JESSE SADIKMAN, M.D., LLC
PHYSICIAN-PATIENT AGREEMENT

I, the undersigned, wish to receive my family medicine services from Jesse Sadikman, M.D., LLC (the "Practice") and Dr. Jesse Sadikman ("Dr. Sadikman"). I understand these medical services are offered subject to the following terms and conditions:

1. **Effective Date**. This Physician-Patient Agreement (the "Agreement") shall be in effect for a period of one (1) year beginning on . This Agreement will automatically renew each year thereafter for an additional one-year renewal period, provided that I pay the Annual Fee listed in Attachment B prior to the renewal date. If I do not make such payment by the renewal date, this Agreement will automatically terminate.

2. **Covered Services**. I understand that the Practice will provide (a) certain standard family medicine services as requested by me or as deemed necessary by Dr. Sadikman, and (b) certain enhanced services in connection with or as a supplement to these standard family medicine services. All of these standard and enhanced services are listed in Attachment A and included in the Annual Fee, except as expressly stated otherwise in Attachment A. Additional services beyond those included in the Annual Fee will be billed to me at the rates indicated in Attachment A, or at the Practice's standard rates if no specific rates are indicated in Attachment A.

3. **Non-Participation in Medicare and Insurance Plans**. I understand that the Practice and Dr. Sadikman do NOT participate or contract with any insurance plans, including, but not limited to, Health Maintenance Organizations (HMOs), Point of Service Plans (POSs), Preferred Provider Organizations (PPOs), or Preferred Provider Networks (PPNs), and that Dr. Sadikman has opted out of the Medicare program (including Medigap and Medicare Advantage plans). I therefore acknowledge that: (a) the Practice will bill me, and not Medicare or my insurance plan, directly for the Annual Fee and any applicable additional charges; (b) payment of any additional charges is due at the time the services are rendered; and (c) I, instead of Medicare or my insurance plan, will be fully and personally responsible for paying the Annual Fee and any applicable additional charges. I agree not to submit the Annual Fee or any applicable additional charges to Medicare or my insurance plan (except as noted in Section 5 below) for reimbursement, and the Practice will not do so either. I understand that I may, at any point, elect to obtain medical care from a health care provider who has not opted out of the Medicare program or who participates with my insurance plan, rather than receiving medical care from Dr. Sadikman and the Practice.

4. **Medicare Part B Beneficiaries**. If I am a Medicare Part B beneficiary, or if I will become a Medicare Part B beneficiary at any time within two (2) years after the date of this Agreement, I also agree to the terms listed in Attachment C and will sign Attachment C in addition to this Agreement to confirm my acceptance of those terms. I understand that Dr. Sadikman is required to enter into a new private contract with me for each two-year period that he has opted out of the Medicare program.

5. **Submission of Charges to Insurance Plans**. Certain insurance plans may permit patients of the Practice to submit claims for services provided by the Practice and Dr. Sadikman. If my insurance plan is one of those, upon request, the Practice will provide me with a statement that I may submit to my insurance plan in accordance with the plan's rules. Medicare, Medigap, Medicare Advantage, TRICARE, and HMOs do NOT permit me to submit claims for services provided by the Practice, and I agree not to submit a claim for any such services to Medicare, Medigap, Medicare Advantage, TRICARE, or any HMO.

6. **Termination of this Agreement**. I understand that I may choose not to renew this Agreement by not paying the Annual Fee by the renewal date, after which this Agreement is considered terminated and I will no longer be considered a patient of the Practice. I may also cancel this Agreement at any time by sending the Practice written notice (a) stating that I wish to cease using the Practice for my medical services, and (b) requesting that a copy of my medical record be sent to either another physician or directly to me. The Practice may also terminate this Agreement and Dr. Sadikman's physician-patient relationship with me at any time upon sixty (60) days written notice; in such case, the Practice will assist me in finding another primary care physician to take over my care at the end of the 60-day notice period. If this Agreement is terminated by either the Practice or me before the expiration date of this Agreement, a pro-rata portion of the Annual Fee (based on whole months remaining in the Agreement) will be refunded to me within thirty (30) days after the effective date of termination. If I have already

received my annual comprehensive preventative health assessment and exam for the year, then $350 will be deducted from any pro-rata refund owed to me.

