MITCHELL MEDICAL GROUP OF NY, PC
PATIENT MEMBERSHIP AGREEMENT

This Membership Agreement ("Agreement") is entered into and effective as of the_____day of _____, 20___ (the "Effective Date"), by and between the person signing below ("Member" or "you") and Mitchell Medical Group of NY, PC ("Mitchell Medical Group").

Mitchell Medical Group provides medical services to patients, and employs Dean C. Mitchell, M.D. (the "Physician") for the purpose of providing the services defined in this Agreement. You desire to receive, in exchange for a fee, certain medical services ("Medical Services") and non-medical services ("Non-Medical Services") (collectively the "Services") from MMG as part of and by virtue of this Agreement. The purpose of this Agreement is to set forth the terms and conditions of how the Services will be furnished you by MMG. You and MMG therefore agree as follows:

1. **Medical Services**. MMG will provide you with the Medical Services described in this Table 1 (see page 6). As used in this Agreement, the term Medical Services means only those medical services that the Physician is permitted to perform under the law of the State of New York and that are consistent with his training and experience as a medical doctor. Generally, such services encompass health promotion, disease prevention, diagnosis, care, and treatment of patients during health and all stages of illness, with a focus on preventive care.

   EXCLUSIONS: Your Membership Fee **DOES NOT COVER**, and you may incur additional out-of-pocket costs for: hospitalization, surgical procedures, vaccines, medications, skin testing, sublingual oral immunotherapy, X-rays, and any diagnostic testing or lab work, pathology (pap smears, biopsies), emergency room visits, prenatal care, and other services not typically rendered by medical physicians in their medical offices. You or your insurance will be responsible for payment of all medical costs not covered by your Membership Fee.

2. **Non-Medical Services.** Your physician will make every effort to accommodate your health care needs as quickly as possible. There may be times when a physician or staff member is not immediately available. By signing this agreement you acknowledge that your physician may not be immediately available. You also acknowledge that the services under this Agreement are not intended to be a substitute for emergency care. If you believe you are in need of emergency care or treatment you should always call 911.

   E-Mail Access. You will be given the Physician's facsimile number and e- mail address to which non-urgent communications may be addressed. Such communications will be dealt with and responded to by the Physician or a staff member of the Practice in a reasonably timely manner.

3. **Membership Fees and Payment.** In exchange for the Services provided for in this Agreement, you agree to pay an annual membership fee ("Membership Fee") to MMG in the amount specified on the attached **Schedule "A" (see page 7).** You may elect to pay your Membership Fee annually,

quarterly, or monthly. You will designate your selected payment plan on Schedule "A". Membership Fee payments not received by the office will become inactive.

The annual Membership Fee covers a minimum period of a twelve month starting on the Effective Date of this Agreement. The fee schedule is subject to change in subsequent years. Members will be notified upon renewal of the annual membership of any fee increases and may elect to not renew without penalty. Your initial payment must be paid prior to your first visit. The Membership Fee is paid in addition to and not in exchange for any copayments, deductibles, or coinsurances,

MMG reserves the right to assess a returned check fee in the amount of $35.00 for any returned or declined check or ACH payment. lf this occurs, the member will no longer be eligible to remit payment by check or ACH.

4. **Membership Services.** The Membership Fee covers **ONLY** the defined Services described in Sections 1 and 2 of this Agreement. The defined services are not covered, in whole or in part, by private health insurance or third party payment programs providing health related benefits (including Medicare or any other Government payor) (collectively "Payors"). You represent and agree that the Services and the Membership Fee are not covered or reimbursable by any Payors. Neither you nor MMG shall submit a bill nor seek reimbursement or payment from any Payors for any portion of the Membership Fee or Services covered by the Membership Fee.

5. **Renewals and Termination.** This agreement will commence on the Effective Date and will extend for a minimum six month enrollment thereafter, except that either party shall have the absolute and unconditional right to terminate this Agreement for any reason by giving 30 days' prior written notice to the other party. Additionally, MMG may terminate this Agreement immediately upon your failure to pay the Membership Fee or for incompatible issues between the doctor and patient without cause.

