

31 E. Lee Street, Bel Air, MD 21014
P: 410-638-5339 F: 410-638-8877

REASON FOR COMING TO LPC:
(check all that apply)

Primary care ____ HRT ____
Pediatrics ____ GYN ____

PATIENT REGISTRATION

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NO: ____ - ____ - ____

LOCAL ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME PHONE: (____) ____ - ____ CELL PHONE: (____) ____ - ____

WORK PHONE: (____) ____ - ____ EMAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

MARITAL STATUS: ____ NAME OF SPOUSE/SIGNIFICANT OTHER: _____

.....
EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____

Relationship to Patient: _____

Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____

DO YOU HAVE A LIVING WILL OR SOMEONE WHO MAKES MEDICAL DECISIONS FOR YOU?
YES OR NO

IF YES, NAME _____

RELATIONSHIP _____ PHONE _____

.....
PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: (____) ____ - ____ Pharmacy Fax (____) ____ - ____

HOW DID YOU HEAR OF LYNCH PRIMARY CARE? _____

WHICH DOCTOR ARE YOU HERE TO SEE? _____

LYNCH PRIMARY CARE

31 E. Lee Street
Bel Air, MD 21014

MEMBERSHIP AGREEMENT

This Membership Agreement (this "Agreement") is by and between Lynch Internal Medicine, LLC, a limited liability company that practices medicine ("Lynch Primary Care"), and _____ (the "Member"), a Maryland resident, and specifies the terms and conditions under which the Member may participate in the "Program" offered by Lynch Internal Medicine. This Agreement between Lynch Internal Medicine and the Member will become effective on the date this Agreement is signed by the Member and the first payment is received; provided, however, that such effective date shall not be before October 5, 2009.

I. The Program

In exchange for the Membership Fee (as defined below), Lynch Internal Medicine agrees to limit the number of members the practice serves in order to provide the following amenities:

- Personalized, coordinated preventative health care
- Same day or next day appointments
- Appointments with minimal or no wait time
- Extended appointment times
- 24/7 contact with Dr. Lynch or Dr. O'Hare (or covering practitioner)
- Assistance in handling medical needs while traveling

The Member acknowledges that these amenities are not covered by insurance and are not reimbursable by the Member's insurer or other health plan.

II. Annual Membership Fee and Deposit

There will be an annual membership fee (the "Membership Fee") which is currently two thousand Dollars (\$2000) per year provided that you pay the entire Membership Fee by the time of your first office visit. If you choose to pay the Membership Fee in installments as set forth in Exhibit A, "Retainer Fee Schedule", which is attached hereto, then additional charges apply. *Please see attached Exhibit A, "Retainer Fee Schedule - Member Program", for payment options, which is attached hereto and made a part hereof.*

Upon signing this Agreement, Lynch Internal Medicine acknowledges that the Member has either paid the Membership Fee in full or has made the first payment of the installment plan that the Member has chosen to accept.

The amount of the annual Membership Fee will not change from year-to-year unless Lynch Internal Medicine provides the Member with thirty (30) days advanced notice prior to the end of a membership year.

III. Renewals and Termination

The Initial Term of this Agreement shall be for one (1) year, and this Agreement shall renew automatically for successive one-year renewal terms (each a "Renewal Term") unless either party gives the other party written notice of intent not to renew in accordance with the provisions stated below. Failure to pay the Membership Fee within the first two (2) weeks of a Renewal Term may result in termination of the Member's membership in the Program.

Lynch Internal Medicine may terminate this Agreement for any reason with thirty (30) days prior written notice to the Member, and the Member is entitled to a monthly prorated refund of the Membership Fee.

The Member may terminate this Agreement for any reason at any time with prior written notice in which case the Member is entitled to a monthly prorated refund of the Membership Fee.

IV. Health Care Services Excluded from Membership Fee

The Membership Fee covers only the amenities stated herein. Lynch Internal Medicine will also provide internal medicine services to the Member at no additional cost to the Member and in accordance with the Member's insurance coverage.

Lynch Internal Medicine will use other physicians or practitioners to cover patients during those infrequent times when J. Kevin Lynch, M.D. or Kendal O'Hare is out of town or during such time as he may be unavailable by cell phone.

V. E-mail Communications

If the Member wishes to send e-mail communications to, and receive email responses from, Lynch Internal Medicine or its agents or representatives, the Member should be aware that e-mail is not a secure medium for sending or receiving sensitive personal health information. Lynch Internal Medicine will take steps to keep your communications confidential and secure in compliance with state and federal laws governing the confidentiality of medical records and protected health information. The Member acknowledges and understands that e-mail is not a good medium for urgent or time-sensitive communications. In the event a communication is time-sensitive, the Member agrees to communicate with Lynch Internal Medicine by telephone or in person. The Member acknowledges and understands that e-mail communications may become part of the Member's permanent medical record.

