



Services and Payment Terms for Concierge Membership

1. **Medical Services.**

As used in this Agreement, the term Medical Services shall mean those medical services that the Physician, himself, and or Viva Med is permitted to perform under the laws of North Carolina and that are consistent with his training and experience as an Internal Medicine/Family Practitioner include but are limited to the following:

a. **Wellness Examination:**

Yearly physical to include an EKG, Chest X-ray, Pulmonary Function studies, Comprehensive Lab screening (CBC, TSH, CMP, PSA, and Pap smear), advanced cholesterol testing, Wellness Plan, Health Risk Assessment, Vision and Hearing screening. In addition, yearly TSH (thyroid), PSA level (prostate) are included.

b. **Basic Lab testing:**

"Basic Lab testing" is included with the Concierge Membership for the members(s) as medically necessary. "Basic Lab testing" is defined as follows: Complete blood cell count (CBC), Complete metabolic profile (CMP), cholesterol profile, A1C (diabetes testing), urinalysis, Strep testing, and influenza testing. For labs that fall outside of "Basic Lab testing", the patient will be offered a discounted cash price from Viva Med or choose to be billed by the reference lab at the reference labs rates, or the patient's insurance rates. A detailed listing of Viva Med's lab prices shall be made available for reference at the patient's request. If the patient chooses to use Viva Med's discounted cash pricing, payment of fees will be due and will be collected the day the tests are ordered. If you have insurance this can still be used at the reference lab.

c. **Yearly Flu Shot**

A yearly flu shot between September and February of each plan year is offered to all members as part of this agreement.

d. **Unlimited scheduled office visits**

All members can see their provider as many times as medically necessary as part of this agreement. Prior scheduling is required.

2. **Non-Medical, Personalized Services.** Viva Med shall also provide Patient with the following non-medical services ("**Non-Medical Services**"):

a. **Enhanced Access.** Patient shall have enhanced access to his or her provider. This includes extended office visits with minimal wait times as well as the provider's personal cell phone number, email address, and a HIPPA secured digital messaging application to contact the physician. Patient understands that email is reserved for non-urgent communications only, and that the provider or staff member of Viva Med shall deal with such communications in a timely



manner. Patient understands and agrees that email and digital messaging should never be used to access medical care in the event of an emergency, or any situation that the Patient could reasonably expect may develop into an emergency. Patient agrees that in such situations, he or she should speak directly to the practice during business hours or directly to the provider over the phone during nonbusiness hours. In the event that a phone conversation with the Viva Med personnel cannot occur in a timely fashion, the patient or patient's family member agrees to call 911 or go to the nearest emergency medical provider.

b. **Forms of Contact:** The patient Agrees to allow Viva Med personnel to contact you via Email or leave you a phone message to the contact information listed on your intake forms for any issue related to your care, payments, or other necessary communication. Patient agrees to update Viva Med as soon as possible with any changes or preferences in contact information to avoid delays in care.

c. **Non-Wait or Minimal Wait Appointment.** Every effort shall be made to assure that the Patient is seen by the Physician immediately upon arriving for a scheduled office visit or after a minimal wait. If the Physician or Viva Med staff foresee a wait time longer than expected, the patient will be contacted and advised of the projected wait time.

d. **Same Day/Next Day Appointments.** Viva Med will make every reasonable effort to provide same/day or next day access to a provider for sick visits or urgent needs. This excludes emergent care defined in paragraph 2a above. If same day appointment is not possible, Viva Med will make an appointment with the physician on the next normal business day. Should the request occur during the time noted in section 7, "outside call coverage", every attempt will be made to see you the patient the next day by a covering provider if your provider's absence will be longer than what is medically necessary to take care of your specific concern.

e. **Specialists.** Viva Med shall coordinate care with medical specialists to whom the Patient is referred, to assist the Patient in obtaining specialty care. Patient understands that fees paid under this Agreement do not include and do not cover specialist's fees or fees due to any medical professional other than the Viva Med Physician. _____ (Initial)

f. **Reduced rate Home/employment visits:** The enrolled member can request non-emergent home or place of employment visits. Pricing for these visits will be made available on request. Timing of such visit will be at the provider's convenience. Visit requests over 7 miles from Viva Med office at 705 W.H. Blvd Greenville, NC 27834 will also include a mileage fee. These charges



will be made fully known to the patient prior to care being initiated in this fashion. Patient also agrees and understands it is their responsibility to secure a private room suitable for outpatient medical care, and provide sufficient privacy for all parties involved in home or workplace care that takes place outside of Viva Med's office at 705 W.H. Smith Blvd.

3. Term: The term of this agreement is for 1 year from the date of signature and will renew automatically for another 1-year term at each anniversary of the signature of this agreement.

4. Disclaimer:

This agreement does not provide comprehensive health plan or insurance coverage. It provides only the services described herein. It is recommended that health insurance or other medical coverage be obtained to cover medical services outside of Viva Med and are not provided for under this direct care agreement. _____ **(Initial)**

5. Billing Cycle:

The signing party/guarantor understands that the services listed in this agreement are billed in arrears. Thus, all monies billed and or collected as part of this agreement are for services that have already been rendered. Therefore, no refunds will be given for services already rendered. A nonrefundable initiation fee at the beginning of the plan will be charged to set the plan up. Either party can terminate this agreement with or without cause. A 30-day written notification must be given to terminate this agreement by the patient. Monthly fee drafts, credit card charges, or other forms of monthly payment will be discontinued 30 days after said written notification. Any membership that is 90 days past due will be terminated along with access to their provider at Viva Med.