_____ Jesse Sadikman, M.D., LLC
Patient Name (*please print*)

_____ By: _____
Patient Signature Jesse Sadikman, M.D.
Date: _____ Date: _____

or

_____
Name of Minor's Parent or Legal Guardian (*please print*)

_____
Parent/Legal Guardian Signature

Date: _____

ATTACHMENT A
SERVICES INCLUDED IN THE ANNUAL FEE

Annual comprehensive preventative health assessment and exam

- EKG;
- Comprehensive lab panel (includes CBC, biochemical profile, glucose, renal function, liver panel, lipid panel, thyroid panel with TSH, cardio CRP, PSA for men, PAP for women);
- Pulmonary functions, if medically indicated;
- Vision testing;
- Stool cards, as medically indicated;
- Urinalysis;
- Nutrition and exercise counseling; and
- Formulation of a personalized preventive medicine plan

Additional Medical Care

- Administration of annual flu immunization.
- Immunization recommendations and administration of recommended vaccines (*cost of vaccines charged separately*).
- Unlimited blood draws & urine collections (when ordered by Dr. Sadikman, laboratory samples can be drawn at our office and sent to your insurance company's approved lab for testing).
- 10 office/video visits per year (additional visits at $25 each):
  - Routine office testing and procedures;
  - Sick visits;
  - Blood pressure checks; and
  - Weigh-ins.
- House calls and nursing home visits, when clinically indicated and appropriate:
  - Each house call/nursing home visit counts as 2 office/video visits;
  - Additional house calls/nursing home visits at $100 each.
- Enhanced preventative care services, such as diet, nutrition, and exercise counseling.
- Consultation with emergency room providers, as necessary and appropriate.
- Hospital visits, as appropriate; not as attending of record or official consultant, but to advise you and your family when you are admitted as an inpatient, and to coordinate care with hospital team.
- Review of tests and consults from other providers as they become available.

Coordination of Care

- Referrals to, assistance in scheduling appointments with, and coordination of your care with appropriate specialists and facilities.
- Coordination and monitoring of hospital admissions, inpatient care, and rehabilitation care.

Administrative & Access

- Direct access to Dr. Sadikman by cell phone - except during vacations/continuing medical education, where coverage will be provided by a qualified colleague.
- Completion of pre-authorization forms for medical services and prescription medications (except where an in-plan physician referral is required).
- Copies of lab and other diagnostic test results by telephone, fax, or email, if requested.
- Completion of medical history forms and medical necessity forms.
- Office announcements and reminders (e.g., arrival of flu vaccines, Dr. Sadikman's vacation schedule) emailed directly to you.
- Total number of patients in Practice limited in order to permit more personalized care and service.
- Access to your personal health record on-line via computer, smart phone, or tablet.
- Wait times for scheduled visits of less than 15 minutes (except in cases of unanticipated patient emergency).
- Regular office appointments available same day or next day; urgent visits available within 24 hours on weekdays.
- Portal access to review labs and to communicate with Dr. Sadikman.
- Video conferencing when appropriate.

ATTACHMENT B
ANNUAL FEE PAYMENT OPTIONS

Initial the option of your choice. (If you choose to pay by credit card, please complete and sign Attachment D - "Credit Card Charge Authorization".)

Individual Adult Membership

_____ One payment in full of $1,800 by check or credit card with return of Physician-Patient Agreement.

_____ Two semi-annual payments of $900 each by check or credit card; first installment due with return of Physician-Patient Agreement.

_____ Four quarterly payments of $450 each by check or credit card; first installment due with return of Physician-Patient Agreement.

Additional Adult Spouse Membership (if both spouses join the Practice, discounted rate for second adult patient in family)

_____ One payment in full of $1,700 by check or credit card with return of Physician-Patient Agreement.

_____ Two semi-annual payments of $850 each by check or credit card; first installment due with return of Physician-Patient Agreement.

