LIVING WELL FAMILY MEDICINE
CONCIERGE MEDICINE PATIENT AGREEMENT

This Concierge Medicine Patient Agreement ("Agreement") is entered into by and between the undersigned patient(s) ("You" or "Patient")[1] and Living Well Family Medicine, LLC ("Practice") and is effective as of the date of Your signature.

In exchange for certain fees paid by You in accordance with this Agreement, the Practice, through Dee H. Carter, M.D. ("Physician") and its clinical and administrative staff, agrees to provide You with the "Services," as defined below, pursuant to the terms and conditions set forth in this Agreement.

NO MEDICARE REIMBURSEMENT

IF YOU ARE A MEDICARE BENEFICIARY, you are required to execute the Medicare Beneficiary Acknowledgement (Exhibit 3) for this Agreement to be effective. It is important that You understand that the items and services provided by Your Physician will not be covered by Medicare and that neither You, Your Physician, or the Practice may submit a claim to Medicare for any items or services You receive. Please carefully read the Acknowledgement for a full understanding of Your rights and responsibilities. If you have questions, please do not hesitate to ask Your Physician or to seek counsel of Your choosing prior to entering into this Agreement.

TERMS OF AGREEMENT

1. Services. In exchange for the fees, set forth in Paragraph 5 below, Physician agrees to provide all "Services" listed in Exhibit 1 to this Agreement. You understand and agree that the Services listed on Exhibit 1 are the only Services that will be provided under the terms of this Agreement. You understand and agree that the list of Services may be amended from time. However, the Practice will provide You with an updated list of the Services covered by this Agreement no later than thirty (30) days prior to the date any change in the Services will take effect.

You acknowledge and agree that Physician does not provide inpatient care and will not admit, treat, or follow You at any hospital should You need the services of a hospital. You further acknowledge and agree that neither the Physician nor the Practice provide obstetrical services, including midwife, doula, or similar services.

To the extent You require medical care not covered by this Agreement, Your Physician will refer You to another health care provider and/or assist You in finding a provider and will work with the provider of Your choosing to coordinate and ensure appropriate transfer of Your care, including providing him/her with copies of any relevant medical records.

2. Laboratory Testing. Should You require laboratory testing, the Practice will draw blood and/or collect other bodily fluids necessary to facilitate the required tests. The Practice will not bill You for any fees associated with drawing blood or collecting bodily fluids. However, you

[1] The term "You" or "Patient" shall refer to all adult parties to this Agreement (including a patient's legal representative), as well as any minor children for whom the parent or guardian requests that services be provided under this Agreement.

will be responsible for the cost of the laboratory test itself. The Practice contracts with a third-party laboratory to perform these tests, and You will be responsible for the costs of the tests. Any testing/laboratory costs that You incur will be itemized and included on the Practice's monthly invoice. You acknowledge and agree that You are responsible for paying those costs, which are not included as part of the Services provided under this Agreement. In addition, if You require additional tests that are not offered by the third-party laboratory with which the Practice has an agreement, you will be responsible for the costs of any such testing.

3. Medication Dispensing. The Practice will have certain routine medications in stock and may dispense those medications to You as a matter of convenience if You choose to receive them directly from the Physician/Practice. Any medications dispensed by Physician directly to You are not covered by the fees due under this Agreement. You acknowledge and agree that You are responsible for the cost of any medications dispensed directly to You and that the costs of said medications are not included as part of the Services provided under this Agreement and, thus, are not covered by the fees due by You under this Agreement. Physician will inform You of the cost of any medication prior to dispensing so that You may make an informed decision as to whether to pay the Practice for those medications or to have Your prescription filled at a pharmacy of Your choosing.

A. Limitations on Prescriptions for Controlled Substances. Physician may prescribe certain controlled substances for You from time to time as she deems medically appropriate. However, Physician does not provide long-term chronic pain management. As part of this Agreement, you must execute the Controlled Substances Acknowledgement Form, attached as Exhibit 2 to this Agreement, indicating Your understanding that Physician will not prescribe controlled substances on an on-going basis. Should You need long-term chronic pain management, Your Physician can recommend another provider to assist You in the care and treatment of Your pain management issues.

