

INTEGRATIVE HEALTH, LLC

DIRECT PRIMARY CARE MEMBER AGREEMENT

NOTICE: This Member Agreement is NOT a health insurance plan. It is intended to supplement your existing health insurance coverage. This Member Agreement covers only the limited and routine health care services that are specified in this Agreement.

About Us

Welcome to Integrative Health, LLC. This Member Agreement describes our direct primary care program, which is a membership program. Under the membership program, you pay one monthly fee in exchange for access to our high-quality primary care and preventive health care services.

Our Membership Program

Eligibility. In order to participate in our program, you cannot be a beneficiary of any governmental healthcare program such as Medicare, Medicaid, or Tricare. If you are a recipient of a governmental health program, we can offer you our regular practice services consistent with our policies and procedures. You must commit to a 6 Month or 12 Month membership program.

Covered Services. See Exhibit A for the services that we offer as part of our membership fee. We have the right to change the type of covered services at any time, but we will give you at least 60 days' notice before any change. **Note: If you have a medical emergency, you need to call 911.**

Fees. Your membership starts the day you sign and date this Member Agreement and make your first membership fee payment. Your billing cycle automatically renews on the same calendar day each month for the duration of your selected term (6 Month or 12 Month). The monthly membership fees are contained in Exhibit B. The monthly membership fee will be paid by a pre-authorized credit card payment contained in Exhibit C. We reserve the right to change the monthly membership fee. We will notify you of any change in writing at least 60 days before fee changes. Fee changes will become effective for existing members upon completion of their current term (6 Month or 12 Month).

Non-Transferable. Membership benefits and membership cards are non-transferable and cannot be shared.

Your Responsibilities

Not Insurance. Our direct primary care program is not a health insurance plan and does not provide the minimum essential coverage required by federal law. While the majority of primary care services are included within our membership fee, there may be additional costs for non-covered services. Non-covered services may include but are not limited to: surgery, nursing care, specialty physician services, emergency room visits, diagnostic imaging, prescriptions, hospitalization, etc. If you have any questions about whether a service is included within the monthly membership fee, please contact us.

Non-eligible Insurers. Individuals with some insurance programs are not eligible for membership. You agree to disclose all current insurance programs. You also agree to notify us before you either enroll in a new insurance program or change insurers.

Medicare, Medicaid, Tricare. If you are eligible to participate in any governmental health program such as Medicare, Medicaid, or Tricare, you agree to notify us before you enroll. At this time, our membership program is not available to anyone enrolled in Medicare, Medicaid, Tricare, or another governmental health program.

Pre-existing Conditions. You agree to share with us any pre-existing conditions that you may have. You may still participate in our membership program with pre-existing conditions, but there are some conditions that will cost you more money if you go through our membership program since our membership program does not cover all care for these conditions. These conditions may be chronic illnesses or require specialty care and prescription medications. Please contact us before signing this Member Agreement if you have questions about whether our membership program is right for you.

Payment. You agree that you are responsible for paying the monthly membership fee and any additional costs for non-covered services. Membership fees can be paid through a Flexible Spending Account (FSA) or Health Savings Account (HSA). Integrative Health, LLC will submit your bill to your insurance company for any additional costs related to this membership program. If you do not pay us within 30 days of any fee that is due, whether for a monthly membership fee or a fee for non-covered services, we will temporarily suspend your membership. Once you have paid the entire bill, we will reinstate your membership. You understand you are committed to the full term of payments with a 6 Month or 12 Month membership regardless of termination.

Accurate Information. In order to provide you with excellent care, we need to know as much as we can about you. You represent and assure us that all of the information you have given us is accurate to the very best of your knowledge.

Appointments. 24 hours notice is required for cancellation of appointments; cancellation fees may apply.

Terminating the Membership

By signing this agreement you are committing to a 6 Month or 12 Month program beginning on the signing date of your contract. Your membership will automatically renew for the time frame of the previous term.

If you wish to end your membership in our direct primary care program, you can terminate this Member Agreement by notifying us in writing 30 days before the end date of your current term (6 Month, or 12 Month). If you have a 6 Month or 12 Month commitment, the member is understood to be responsible for payments for the full term upon termination.

We can also terminate this Member Agreement by notifying you in writing 30 days before we end your membership. If you violate any terms of this Member Agreement (such as not paying the monthly membership fee or being enrolled in a governmental health care program), we can terminate this Member Agreement immediately.

Acknowledgements

We may change the terms and conditions of this Member Agreement (such as the type of services we offer or the monthly membership fee) at any time and for any reason. Fee changes will become effective following the completion of your current term (6 Month or 12 Month). We will provide at least 60 days' notice before we change any terms or conditions.

By participating in our direct primary care program; we will establish a provider-patient relationship with you. Just like with our patients who are not part of our membership program, we agree to provide you high-quality care and to keep confidential any information that you share with us in accordance with applicable laws. We encourage you to actively participate in your care.

While we strive to make our policies and procedures clear to you, if you do have a complaint, we will review that complaint in a fair and timely manner. If we disagree over any issue related to this Member Agreement, you agree to participate in mediation prior to pursuing litigation.

By signing this Member Agreement, you agree that you have read this Member Agreement and that you will follow the terms of the Member Agreement. If you do not understand anything within this Member Agreement, you agree that you have asked questions about it.