_____ Four quarterly payments of $425 each by check or credit card; first installment due with return of Physician-Patient Agreement.

Child/Young Adult Membership (ages 6-26; at least one parent must be a current member of the Practice)

_____ One payment in full of $500 by check or credit card with return of Physician-Patient Agreement.

_____ Two semi-annual payments of $250 each by check or credit card; first installment due with return of Physician-Patient Agreement.

_____ Four quarterly payments of $125 each by check or credit card; first installment due with return of Physician-Patient Agreement.

ATTACHMENT C
MEDICARE BENEFICIARY CONDITIONS

I [OR MY LEGAL REPRESENTATIVE ON MY BEHALF] AGREE, UNDERSTAND, AND EXPRESSLY ACKNOWLEDGE THE FOLLOWING:

- Dr. Sadikman has opted out of the Medicare program effective January 1, 2019, for a period of two years, through December 31, 2020.

- Neither the Practice nor Dr. Sadikman is excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892, or any other section of the Social Security Act.

- I accept full responsibility for payment of the Practice's charges for all items and services furnished to me by the Practice or Dr. Sadikman.

- Medicare fee limitations do not apply to what the Practice and Dr. Sadikman may charge for items and services they provide to me.

- I will not submit a claim (or request that the Practice or Dr. Sadikman submit a claim) to the Medicare program for payment for any items and services provided to me by the Practice or Dr. Sadikman, even if the items and services are covered by Medicare Part B.

- Medicare payment will not be made for any items and services provided to me by the Practice or Dr. Sadikman even if those items and services would have otherwise been covered by Medicare if I had not signed this Physician-Patient Agreement and this Attachment C, and a proper Medicare claim had been submitted.

- I enter into this Physician-Patient Agreement with the knowledge that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other physicians or practitioners who have not opted out of Medicare.

- Medigap plans do not provide payment or reimbursement for items and services (such as any items and services provided to me by the Practice or Dr. Sadikman) not paid for by Medicare, and other supplemental plans may likewise deny payment or reimbursement for such items and services.

- I am not currently in an emergency or urgent health care situation, and do not currently require emergency care or urgent health care services.

- A copy of this Physician-Patient Agreement with this Attachment C has been provided to me.

_____	_____
Patient Name (*please print*)	Patient's Legal Representative
_____	_____
Patient Signature Date: _____	Legal Representative's Signature Date: _____

ATTACHMENT D
CREDIT CARD CHARGE AUTHORIZATION

I understand that I am responsible for the Annual Fee as outlined in Attachment B of the Physician-Patient Agreement commencing on . I have initialed next to the payment option of my choice and hereby authorize the Practice to charge the below credit card as follows:

Individual Adult Membership

_____ One payment in full of $1,800 with return of Physician-Patient Agreement.

_____ Two semi-annual payments of $900 each; first installment due with return of Physician-Patient Agreement.

_____ Four quarterly payments of $450 each; first installment due with return of Physician-Patient Agreement.

Additional Adult Spouse Membership (if both spouses join the Practice, discounted rate for second adult patient in family)

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Child/Young Adult Membership (ages 6-26; at least one parent must be a current member of the Practice)

_____ One payment in full of $500 with return of Physician-Patient Agreement.

_____ Two semi-annual payments of $250 each; first installment due with return of Physician-Patient Agreement.

_____ Four quarterly payments of $125 each; first installment due with return of Physician-Patient Agreement.

I understand that in order to protect my credit card payment information, the Practice will securely destroy this authorization immediately after the charge has been successfully processed with my credit card company for the year's Annual Fee. I understand and agree that I will need to submit a new credit card authorization for any subsequent contract year's Fees that I wish to pay for by credit card.

Name of Patient (please print): _____

Cardholder's Name (please print name as it appears on card): _____

Credit Card (please check one): _____ VISA _____ MasterCard _____ American Express _____ Discover

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

_____ _____
Cardholder's Signature Date

_____ _____
Billing Address City State Zip