4. Physician Availability. Concierge medicine is intended to provide You with excellent, primary care/family medicine services in a convenient, professional manner. In that regard, Your Physician will make every effort to accommodate Your health care needs as quickly as possible. To ensure that You are provided with efficient yet exceptional health care, the Practice has limited membership in its concierge medicine program to approximately 600 patients at any given time. Your prompt care is important to us, and we intend to make every effort to ensure that Your experience with our concierge practice is a positive one. However, there may be times when Your Physician or another clinical staff member is not immediately available to treat You. For example, there may be holidays or other days in which Your Physician is not available. By signing this Agreement, you acknowledge that Your Physician may not be immediately available. You also acknowledge that You understand that the Services rendered 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 seek care from Your local hospital and/or call 911 for emergency medical services.

5. Fees. In exchange for the Services described on Exhibit 1, You agree to pay Practice a recurring monthly fee in accordance with the following schedule:

Age	Fee
5 – 17	$15.00 per month, per Patient in category (parent must also be a patient)[2]
18 – 49	$55.00 per month, per Patient in category
50 – 64	$70.00 per month, per Patient in category
Over 65	$85.00 per month, per Patient in category

The Practice will bill You this monthly fee, along with any additional costs at the end of each calendar month. Payment is due within ten (10) days of receipt of the invoice. Late payments will be assessed a fifteen (15%) percent penalty. The first payment due under this Agreement will be billed at the end of the calendar month in which this Agreement takes effect and will be pro-rated to cover only the number of days in the month in which this Agreement was in effect. Likewise, should this Agreement be terminated for any reason, you will be billed only a pro-rated amount covering the days of the most recent calendar month in which this Agreement was in effect.

6. Insurance. You understand and acknowledge that this Agreement is not an insurance plan and is not a substitute for a health insurance plan or health insurance coverage. **It is not intended to replace any health insurance plan or coverage that You may carry. You further understand and acknowledge that the Practice does not accept health insurance, including Medicare, and will not bill or submit any claim for any Services rendered under this Agreement, and You understand and acknowledge that the fees paid under this Agreement are not covered by any health insurance plan or coverage, including Medicare, you may carry.**

IF YOU ARE A MEDICARE BENEFICIARY, YOU MUST REVIEW AND SIGN THE MEDICARE BENEFICIARY ACKNOWLEDGEMENT.

7. Term and Termination. The term of this Agreement is month-to-month and may be cancelled by You at any time by notifying the Practice of Your desire to terminate the Agreement. The Practice may terminate this Agreement, for any reason, by giving You thirty (30) days prior written notice of its intent to cancel the Agreement and terminate the Physician-Patient relationship. Should the Practice and/or Your Physician choose to terminate this Agreement, the Practice and/or Your Physician will assist You in the transfer of Your care to another provider of Your choosing. Should this Agreement be terminated for any reason, you will be billed a pro-rated amount for the number of actual days in the last calendar month in which the Agreement was still in effect.

8. Notices. Any notice required to be provided to You under this Agreement will be delivered to the most recent address in Your Patient file at the Practice. Any notice that You may be required to provide under this Agreement may be delivered to the address set forth above or at such other address as may be provided to You by the Practice from time to time.

[2] The Practice does not accept patients under the age of 10. Persons between the ages of 10 and 17 are accepted as patients only if a parent is a patient as well.

9. Legal Significance. You acknowledge and understand that this is a legal document that creates certain legal rights and responsibilities. You have the right to seek legal counsel of Your choosing to advise You of Your rights and responsibilities prior to entering into this Agreement.

