Patient Agreement (the "Agreement") shall be in effect for a period of one year beginning the date contract and is signed and payment is received. This Agreement will automatically renew each year thereafter for an additional one-year renewal period, provided that I pay the Annual Fee listed in Attachment A by the due date(s) indicated. If I do not make such payment(s) by the applicable due date(s), this Agreement will automatically terminate.

**2. Services**. I understand that the Practice will provide certain standard primary care medical services as requested by me or as deemed necessary by Dr. Gordon in accordance with the established standard of care for internal medicine physicians, and certain additional services in connection with or as a supplement to these standard primary care medical services. All of these standard and additional services are listed in Attachment A. The services provided by the Practice and the applicable charges are all listed in Attachment A.

**3. Non-Participation in Medicare and Insurance Plans**. I understand that the Practice and Dr. Gordon do NOT participate or contract with any insurance plans, including, but not limited to, Health Maintenance Organizations (HMOs), Point of Service Plans (POSs), Preferred Provider Organizations (PPOs) or Preferred Provider Networks (PPNs), and that Dr. Gordon has opted out of the Medicare program. I therefore acknowledge that (a) the Practice will bill me, and not Medicare or my insurance plan, directly for the Annual Fee and any applicable additional charges; (b) payment of any such additional charges is due at the time the services are rendered; and (c) I, instead of Medicare or my insurance plan, will be fully and personally responsible for paying the Annual Fee and any applicable additional charges. I agree not to submit the Annual Fee or any applicable additional charges to Medicare or my insurance plan for reimbursement except as specifically noted in 5. below, and the Practice will not do so either. I understand that I may, at any point, elect to obtain medical care from a health care provider who has not opted out of the Medicare program or who participates with my insurance plan, rather than receiving medical care from the Practice, and that if I obtain medical services from such other health care provider, more favorable reimbursement may be available to me.

**4.** **Medicare Part B Beneficiaries**. If I am a Medicare Part B beneficiary, or if I will become a Medicare Part B beneficiary at any time during the initial one-year term of this Agreement, I also agree to the terms listed in Attachment B and will sign the Attachment B in addition to this Agreement to confirm my acceptance of those terms. If I become a Medicare Part B beneficiary during any renewal term of this Agreement, I agree to sign Attachment B and submit it to the Practice.

**5.** **Submission of Charges to Insurance Plans**.

a. Medical Services Covered by the Annual Fee. Certain insurance plans permit patients of the Practice to submit claims for medical services covered by the Annual Fee.

b. Medical Services Not Covered by the Annual Fee. Unless I belong to an HMO or am a Medicare Part B beneficiary, I understand that I may submit to my insurance plan claims for medical services covered by my insurance plan and not covered by the Annual Fee. Because I will pay the Practice directly for such services, any reimbursement by my insurance plan will be sent directly to me. If the Practice is mistakenly reimbursed by my insurance plan or Medicare, then the Practice will return the check to the payor. I understand that my insurance plan may not pay at all for some services provided by the Practice, and may only make a partial payment for other services provided by the Practice. I further understand that the Practice makes no representations or promises regarding the amount of payment to be received for any claim(s) I may submit to my insurance plan.

c. ***Medicare and HMOs do NOT permit me to submit claims for any services provided by the Practice, and I agree not to submit a claim for any such services to Medicare or any HMO***.

**6.** **Termination of this Agreement**. I understand that I may choose not to renew this Agreement by not paying the Annual Fee by the renewal date, after which this Agreement is considered terminated and I will no longer be considered a patient of the Practice. I may also cancel this Agreement at any time by sending the Practice written notice (a) stating that I wish to cease using the Practice for my medical services and (b) requesting that a copy of my medical record be sent to either another physician or directly to me. The Practice may also terminate this Agreement and Dr. Gordon's physician-

patient relationship with me at any time upon ninety (90) days' written notice; in such case, the Practice will assist me in finding another primary care physician to take over my care at the end of the 90-day notice period. If this Agreement is terminated by either the Practice or me before the end of the contract year, a pro-rata portion of the Annual Fee (based on whole months remaining in the contract year) or of the most recent quarterly installment of the Annual Fee if I have chosen to pay quarterly (based on whole months remaining in the contract quarter) will be refunded to me within ninety (90) days after the effective date of termination. If I have already received my Annual Physical Examination for the year, then $750 will be deducted from any pro-rata refund owed to me.