   MMG will notify you of the renewal fee prior to the one (1) year anniversary of the Effective Date (the "Anniversary Date"). Unless terminated as set forth above, at the expiration of the initial one-year period (and each succeeding one-year period), this Agreement will automatically renew for successive one-year periods upon your payment of the Membership Fee. Failure to pay all or a portion of the Membership Fee by the Anniversary Date shall result in automatic termination of your membership.

6. **Medicare.** You acknowledge that MMG and the Physician will not provide services to you covered by Medicare and will not bill Medicare or receive payment from Medicare for any services provided to you. To the extent you receive services covered by Medicare from any other provider, you will make arrangements with such provider for payment. Neither MMG nor the Physician makes any representations whatsoever that the fees paid under this Agreement are or are not covered by your health insurance or by other third party payment plans applicable to you or your family. You will have the full and complete responsibility for any such determination.

7. **Insurance; Member Responsibility for Other Medical Coverage**. You or your insurance company will be responsible for paying any medical, clinical, diagnostic, or therapeutic services or items provided to you outside of MMG. This Agreement is not a substitute for health insurance or other health plan coverage (such as membership in an HMO). **You acknowledge that the Physician has advised you to keep in full force (or to purchase) your health insurance policy(ies) or plans in order to cover you and your family members for healthcare costs not covered by your**

Membership Fee under this Agreement (or if this Agreement is terminated) and to prevent gaps in health coverage.

8. **Communications**. You acknowledge that communications with MMG or the Physician using e-mail, facsimile, and cell phone are not guaranteed to be secure or confidential methods of communication. As such, you expressly waive the Physician's obligation to ensure confidentiality with respect to correspondence using such means of communication. You acknowledge that all such communications may become a part of your medical records.

   You authorize the Physician to communicate with you by e-mail regarding your "protected health information" (PHl) (as that term is defined in the Health Insurance portability and Accountability Act (HIPAA) of 1996 and its implementing regulations) using the e-mail address you provide to MMG. By providing MMG with your e-mail address, you acknowledge that:

   - E-mail is not a secure medium for sending or receiving PHI and, in particular, if you send or receive e-mail through your employer's e-mail system, your employer may have the right to review it;

   - Although MMG and the Physician will make reasonable efforts to keep e-mail communications confidential and secure, neither MMG nor the Physician can assure or guarantee the confidentiality of e-mail communications;

   - In the discretion of the Physician, e-mail communications may be made a part of your permanent medical record; and

   - E-mail is not an appropriate means of communication regarding emergency or other time sensitive issues or for inquiries regarding sensitive information.

     lf you do not receive a response to your e-mail message within two days, you agree to use another means of communication to contact the Physician. Neither MMG nor the Physician will be liable to you for any loss, cost, injury, or expense caused by, or resulting from a delay in responding to you as a result of technical failures, including, but not limited to: (i) technical failures attributable to any internet service provider; (ii) power outages or failure of any electronic messaging software; (iii) failure to properly address e-mail messages; (iv) failure of MMG'S or the Physician's computers or computer network, or faulty telephone or cable data transmission; (v) any interception of e-mail communications by a third party; or (vi) your failure to comply with the guidelines regarding use of e-mail communications set forth in this section.

   _____Please initial here to acknowledge that you have read and understood this Section 8.

9. **Assignment**. You may not assign this Agreement, or any of the rights and benefits provided in this Agreement, without prior written consent from MMG. Any attempt to assign this Agreement without such consent shall be null, void, and of no legal effect. MMG may assign this Agreement to any entity that is a successor to MMG, provided that Dean C. Mitchell, M.D. will continue to serve as the Physician hereunder.

10. **Notices**. Any communication required or permitted to be sent to the other party under this Agreement shall be in writing sent via certified mail, return receipt requested, to the address set forth

in this Agreement, or by hand delivery or delivery by Fed Ex or similar delivery service. Any changes in address shall be communicated to MMG in accordance with this section.

