Member Name_____

Effective Date of Membership_____

WELLESLEY PERSONAL CARE, LLC

NEW PARTICIPATION AGREEMENT: 2025

We are delighted that you have chosen to be a Participating Patient in Wellesley Personal Care, LLC (the "Practice"). This Participation Agreement describes the terms and conditions of your participation as a Patient of the Practice.

In exchange for your payment of an Annual Fee, payable as described in this Agreement, the Practice will provide for you personalized primary care. Additional Services ("Concierge Services") include extended time during your annual exam and other visits when necessary, wellness coaching and preventive care; a comprehensive, written health report after every annual physical exam; cell phone and email physician access; scheduling assistance for medical testing and specialty care; regular communication with hospital attending physician or team during hospitalizations. Other health-related services will also be provided as listed on the attached List of Services, which specifies the Medical Services and Concierge Services the Practice will provide for you.

Participating Patient's Rights and Responsibilities

Participation. It is your choice to be a Participating Patient of the Practice under this Agreement. You may terminate this Agreement at any time upon thirty (30) days advance written notice. If you decide to cancel, the Practice will make reasonable efforts to help you find another physician in the area if requested.

Covered Services/Billing. Some or all of the Internal Medicine Services that the Practice may provide to you may be partially or fully covered by your Health Insurance, including Medicare. The Practice will bill your Health Insurance for covered medical services. As a Participating Patient, you will be responsible for any portion not covered by your insurance.

Insurance Matters. The Practice is not a health insurance carrier or a health benefit plan. We encourage you to maintain adequate insurance to cover the costs of hospitalization, diagnostic testing and other Medical Services. At your request, the Practice will provide you with copies of medical records related to the Medical Services provided by the Practice if they are necessary for you to obtain reimbursement from your Health Insurance.

Fees, Renewal and Cancellation

Participation. Unless otherwise specified, your enrollment in the Medical and Concierge Services provided by the Practice begins on the date of the receipt of your Signed Agreement and Payment of the Participation fee according to the terms of this Agreement. Billing is based upon a January through December billing cycle. Your initial fee covers a period from your Effective Date through December 31st of the calendar year. Your status as a Participating Patient will renew on January 1st of each subsequent year. Renewal information including subsequent invoices and notice of any update to our fee will be sent around January 1st of each subsequent year.

Participation Fee Schedule.
- The annual Participation Fee is **$4,000** per adult.
- A dual-membership discount is offered to spouses or domestic partners who are both Participating Patients. To activate a dual membership, please indicate your request on the signature line (at the bottom of page 3). The discounted dual-member Annual Fee is $7,600. The dual membership will renew annually as long as both members remain in the practice. If one member leaves the practice, the remaining member will be invoiced the standard adult Participation Fee for their next annual renewal.
- Young adult child(ren) through age 29 may be enrolled as Participating Patients on a family plan with a paid-up adult membership. Please ask us for details if this situation may apply to your family.

Payment Plan. Please choose from the following payment plans by initialing your choice.
The first payment is due at the time the Agreement is signed.

_____ **Payment In Full**	_____ **Two Biannual Payments**	_____ **Four Quarterly Payments**
(**Initial**)	(**Initial**) January, July	(**Initial**) Jan, Apr, July, Oct

Payment Terms. The Participation Fee is payable in accordance with your payment plan by check, Visa or Master Card. Participation Fees are subject to change from time to time, on at least thirty (30) days prior notice in advance of each annual bill.

How to Renew. Annually, the Practice will send you a renewal notice outlining any changes to the Practice or the Participation Fee for the upcoming Participation Year. Your Participation will renew automatically, and you will be invoiced according to the payment terms set out in the renewal notice. If you wish to cancel, send written notice of cancelation at least thirty (30) days before your renewal date.

How to Cancel. If you choose to cancel your Participation, you must notify the Practice in writing thirty (30) days in advance. In such case, the Practice will refund to you any unused months of your paid-up annual fee.

Communications

Confidentiality of Email and Cell Phone Communications. Communications with the Practice using email or cell phone are not guaranteed to be secure or confidential methods of communication. While we use encrypted devices and software, no form of communication is immune to failure. If you choose to contact your physician or the Practice by email or cell phone, you authorize the Practice to communicate back to the same address or cell phone number, including communications regarding "protected health information" or "PHI" as defined by HIPAA. By providing your email address or cell phone number, you acknowledge that: 1. You are aware that email and cellular communications carry risks, including device, software and network failure; 2. Although the practice will comply with its privacy and security obligations under federal and state law, absolute confidentiality cannot be guaranteed; and 3. Email and portal messaging are not an appropriate way to communicate regarding emergency or other time-sensitive issues.

Miscellaneous

Faxed and Emailed Signatures. Your signature on this Agreement or any other form or document the Practice receives by fax or email will have the same effect as an original signature.

This Agreement. This Agreement is the only agreement between you and the Practice concerning its subject matter, and there are no other promises, representations or agreements between you and the Practice concerning its subject matter. Except as otherwise provided above, this Agreement may be modified or amended only by a written agreement signed by both the Participating Patient and the practice.

Applicable Law. This Agreement shall be governed by the laws of the Commonwealth of Massachusetts.

Participating Patient's Acknowledgments. By signing this Agreement, you acknowledge that neither the Practice nor a physician with the practice has used coercion or has exercised undue influence to induce you to become a Participating Patient, you have had ample time to consider your options for obtaining health care services, and you are not suffering from any urgent or emergency medical condition that might cause you to sign this Agreement. THE PARTICIPATING PATIENT SPECIFICALLY ACKNOWLEDGES: I HAVE READ THIS AGREEMENT AND UNDERSTANDS ALL OF ITS TERMS AND EXECUTE IT VOLUNTARILY WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE.

Member Signature

_____
Please Print Your Name

Signature _____

Date:_____ _____

Please list additional members (if applicable)

Dual Member _____

Child member(s) _____

Wellesley Personal Care, LLC

By _____

Date: _____

For Office Use

_____

_____

_____