PRIVATE MEDICAL PRACTICE AGREEMENT

This Private Medical Practice Agreement sets forth the Setzer Personal Physicians LLC's Medical Practice Program's terms and conditions of your participation. We refer to our services in this Agreement as "the Program." If you have any questions, please contact us at (717) 724-0290. Otherwise, please sign and date this Agreement, provide the information requested below, and return the Agreement to **Setzer Personal Physicians, LLC, 645 North 12th Street Suite 300 Lemoyne, PA 17043.**

1. The Services We Provide

This agreement is for the purpose of creating an understanding whereby you, the patient, engage Setzer Personal Physicians, LLC in a private medical practice relationship in which William Scott Setzer, M.D. and his staff provide you with primary care medical services in return for the payment by you of an annual fee.

In return for the payment of annual fee by you, we will provide you with the following services:

- Dr. Setzer will serve as your primary care physician and provide you with diagnosis and management of acute and chronic medical problems.
- One (1) Annual Comprehensive Physical Examination and Cardiovascular Risk Assessment. In addition, you will receive a detailed report of the examination and an "action plan" for future wellness.
- Ten (10) acute-care visits per year for evaluation and treatment of medical conditions. When necessary, Dr. Setzer will see you at your house.
- Same day or next-day acute care appointments.
- Twenty-four (24) hour per day, seven (7) days per week telephone access to Dr. Setzer.
- Electronic access to your medical record.
- A personal USB Drive containing HIPAA compliant data storage and updated results of your Annual Comprehensive Physical Examination and Cardiovascular Risk Assessment and health history.
- Access to our office by email. This means that email may be used for services including prescription refills, appointment scheduling, patient education, and online consultations. **Email should never be used for urgent or emergent communications as we may not see your email right away. When in doubt, call us. In an emergency call 911.**

2. The Fee for Our Services

The term of this Agreement is one (1) year. The annual participation fee is $3,000. The annual participation fee is payable in full upon your signing and returning this Agreement. Our relationship does not begin until you sign this Agreement and pay the annual participation fee. You may pay this fee in one of the following ways:

By personal check. Please make check to Setzer Personal Physicians, LLC.

By credit card. Complete the Credit Card Authorization below or present the credit card in the office for payment.

Participation fees are subject to change upon annual renewal to the Program.

You may cancel your participation at any time. If you wish to cancel, please notify us by email at scott@setzermd.com or by letter. We may cancel your participation at any time provided that we give you at least thirty (30) days advance notice of termination. We will refund a pro-rata portion of your annual participation fee for the months remaining under this Agreement from the date we receive your cancellation notice. If we cancel your participation, we will refund a pro-rata portion of your annual participation fee for the months in which we are no longer obligated to provide you with services.

We will renew your participation automatically each year. You will receive a reminder letter, sent to the address below, sixty (60) days before this Agreement expires. If you do not wish to renew, please notify us by email at scott@setzermd.com or by letter at least thirty (30) days before this Agreement expires. If you do not cancel your participation, the fee to renew your participation for the next year will be billed to you or charged to your credit card.

3. Additional Services for Additional Fees

We may, from time to time, offer additional products and services which are outside the scope of this Agreement. You are not obligated to purchase additional services and products, however, if you want additional services and products you agree to pay an additional fee.

4. Health Insurance

Dr. Setzer does not participate with any health insurance carriers and has opted out of Medicare. We do not process or submit any claims to health insurance carriers or to Medicare. Your retainer fee encompasses the above listed office visits and services provided by Dr. Setzer. Upon request, superbills can be provided for services performed. However, the superbills may not meet the requirements of insurance carriers. If you have Medicare coverage, you will also be required to sign a Medicare Private Contract which explains both of our obligations regarding Medicare.

5. What We Do Not Provide

The Program does not include hospitalization, specialty health care, x-rays, laboratory work, prescription drugs, emergency room visits, and mental health care. You should maintain health insurance coverage for these services. Dr. Setzer does not admit patients to the hospital nor does Dr. Setzer see patients in the hospital.

The Program is not health insurance and is not a health benefit plan.

6. This Agreement May Not Be Assigned to Another Person

This Agreement is between you and Setzer Personal Physicians, LLC. You may not assign to another person the services which we have agreed to provide you.

Setzer Personal Physicians, LLC

By: ______________________________ Date: ___________________________

William Scott Setzer, M.D.

I wish to participate in the Setzer Personal Physicians, LLC's Private Medical Practice Program. I understand and agree to all of the terms of the Program described.

Your Signature: __________________________________ Date: ___________________________

Your Name: ____

Street Address: ____

City: ____ Zip Code: _______________________

Home Phone: ____________________________ Cell Phone: _______________________

Work Phone: ___________________________ Other Phone: _______________________

Email: ____

Emergency Contact: ____________________________ Relationship: ________________________

Telephone Number(s): ____

Credit Card Authorization

Name as it appears on the credit card: ____

Billing address: ____

Card Type: ________________________

Card Number: ____ Exp Date: _________________

I hereby authorize the Setzer Personal Physicians, LLC to charge this credit card for annual retainer practice enrollment fees.

Signature: _____________________________________ Date: _____________________________