Patient Name: _____ AMY H. GORDON, M.D., LLC
(*please print*)

Patient Signature: _____ By: _____
Amy H. Gordon, M.D., Member

Date: _____ Date: _____

*If the Patient is a minor, the Patient's parent or legal guardian must sign below indicating the parent or guardian's acceptance of the above terms and agreement to pay the Annual Fee on behalf of the Patient:*

Name of Parent or Legal Guardian: _____

Signature: _____ Date: _____

**AMY H. GORDON, M.D., LLC**

**PHYSICIAN/PATIENT AGREEMENT**

## ATTACHMENT A

**ANNUAL FEE** (check the option of your choice)

____ $2000 per year per adult patient, payable at the beginning of the contract year by personal check.

____ $2000 per year per adult patient, payable in four quarterly installments of $500.00 each by personal check by the following dates: January 5, April 5, July 5, October 5.

____ $2050 per year per adult patient, payable at the beginning of the contract year by credit card.

____ $2050 per year per adult patient, payable in four quarterly installments of $512.50 each by credit card by the following dates: January 5, April 5, July 5, October 5.

- Where both spouses are signed-up for the Practice, the second spouse will receive a $500 discount off the regular Annual Fee ($3500 per couple).

- Annual fee for young adult patients (16 – 25 years old) is half of the adult patient fee ($1000) if a parent is in the practice.

**AMY H. GORDON, M.D., LLC**

**PHYSICIAN/PATIENT AGREEMENT**

## ATTACHMENT A (continued)

## SERVICES COVERED BY THE ANNUAL FEE

- **Annual comprehensive preventative health assessment***
- **Office visits**: Up to 10 routine or sick visits per year
- **Additional Services**
    - 24-hour direct access to Dr. Gordon by cell phone and email (except during vacations/continuing medical education, where coverage will be provided by another board-certified internist). Emails received after 5 pm to be returned on or before next business day.
    - Scheduling of appointments with physicians and facilities for tests, consultations
    - Coordination of your care with specialists and other providers
    - Physician review of testing and consults from other providers
    - Prescription refills or changes handled outside of an office visit
    - Blood pressure checks, weigh ins
    - Prior authorization of medications required by your insurance company
    - Pre-authorization forms for medical services**
    - Faxing/emailing of test results to you

* Associated labs, EKG, and other diagnostic testing are provided outside of the Practice and billed separately to patient's insurance.

**Except where in-plan physician referral is necessary.

**AMY H. GORDON, M.D., LLC**

**PHYSICIAN/PATIENT AGREEMENT**

## ATTACHMENT A (continued)

## SERVICES BILLED SEPARATELY ON FEE-FOR-SERVICE BASIS

- **Office visits ( in excess of 10 per year):** $30/each
- **House calls** (where needed): $50/each

**AMY H. GORDON, M.D., LLC**

**PHYSICIAN/PATIENT AGREEMENT**

## ATTACHMENT B (for Medicare Beneficiaries Only)

*I AGREE, UNDERSTAND AND EXPRESSLY ACKNOWLEDGE THE FOLLOWING*:

- Dr. Gordon has opted out of the Medicare program effective July 1, 2011, for a period of at least two years.

- Neither the Practice nor Dr. Gordon is involuntarily excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

- I accept full responsibility for payment of the Practice's charges for all primary care medical and other related items and services ("Services") furnished to me by the Practice.

- Medicare fee limitations do not apply to what the Practice and Dr. Gordon may charge for the Services they provide to me.

- I will not submit a claim (or request that the Practice or Dr. Gordon submit a claim) to the Medicare program for payment for any Services provided to me by the Practice or Dr. Gordon, even if the Services are covered by Medicare Part B.

- Neither the Practice nor Dr. Gordon will submit a Medicare claim for Services they furnish to me, and no Medicare reimbursement will be provided for such Services.

- No Medicare payment will be made for any Services provided to me by the Practice or Dr. Gordon even if those Services would have otherwise been covered by Medicare if I had not signed this Physician/Patient Agreement and this Attachment B, and a proper Medicare claim had been submitted.

- I enter into this Physician/Patient Agreement with the knowledge that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare-covered or services furnished by other physicians or practitioners who have not opted out of Medicare.

**AMY H. GORDON, M.D., LLC**

**PHYSICIAN/PATIENT AGREEMENT**

## ATTACHMENT B (for Medicare Beneficiaries Only)

- Medigap plans do not provide payment or reimbursement for items and services (such as any Services provided to me by the Practice or Dr. Gordon) not paid for by Medicare, and other supplemental plans may likewise deny payment or reimbursement for such services.

- I am not currently in an emergency or urgent health care situation, and do not currently require emergency care or urgent health care services.

- A copy of this Physician/Patient Agreement with this Attachment B has been provided to me.

  Patient Name (*please print*): _____

  Patient Signature: _____ Date: _____