11. **Amendment**. No modification or amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties hereto. Notwithstanding the foregoing, MMG may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending you written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by MMG, except that you shall initial any such change at MMG's request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

12. **Severability; Payment**. lf for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with Applicable Law in its modified form, and that provision shall then be enforceable.

13. **Arbitration of Disputes**. All disputes arising out of this Agreement will be submitted to arbitration in the county in which the Physician is located, pursuant to the rules of the American Arbitration Association then in existence in New York. The decision in arbitration shall be conclusive and binding on the parties and may be reduced to judgment in any court of competent jurisdiction- The parties expressly waive their right to trial in any court.

14. **Relationship of Parties**. You and the Physician intend and agree that the Physician, in performing his duties under this Agreement, is an independent contractor, as defined by the guidelines promulgated by the United States Internal Revenue Service and/or the United States Department of Labor, and the Physician shall have exclusive control of his work and the manner in which it is performed.

15. **Legal Significance**. You acknowledge that this Agreement is a legal document and creates certain rights and responsibilities. You also acknowledge that you have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

16. **Effective Date**. This Agreement shall be effective on the date provided above, provided that your Membership Fee payment has been received. MMG is not obligated to accept this Agreement or payment, and may, in its sole discretion, elect not to do so, based on limitation on the number of Members and other restrictions deemed appropriate by MMG.

17. **Miscellaneous**. This Agreement shall be governed by and construed in accordance with the laws of the State of New York notwithstanding the principles of conflicts of law. This Agreement contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement. This Agreement should be understood in its entirety by the Member prior to signing.

By signing below, the undersigned Member(s) acknowledges that he or she has read and understood this Agreement and is signing this Agreement freely and voluntarily.

MEMBER

Signature:_____

Print Name:_____

Date:_____

Acknowledged and accepted by MMG:

Mitchell Medical Group of NY, PC

By:_____
Dean C. Mitchell, M.D.

Date:_____

You may receive a copy of this Membership Agreement upon request.

TABLE 1

ANNUAL LIST OF SERVICES

(ANY UNUSED PORTION WILL BE FORTIFIED)

OPTION 1
$250 MONTHLY

★ A total of 8 of telehealth or in-person visits with Dr. Mitchell
★ 1 set of Intramuscular Vitamin Injections three months
★ Email correspondence
★ 10% discount on all services

ADDITIONAL SERVICES: _____ INITIALS

OPTION 2
$300 MONTHLY

★ A total of 6 of telehealth or in-person visits with Dr. Mitchell
★ 1 set of vitamin injections every other month
★ Email correspondence
★ 10% discount on all services

ADDITIONAL SERVICES: _____ INITIALS

OPTION 3
$375 MONTHLY

★ A total of 4 telehealth or in-person visits with Dr. Mitchell
★ 5 Intravenous Vitamin Infusion
★ 1 set of Intramuscualr Vitamin Injections per month
★ Email correspondence
★ 15% discount on all services

ADDITIONAL SERVICES: _____ INITIALS

Membership Plans

FEATURES	OPTION 1 $250 MONTHLY	OPTION 2 $300 MONTHLY	OPTION 3 $375 MONTHLY
Total Visits with Dr. Mitchell	8 visits (telehealth or in-person)	6 visits (telehealth or in-person)	4 visits (telehealth or in-person)
Intramuscular Vitamin Injections	1 set every 3 months	1 set every other month	1 set monthly
IV Vitamin Infusions	---	---	5 included per year
Email Correspondence with Dr. Mitchell	Yes	Yes	Yes
Discount on All Services	10%	10%	15%
Best For	Patients needing consistent medical oversight + light vitamin support.	Patients who rely on frequent vitamin injections + steady follow-up	Patients needing intensive support, especially mold, chronic fatigue, & complex illness care.