VI. Miscellaneous

1. The Agreement may not be assigned by the Member and may not be assigned by Lynch Internal Medicine without the Member's prior written approval. No amendments or additions to this Agreement shall be binding unless set forth in writing and signed by the parties. Any waiver by either party of any breach of any provision of this Agreement shall not be considered as, or constitute a continuing waiver or waiver of any other breach of any provision of this Agreement.
2. In the event any term or provision of this Agreement is rendered invalid or unenforceable by any federal or state law, rule or regulation or is held by any court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions of this Agreement shall remain in full force and effect.
3. Any communication required or permitted to be sent under this Agreement shall be in writing and hand delivered, sent overnight delivery by a nationally recognized courier or sent via certified mail, return receipt requested. Any notification to Lynch Internal Medicine shall be sent to the office address listed on this agreement, and any notification to the Member shall be sent to the Member's address on file. Any change in address for either party shall be communicated to the other party in writing in accordance with this Section VI.3.
4. This Agreement shall be binding upon and inure to the benefit of the parties and their respective heirs, legal representatives, successors and assigns.

5. This Agreement constitutes the entire Agreement between the parties and supersedes all prior discussions, representations, understandings or agreements whether oral or in writing between Lynch Internal Medicine and Member pertaining to the subject matter of this Agreement.

6. Nothing in this Agreement shall be deemed to influence or construed to influence or affect a physician's independent medical judgment on behalf of the Member.

VII. Change of Law

If there is a change of any state or federal law, regulation, or rule that affects this Agreement or the activities of either party under this Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and either party reasonably believes in good faith that the change will have substantial adverse effect on that party's rights or obligations under this Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of this Agreement. The parties shall use their best efforts during a thirty (30) day period thereafter to mutually agree to such amendments. If after such thirty (30) day period the parties are unable to agree to amend this Agreement, this Agreement shall automatically terminate. If the change in law, regulation or interpretation is effective immediately, then either party may immediately terminate this Agreement by written notice to the other party.

VIII. Governing Law

This Agreement shall be governed by, and construed in accordance with, the internal laws of the state of Maryland.

IN WITNESS WHEREOF, the parties have agreed to execute this Agreement as of the date set forth below.

Lynch Internal Medicine, LLC

By: _____
J. Kevin Lynch, M.D.
Managing Member

Date

Member's Name (Printed)

Member's Signature

Date

Date of Birth

LYNCH INTERNAL MEDICINE, LLC

Exhibit A
To Membership Agreement

Retainer Fee Schedule - Member Program

1. Patients can become Members in the Program by making their first installment payment or paying the \$2000 annual fee in full at the time of signing the Membership Agreement.

2. All payments may be made using cash, check or credit card.

3. Please check the option that you prefer for paying the annual membership fee:

- ☐ Plan 1 - Pay \$2000 at the time you sign and send in your Membership Agreement. (Total payment = \$2000).
- ☐ Plan 2 - Pay in quarterly installments* of \$515 per quarter beginning at the time you sign and send in your Membership Agreement. (Total payment = \$2060).
- ☐ Plan 3 - Pay in monthly installments* of \$171.65 per month beginning at the time you sign and send in your Membership Agreement. (Total payment = 2060).

*** PLEASE NOTE: *Any installment payments must be made using a credit card or other automatic payment source, and will incur a 3% fee.***

Please indicate your preferred method of payment. NOTE: This is a one year commitment. If your payments are late, please note that you will need to pay retroactively in order to be seen by the doctor again. We will assess a late fee after a two-week (14 days) grace period unless other arrangements have been made. *The late fee will be ten percent (10%) of the payment amount that is past due.*

- ☐ Personal check, made payable to Lynch Internal Medicine, LLC
- ☐ Credit card (circle one): MasterCard or Visa
By agreeing to pay with your credit card, you are authorizing Us to automatically run your credit card when your scheduled Payment is due.

Card #: _____ Expiration _____

CVV #: _____ (This is the 3 or 4 digit number located on the back of your credit card.)

By signing below, I agree to the payment amount and schedule that I indicated above.

Print name _____ Date of birth ____/____/____

Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that the providers of Lynch Primary Care has provided you access to a copy of its Privacy Notice which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us. If your first date of service with us was due to an emergency, we must try to provide you access to this notice and have you sign this form as soon as we can after the emergency.

*Please specify by checking the appropriate answer below how we may **BEST** contact you or leave a message for you:*

Home and/or answering machine	☐ YES	☐ NO
Work	☐ YES	☐ NO
Cell Phone	☐ YES	☐ NO
Personal E-mail	☐ YES	☐ NO

****Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of the above methods.**

THE PRACTICE HAS PROVIDED ME ACCESS TO ITS PRIVACY NOTICE. I UNDERSTAND I MAY REQUEST A COPY FOR MY PERSONAL USE.

THIS PRACTICE HAS CHOSEN TO PARTICIPATE IN THE CHESAPEAKE REGIONAL INFORMATION SYSTEM for our PATIENTS , INC. (CRISP), a statewide health information exchange. For more information on CRISP, please see our Notice of Privacy Practices.

Print Name

Date

Signature

FINALLY: The Federal Government now restricts this OFFICE and the providers of Lynch Primary Care from discussing your health information and condition with other family members or persons - unless you specifically give your written permission.

By my signature below, I grant the office of Lynch Primary Care permission to discuss my protected medical information with the following individuals:

1. _____

2. _____

SIGNATURE OF PATIENT:

(parent/guardian if a minor)