MEMBER INFORMATION **Physician's Name: _Dr. Lyle D. Kurtz__ Code: 2761**

Your name			
Gender	Date of birth (mm/dd/year)		
Street address			
City	State	Zip code	
Home phone	Cell phone	Work phone	
Email address	**Signature**		

SPOUSE INFORMATION (if joining)

Spouse name			
Gender	Date of birth (mm/dd/year)		
Street address			
City	State	Zip code	
Home phone	Work phone	Cell phone	
Email address	**Signature**		

CHILDREN INFORMATION (if participating must be between ages 18-26)

Child name	Date of birth (mm/dd/year)
Child name	Date of birth (mm/dd/year)

PAYMENT INFO

Number of members _____ at $5,000 per member = Total Annual $ _____

Fee may be paid (please choose one): ☐ Annual ☐ Semi-Annual

Please note: If you choose not to pay annually, there is a $10 processing fee associated with each payment beyond the first payment of each membership year.

Membership may be paid by:

- ☐ Check (please make checks payable to your physician)
- ☐ Automatic electronic debit from checking or savings account (attach a voided check)*
- ☐ Credit card*

Name on card	
Billing address if different from primary patient address	
Credit card number	
Expiration date (mm/yy)	Security code

***You authorize both the initial credit card or electronic debit and subsequent payments to be charged to your account 30 days prior to the start of each subsequent period.**

CONCIERGE CHOICE PHYSICIANS

MEMBERSHIP AGREEMENT FORM

LYLE D. KURTZ, M.D.

8920 WILSHIRE BOULEVARD • SUITE 323 • BEVERLY HILLS, CA 90211
(877) 888-5590

This Agreement (the "Agreement") between you and your physician ("Physician") sets forth the terms and conditions under which you shall participate in Physician's Concierge Choice Physicians Program (the "Program"). The Agreement will become effective on the later of (i) the date Physician begins the Program or (ii) on the first day of the month following the date that you sign this Agreement and pay your Membership Fee (the "Effective Date").

1. **The Services**. All participating members in the Program shall receive the comprehensive annual physical examination in exchange for their membership fee.

2. **The Cost**. The fee for a single membership in the program is $5,000.

3. **Your Physician**. We understand that you have chosen to participate in the Program because your Physician has chosen to participate. As your designated Physician may at some point in the future no longer be able to accept new Members or to continue the program due to disability, retirement, or other reasons, we will notify you of such unavailability and we will refund membership fee according to the terms in section 4.

4. **Term of Agreement**. Your membership terminates one year from the Effective Date unless renewed. Your membership will be automatically renewed thirty (30) days before its expiration unless you notify us to the contrary. This agreement can be terminated upon 30 days written notice. If the Agreement is terminated before you receive the services outlined in Section 1, above, you will receive a prorated refund of your membership fee. If you have already received those services, you will not be eligible for a refund and will be liable for any unpaid portion of your annual agreement. Unless otherwise terminated, this Agreement shall automatically renew for additional one year periods when each Term expires. Should your Physician's concierge practice reach the agreed upon limit of 600 Members before this Agreement is reviewed, or if your Physician decides to limit their Program to less than 600 members, we reserve the right to decline this Agreement. Once you have been accepted you will have the right to renew for as long as your Physician continues to participate in the Program.

5. **Reimbursement by Third Parties.** The Annual Membership Fee is intended to be strictly for services provided under this Membership Agreement that are not covered by your health insurance or other third party program. If for any reason, your Physician receives reimbursement from your health insurer for services provided under this Agreement that are covered services under your health benefit plan or other third party program, your Physician is required to refund to you a portion of your Membership Fee in the amount of reimbursement received or refund the amount received to the payer. You shall be responsible for the cost of any health care services furnished by your Physician that are not provided as part of this Agreement.

6. **Entire Agreement.** This shall constitute the sole and entire agreement between the parties, and no representations or promises not contained herein shall be binding. Any changes to this agreement shall only be effective if they are in writing, signed by all parties to this agreement.

7. **Notices.** Any communication required hereunder shall be made in writing to be sent via certified mail, return receipt requested to Concierge Choice Physicians, LLC at the address below.

8. **Applicable Law.** Any issue or question arising from the Agreement shall be decided based upon the laws of the State of California.

9. **Headings.** The descriptive headings of the sections of this Agreement are inserted for convenience only, do not constitute a part of this Agreement and shall not affect, in any way, the meaning or interpretation of this Agreement.

INTERNAL USE ONLY

process date_____ by_____ member number_____

check/confirmation number_____ amount paid_____

Billing and collection services provided by:
Concierge Choice Physicians, LLC
100 Merrick Road, Suite 410W • Rockville Centre, NY 11570
phone 516-766-0555 • fax 516-204-4013
email: members@choice.md