SCHEDULE A
Payment Options

MEMBERSHIP FEE SCHEDULE:

PLEASE SELECT A PLAN (CHECK BOX AND PRINT/SIGN NAME)

Membership Options	SIGNATURE	PRINT NAME
Option 1 □ A-$3,000		
Option 2 □ $3,600		
Option 3 □ A-$4,500		
Option 4 Family □ $5,500		

1. How will you pay the total membership fee (check one)?

   □ Annually *(1 lump sum payment)*
   □ Quarterly *(4 equal installments)*
   □ Monthly *(12 equal installments)*

   ●*Payments not received by due date will cause your membership to become inactive.*

2. Please select method of payment (check one):

   □ Check (please make checks payable to: Mitchell Medical Group of NY, PC)
   □ Credit/ Debit Card*
   □ ACH (checking account)*

   **If you are paying by Credit/ Debit Card or ACH, you must complete the PAYMENT AUTHORIZATION Form of this Agreement. Payment by Credit/ Debit Card or ACH will auto renew based on the payment frequency you selected.*

Credit Card Number Exp Billing Zip

SCHEDULE B

Medicare Opt-Out Agreement

This Medicare Opt-Out Agreement ("Opt-Out Agreement") is between Mitchell Medical Group of NY, PC, a New York limited liability company, and Dean C. Mitchell, M.D. (collectively, the "Physician"), whose principal medical office is located at 57 West 57th Street, Suite 601 New York, New York 10019 and 165 North Village Avenue, Suite 129 Rockville Centre, New York 11570
and _____(the "Member"), who resides at

_____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997.

1. Physician agrees to provide the medical services described in the Patient Membership Agreement (the "Services") to the Patient. In exchange for these Services, the Member agrees to make payments to Physician pursuant to the Membership Fee Schedule attached to the Patient Membership Agreement.

2. **Member agrees, understands, and expressly acknowledges the following:**

   - Member accepts full responsibility to make payment in full for the Services.
   - Member acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to changes for the Services.
   - Member agrees not to submit a claim (or to request that physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare part B.
   - Member acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
   - Member understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
   - Member acknowledges that he has a right, as a Medicare beneficiary to obtain Medicare covered items and services from physicians and practitioners who have not opted-out of Medicare, and that he is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
   - Member acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
   - Member is not currently in an emergency or urgent health care situation.

- Member acknowledges that a copy of this Opt-Out Agreement has been made available to him/her before items or services were furnished to him/her under the terms of the patient Membership Agreement.

3. The Physician has informed the Member that Physician has opted out of the Medicare program effective on _____for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

4. The parties agree that this Opt-Out Agreement shall be fully binding on their heirs, successors, and assigns.

MEMBER

Signature:_____

Print Name:_____

Date:_____

MITCHELL MEDICAL GROUP OF NY, PC
a New York limited liability company

By:_____
Dean C. Mitchell, M.D.

Date:_____

DEAN C. MITCHELL, M.D., individually

Signature:_____

Date:_____

[MINOR CHILDREN TO BE COVERED UNDER THIS AGREEMENT]

Please print the names of any minor children to be covered by this Agreement below:

_____

_____

_____

Please sign below and indicate Your relationship to the minor child(ren) above:

_____ Date:_____

_____
Print name

My relationship to the above child(ren) is _____

CONTROLLED SUBSTANCE ACKNOWLEDGMENT FORM

Your Physician may prescribe certain controlled substances for You from time to time as She/he deems medically appropriate. However, Your Physician does not treat chronic pain and does not provide chronic pain management. As such, any controlled substances that may be prescribed to You will be prescribed on a limited, short-term basis.

By signing below, You understand and acknowledge that neither Your Physician nor the Practice provides long-term pain management/ treatment services and that You will not be prescribed any controlled substances on a long-term basis. You further agree to inform Your Physician of all controlled substances that are prescribed to You by any other provider and acknowledge that this is an on-going obligation on Your part as a Patient of the Practice.

_____ Date:_____

Patient/ Legal Representative Signature

_____

Print Patient Name

_____ _____

Print Legal Representative Name Relationship to Patient

_____ Date:_____

Patient/ Legal Representative Signature

_____

Print Patient Name

_____ _____

Print Legal Representative Name Relationship to Patient