LYNCH PRIMARY CARE

PATIENT REGISTRATION

DATE:
PATIENT NAME: ____ DOB: ______________

LOCAL ADDRESS: ____

CITY/STATE/ZIP: ____

SOCIAL SECURITY #: ______________________ EMAIL: _________________________

HOME PHONE: (___)__________________ CELL PHONE: (__)_____________________

WORK PHONE: (___)__________________ EMPLOYER: __________________________

OCCUPATION: _______________________ RETIRED (circle one): Yes No

MARITAL STATUS (circle one): S M D W

NAME OF SPOUSE/SIGNIFICANT OTHER: __________________________DOB: _________
(If your insurance is carried by your spouse, we need their date of birth and who the insurance is through.) Company: _________________________________

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? Y / N

IF YES, NAME ____________________________ PHONE: (____)__________________
RELATIONSHIP _____________________

PHARMACY INFORMATION:

PHARMACY NAME AND PHONE: ____
PHARMACY ADDRESS: ____

HOW DID YOU HEAR OF LYNCH PRIMARY CARE? ________________________________
WHICH DOCTOR ARE YOU HERE TO SEE? _______________________________________

LYNCH INTERNAL MEDICINE, LLC

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"), 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 before), Lynch Internal Medicine agrees to limit the number of members the practice services 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 the physicians (or covering doctor)
- Assistance in handling medical needs while traveling
- Appointment for out of town guests in need of unexpected care.

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 "One Thousand Eight Hundred Dollars ($1800) per year provided that you pay the entire Membership Fee by the time of your first 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 Terminations

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 this 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 (excluding the initial $300 set up/extended visit 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 (excluding the initial $300 set up/extended visit 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 in accordance with the Member's insurance coverage.

Lynch Internal Medicine physicians will usually cover for one another when unavailable. However, in the event when both physicians are not easily reachable, we use other physicians or practitioners to cover patients during those infrequent times when your physician is out of town or during such time as he/she may be unavailable by cell phone.

V Email Communications

If the Member wishes to send email communications to and from Lynch Internal Medicine or its' agents or representatives, the Member should be aware that email 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 email 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 email 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 V1.3.

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 the 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 judgement on behalf of the Member.

VII Change of Law

If there is a change of any State of 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

The 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: ____________________ Date: ______
J. Kevin Lynch, M.D., F.A.C.P.
Managing Member

____
Member's Name (Printed)

____
Member's Signature

____________ ____________
DOB Date

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 $1800 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. The first $300 of your membership fee is due at the time of your initial visit and is ***non-refundable***. Should you leave the practice, your refund will be pro-rated based on the number of months utilized during the annual period.
4. Please check the option that you prefer for paying the annual membership fee:

- ○ Plan 1 – Pay $1800 at the time you sign the Membership Agreement and come in for your first visit. (Total fee = $1800)

- ○ Plan 2 – Pay quarterly installments* of $460 beginning at the time you sign the contract and come in for your first visit. (Total fee = $1840)

- ○ Plan 3 – Pay in monthly installments* of $140 for the first year. $300 is to be paid at the time of your first visit. For the first year, the monthly payment will be $140. The payment for the second year onward will be $154 as you aren't paying the $300 again. (Total fee = $1840)

NOTE: To help make this affordable for every family member, we do offer a discount to the 2nd adult in a household which is $1400 per year.

***SPECIAL NOTE: *Any installment payments MUST be made using a credit/debit card or other automatic payment source.*

Please indicate your preferred method of payment below by checking off one of the circles. 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 2-week (14 days) grace period unless other arrangements have been made. The late fee will be 10% of the payment amount that is past due.

- ○ Personal check made payable to Lynch Internal Medicine, LLC
- ○ Credit card (circle one): VISA MASTERCARD AMX DISCOVER
  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 #: ______________________________ Exp Date: ____________

CVV #: ________ (This is the 3-4 digit number normally located on the back of your card)

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

Printed 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

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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)

LYNCH PRIMARY CARE, LLC
31 E. Lee Street
Bel Air, MD 21014
Lynchprimarycare.com

P: 410-638-5339
F: 410-638-8877

AUTHORIZATION to RELEASE MEDICAL RECORDS

I, ______________________________, authorize the release of my medical records from the

office of ____

____

____

To be sent to: Lynch Primary Care
31 E. Lee Street
Bel Air, MD 21014

Upon receipt of this document, please send the following information:

_____ Problem List
_____ Medication List
_____ Office Notes (past year)
_____ Discharge Summaries
_____ Cardiac Procedures
_____ Dexa Scans (last 2)

_____ Consultation Notes (past 5 yrs)
_____ History & Physical (most recent)
_____ Laboratory Data (past 2 yrs)
_____ X-ray Reports (past 5 yrs)
_____ Pathology Reports

I am aware that these records may contain information relating to psychiatric or psychological testing or treatment, biofeedback training and/or alcohol/drug abuse.

This consent is subject to written revocation by the undersigned at any time, except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid six months from the date of signature.

I understand that I have the right to receive a copy of this authorization upon my request.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________

PATIENT NAME (Please print): ______________________________

PATIENT DATE OF BIRTH: ______________________________