Patient:

Name: _____

Email: _____

Signature: _____

Phone: _____

Date: _____

Integrative Health, LLC

By: _____

Its: _____

Date: _____

Exhibit A Covered Services

Integrative Health, LLC members have access to regular primary healthcare services, acute care services, comprehensive diagnostic testing, preventive services, chiropractic care, acupuncture, physical therapy, therapeutic massage, discounted medications and nutritional supplements, pediatric services (well-child visits, immunizations, and sports physicals), a fitness assessment and exercise plan, discounted aesthetic services, and much more. Please refer to the complete listing of diagnostic, preventive and wellness services below:

Primary Care

- Unlimited number of primary care visits as needed (i.e., illnesses, injuries, injections, stitches, flu shots, school & sports physicals, allergies strep tests, well child visits, allergies, fitness assessments, immunizations)
- An annual wellness physical (Includes PAP smear and breast exam for women, and prostate check for men, when appropriate)
- Additional visits with your primary care provider (three times per year) to review your laboratory panel and adjust treatment plan
- Wholesale-priced medications
- Chiropractic care and treatment
- Physical Therapy treatments as prescribed
- Acupuncture and oriental medicine
- Therapeutic massage

Diagnostic Testing and Modalities

- A Wellness Laboratory Panel three times per year for adults, including:
 - Complete blood count*
 - Complete metabolic panel
 - Advanced lipid panel (in addition to standard cholesterol testing)
 - Bio-markers of blood sugar metabolism such as HgbA1-C, Insulin
 - Bio-markers of inflammation such as hs-CRP, Fibrinogen, LpPLA-2
 - Vitamin D, Iron, B12 and Folate levels
 - Comprehensive thyroid panel
 - Sex hormone panel
 - Adrenal hormone test
- Regular body composition analysis
- Complete orthopedic/neurologic exam
- Annual electrocardiogram
- Therapeutic ultrasound
- Electrical muscle stimulation
- Postural exercises
- Kinesio Taping® rehabilitative technique
- Screening for food and environmental allergies as well as treatment

- Screening for auto-immune disorders
- Gua Sha treatments
- X-rays*
- MRI's*

* X-rays are at discounted pricing, and range from \$125-\$175 depending on views ordered

* MRI's are at discounted pricing; and range from \$500-\$700 for spine and other joints

* Specialized blood work may result in additional costs

Preventive Medical Services

- Nutrition guidance
- Skin exam and treatment of pre-cancerous and unsightly lesions
- Biopsy and excision of skin lesions when appropriate
- Fitness assessment and individualized exercise prescription
- Physical Therapy benefits (unlimited)
- Athletic training
- Discounted nutritional supplements

Pediatric Services

- Well child visits
- Sports physicals
- Immunizations

Aesthetic Services

- Monthly Free Service at Restore Beauty
- Discount of 10% on aesthetic services at Restore Beauty Center
 - Laser hair removal
 - Latisse[®] eyelash treatment
 - Skin care and facials
 - Auspect Clinical
 - Antipodes Organic
 - EltaMD[®] sun protection
 - Jet Peel[™] facial
 - Injectables
 - Bellafil[®]
 - Botox[®]
 - Dermal fillers
 - Juvéderm[®] XC
 - Micro needling
 - Restylane[®] Silk
 - Sculptra[®]
 - Voluma[®]

- “Vampire” facial and facelift (Selphyl)
- Fat & Cellulite Reduction
 - CoolSculpting
 - Cellulite Eraser
 - Radiofrequency body contouring
 - UltraShape
 - VelaShape III
- Laser Treatments
 - Fractional CO₂ laser resurfacing
 - elōs IPL photofacial for skin discolorations
 - elōs subablative skin rejuvenation
 - Profound non-surgical face lift
 - GentleLASE[®] Pro for brown spots
 - Skin Gym Liftmassage and Skin Tight
 - Madonna eye lift
 - Skin tightening
- Laser vein therapy
- Tattoo removal
- Sexual health treatments
 - O-Shot[®] for stress incontinence
 - P-Shot (Priapus Shot[®])

Remember: If you have a medical emergency, please call 911.

Exhibit B
Fees

A \$29 signup fee is required for all new members.

12 Month Membership Fees

Adult (18 and older): \$169/month

Additional Adult* in Immediate Family: \$169/month

Dependent (17 and younger): \$25/month

6 Month Membership Fees

Adult (18 and older): \$189/month

Additional Adult* in Immediate Family: \$189/month

Dependent (17 and younger): \$25/month

*Immediate Family membership is determined by common residence and age of member participant.

Exhibit C
Patient Registration

Patient Information

Name: _____

DOB: _____ SSN: _____ Insurance _____ :

Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Membership

Monthly Membership Fee: \$ _____

Last name of Primary Member: _____

Name of Additional Adults under this Membership: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

Payment

I authorize Integrative Health, LLC to charge my credit card in the amount of \$ _____ on the _____ of each month for membership in its direct primary care membership program.

I understand that this authorization remains in effect until this Member Agreement terminates. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, provided that the transactions correspond to the terms on this Exhibit C- Patient Registration form.

Cardholder Name: _____

Billing Address: _____

Card Number: _____

Expiration Date: _____ CSC: _____

Card Type: Visa, MasterCard, Amex, Discover

Printed Name: _____

Signature: _____

Date _____ :