6. Outside Call Coverage: During the Physician's absence for vacations, continuing medical education, illness, emergencies, or days off, Viva Med may, at the discretion of the physician, arrange for call coverage with another provider for you, the patient. Viva Med will make an effort to notify you the patient ahead of time when possible of absences that will be prolonged over many days. During such time, any calls to the Physician, or to the Physician's office, will be directed to a provider who is "covering" for the Physician during his absence and you the patient shall be given instructions as how to contact such healthcare provider. While Viva Med will make every effort to arrange for such coverage for you the patient, Viva Med cannot guarantee such coverage.

Signature: _____ Date: _____

Print Name: _____



For Medicare and Medicaid Patients Only:

At Viva Med our top priority is you and your health, not your insurance plan. Some services provided by us such as routine office visits, physicals, and some lab work could be covered by Medicare if we were a Medicare or Medicaid provider. However, we do not accept any payment from Medicare or Medicaid nor have we ever billed Medicare or Medicaid. Since we are not billing Government or State insurance, we are only able to provide your medical care under a private contract. This means that you agree to pay us for our services, which we will not be reimbursed by Medicare or Medicaid. However, this only applies to services that Viva Med provides. Many times, our Medicare patients have asked us what happens if we refer them to a specialist, to the hospital or for other Medicare covered products or services that we do not provide (x-rays, MRI, specialty labs, medical equipment, etc.). All of these are still covered by Medicare for our patients.

Understanding the fixed income of some individuals on Medicare and Medicaid, we have significantly reduced fees. In some cases, the fees are reduced to levels that are less than your out-of-pocket cost might have been had you billed Medicare or Medicaid. If you would like to be a patient at Viva Medicine and understand and agree to these terms, please sign below indicating that you understand and accept this private contract

I have read and understand the payment procedures of Viva Med PLLC and agree to pay my bill in full at the end of each visit. I also authorize release of any necessary medical records by Viva Med PLLC and to any referrals on my behalf.

Signature: _____ Date: _____

Print Name: _____



Appendix 1

Fee Schedule for Concierge/membership patients are as follows:

Individual Plans:

Age 12 -18: \$10/month
Age 19-30: \$119/month
Age 31+: \$140/month

Family Plans:

2 parents/1 or more child: \$325/month
1 parent/2 children: \$210/month

Add ons:

X-ray Plan:

___ \$10/month covers as many x-rays as you need (Individual)
___ \$25/month covers as many x-rays as you family needs

Plan initiation Fee: (Non-Refundable)

\$99 per Adult charged at sign up
\$25 per Child charged at sign up
Family Max \$125 charged at sign up

Membership fees as set out in this agreement shall apply to all Patient(s) in the enrollment form. The guarantor of payment will be patient "1" on form below and must sign and agree to the financial agreement. The signee/Patient "1" noted below, will be responsible for all monthly fees and agree to the terms and conditions of the Viva Med fee schedule/membership fees. We do not accept split payments. All plans must be paid in full, on time and be up to date in good standing to receive the care outlined in the Concierge Care membership agreement. **I understand that accounts that are past due may result in delay of medical care including prescription refills and or dismissal from the practice. Memberships that are more than 3 months past due will automatically be canceled severing the membership agreement and the provider patient relationship. I understand I will have to find a new primary care doctor in this situation.**

All patients must have a credit/debit card on file or bank draft arrangement to cover the cost of membership and any incidentals not covered by the Concierge Membership Agreement. Incidentals must be paid at the time of service by the payment method on file, or by another card, check or cash. **To help keep our cost down and continue to provide high quality care we prefer to draft your bank account for monthly fees. We do however accept credit and debit cards for your convenience. At this time, we do not accept checks as form of payment for monthly fees. HSA (Health Savings Accounts) and MSA (Medical Savings Accounts) may be used for Viva Med charges, please check with your plan administrator for the details of services these accounts cover.



Enrollment Form

Patient "1" Name	Date of Birth (mm/dd/yyyy)	Age
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Mailing Address	City, State, Zip
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Home Phone	Alternate Phone	Email Address
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Spouse name (if applicable)	Date of Birth (mm/dd/yyyy)	Age
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Home Phone	Alternate Phone	Email Address
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Child(ren) to Whom this Agreement Applies:

Child's name (printed)	Date of Birth (mm/dd/yyyy)	Age
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Child's name (printed)	Date of Birth (mm/dd/yyyy)	Age
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Preferred Payment Method*

Monthly (____ Credit/Debit Card ____ Bank Draft)

Concierge Plan Type: _____	\$ _____
Additional Adults	\$ _____
Add on Plans:	\$ _____
Less any discounts	\$ _____
Total Rate	\$ _____

I certify that I have read, understand and agree to the terms set forth in the Viva Med PLLC Medical Agreement form. I further certify that I have received a copy of this form.

Signature and date: _____



Additional Enrollees:

Additional Adults:

Adult #1 Name	Date of Birth (mm/dd/yyyy)	Age
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Mailing Address	City, State, Zip
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Home Phone	Alternate Phone	Email Address
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Adult #2 Name	Date of Birth (mm/dd/yyyy)	Age
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Home Phone	Alternate Phone	Email Address
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Home Phone	Alternate Phone	Email Address
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Adult #3 Name	Date of Birth (mm/dd/yyyy)	Age
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Home Phone	Alternate Phone	Email Address
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Additional Child(ren) to Whom this Agreement Applies:

Child's name (printed)	Date of Birth (mm/dd/yyyy)	Age
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Child's name (printed)	Date of Birth (mm/dd/yyyy)	Age
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Child's name (printed)	Date of Birth (mm/dd/yyyy)	Age
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Child's name (printed)	Date of Birth (mm/dd/yyyy)	Age
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Signature and date: _____