

**Ann Mai, M.D. 4950 Barranca Parkway, Suite 207 Irvine, CA 92604**

*www.annmaid.com Tel: (949) 262-9700 Fax: (949) 262-0700*

## **PATIENT APPLICATION AND AGREEMENT**

\_\_\_\_\_ (“Patient”) identified would like to participate in the Direct Primary Care or Full Concierge Practice (“Practice”) offered by Dr. Ann Mai (“Provider”). Patient and Provider acknowledge and agree to the following terms and conditions in connection with participation in the Practice.

### **DIRECT PRIMARY CARE SERVICE FOR MEMBER PATIENTS**

- Be a member of Dr. Mai’s Internal Medicine Office in Irvine, CA
- Elimination of all previous administrative fees
- Ability to make appointments online and communicate with the office via **PatientFusion.com**
- Same day, next day appointments and/or Telehealth (eg. via Zoom)
- Medical service to coordinate Patient's complete health care needs, including prescription refills, specialty care referrals, laboratory and diagnostic imaging needs, and prior authorizations for medications or services, form fees (school physical, employer wellness programs, etc.)
- A focus on wellness through the promotion of preventive medicine and the early detection of disease - a comprehensive health assessment in addition to your annual physical

### **FULL CONCIERGE SERVICE FOR MEMBER PATIENTS**

- All of the above benefits as above with prioritized appointments
- Personal coordination of specialty referrals and hospital care
- Annual comprehensive wellness visit to include nutritional counseling
- Direct communication with their doctor via cell phone or text messaging
- FaceTime, Skype and/or Telehealth (eg. via Zoom) access if you are unable to visit the office

### **PATIENT COMMITMENTS**

To participate in the Practice, Patient will be required to pay an annual fee (Annual Fee) according to the following:

<u>Annual Fee Schedule</u>	<u>1 year</u>
Direct Primary Care	\$750
or	
Full Concierge	\$3,000

- The Annual Fee is for a 12 month period (“Term”). Fees are subject to increase at Provider's’ sole discretion
- The Annual Fee is due on the effective date of this Agreement and on or before each anniversary thereafter as a condition for continuing as a Patient of the Practice. We will notify you of any fee increase thirty (30) days prior to your renewal
- The Annual Fee is for services that are not considered covered benefits by insurance plans or Medicare. If any of the listed services are considered covered benefits, then the Annual Fee pays for the remaining list of services
- The Annual Fee is non-refundable. Cancellation requires written notice
- If your Annual Fee is not paid within thirty (30) days of your renewal anniversary, a \$200 re-instatement fee will be added upon renewal
- The Annual Fee is not reimbursable by your medical insurance as it covers non-payable expenses

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**PATIENT ACKNOWLEDGMENTS**

Patient acknowledges that the Practice is a unique program with certain specific limitations, including but not limited to:

- Patient has financial responsibility to pay for services that are provided at regular office visits. The Practice will bill Patient's insurance for services performed and Patient shall remain financially responsible for all charges incurred, including applicable deductibles, co-insurance and co-payments, without exception.
- In the event that Dr. Mai or Dr. Wikle is unavailable, call coverage will be provided by another physician selected and overseen by your doctor
- This Agreement shall automatically renew at the end of the existing Term. Upon expiration or termination of this Agreement, Practice will transfer Patient's medical records and continuing care to any physician requested by Patient with written notice and without charge. If you choose not to accept or renew this agreement, we will continue your care for thirty days for emergency purposes

If any provision of this agreement is held to be invalid or unenforceable in whole or in part, such invalidity or unenforceability shall attach only to such provision or part thereof and the remaining part of such provision and all other provisions hereof shall continue in full force and effect.

**PATIENT ACCEPTANCE:**

\_\_\_\_\_  
Print Name of Primary Patient

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Additional Patients:

Second Adult \_\_\_\_\_

Print Name

\_\_\_\_\_  
Signature

**ANNUAL FEE PAYMENT INFORMATION:** Total Annual Fee: \$ \_\_\_\_\_

Method of Payment:      \_\_\_ Check                      \_\_\_ Visa/Mastercard/Amex

Credit Card #: \_\_\_\_\_ Exp Date: \_\_\_/\_\_\_ Security Code: \_\_\_\_\_

**NOTICE OF ACCEPTANCE ( to be completed by doctor ):**

Dr. Mai acknowledges receipt of this agreement and application to become a Patient of Direct Primary Care Program of Full Concierge Program

This agreement is effective starting \_\_\_\_\_ at 12:00AM until \_\_\_\_\_ at 11:59PM

\_\_\_\_\_  
Ann Mai, M.D.