10. Amendment and Severability. No amendment of this Agreement shall be binding unless made in writing and signed by all parties. Notwithstanding the foregoing, the Practice may unilaterally amend this Agreement to the extent required by federal, state, or local law, upon providing You with timely written notice as may be dictated by the circumstances. If for any reason any provision of this Agreement is deemed by a court of law to be legally invalid or unenforceable, the validity of the remaining provisions shall not be affected, and the Agreement shall be considered modified and amended to the extent necessary to comply with the law.

11. Entire Agreement. This Agreement contains the entire agreement between the parties and supersedes all prior oral or written agreements or understandings between the parties with respect to the subject matter of this Agreement.

12. Assignment. This Agreement, nor any rights Patient may have under it, may be assigned or transferred by Patient to any other individual and any such attempt to assign or transfer this Agreement shall be considered null and void.

13. Governing Law. This Agreement shall be governed by the laws of the State of South Carolina and venue shall be in Lexington County, South Carolina.

[SIGNATURES OF ADULT PATIENTS BELOW]

_____ 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

[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 _____

EXHIBIT 1

COVERED SERVICES

The term "Services," as used in this Agreement, refers to the medical/clinical services provided to You by Your Physician and/or other clinical staff employed by the Practice, depending on the Physician's and the clinical staff's respective scope of practice; training; certification(s); limitation(s) of licensure, if any; and experience and expertise. By entering into this Agreement, you are entitled to the following Services:

- Comprehensive Wellness Examine, including a urinalysis. An EKG is also included for patients over the age of 40;
- Unlimited medically necessary office visits;
- Lesion removal;
- Laceration repair;
- Toenail removal;
- Lesion biopsies;
- Rapid strep test;
- Urine pregnancy test; and
- Ear wax removal.

In addition to the above-referenced clinical Services, you are entitled to the following non-medical Services:

- Timely Access: You will have access to Your Physician via a direct telephone number on a 24 hour per day/7 day per week basis. Your Physician will make every effort to provide a response as quickly as possible. As noted in the Agreement, however, there may be times when Your Physician cannot respond immediately. If Your Physician is unavailable due to vacations, illnesses, continuing medical education conferences, or any other reason, another Physician or another clinical professional designated by the Practice, will cover Your Physician's calls and will respond to You as quickly as possible. In that case, notification of Your Physician's unavailability will be provided to You when You call, and You will have the option, if You choose, to be seen by, or consult with, the covering Physician and/or other clinical staff member of the Practice.

- Email Access: If You completed and executed the Authorization for Communication by Email, you will have access to Your Physician and/or the Practice via email, and Your Physician and/or the Practice will make every effort to respond to Your email as quickly as possible.

- Minimal Wait Times: The Practice will make every effort to ensure that You are seen promptly at Your appointment time or with only a minimal wait. If there is an

unforeseen wait time, the Practice will contact You immediately to make You aware of the projected wait time, allowing You to adjust Your schedule or to reschedule Your appointment as You so choose.

- Same or Next Day Appointments: In addition to being seen timely upon Your arrival, the Practice will make every effort to schedule an appointment with You on the day of, or the next day following, Your request for an appointment.

- Home or Office Visits: You may request that Your Physician see You in Your home or at the Practice. In situations in which Your Physician considers a home visit reasonable and appropriate and/or is able to accommodate such a request, Your Physician will make every reasonable effort to accommodate the request for a home visit.

The above-referenced Services are the only Services provided under this Agreement. Any referrals to other providers are not covered by Your fees. If You have any questions about the Services covered, you are encouraged to speak with the Physician directly.

EXHIBIT 2

CONTROLLED SUBSTANCES ACKNOWLEDGEMENT FORM

Your Physician may prescribe certain controlled substances for You from time to time as she 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. Should You require long-term, chronic pain management, Your Physician will refer You to a provider to treat Your chronic pain and/or will assist You in transferring Your care and treatment to the provider of Your choice.

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

EXHIBIT 3

MEDICARE BENEFICIARY ACKNOWLEDGEMENT FORM

(to Be Attached, if applicable)