Membership Agreement

Coastal Pines Medical Group

This Membership Agreement (the "Agreement") specifies the terms and conditions under which you, the undersigned patient ("you" or "Patient"), may participate in the program (the "Program") offered by Coastal Pines Medical Group (the "Practice"). This Agreement will become effective on the date of your signature at the end of this Agreement (the "Membership Activation Date") unless returned to you by the Practice in accordance with the terms contained herein.

1. The Program. Under the Program, **Medical Practice will provide you with access to certain non-healthcare service amenities, described below, to be provided by Coastal Pines Medical Group physicians and staff. Your membership ("Membership") in the Program encompasses a set of non-healthcare service amenities not covered by your health insurance or Medicare, that are described on the Membership Benefits Sheet, as in effect from time to time** (collectively, the "Program Benefits"). Program Benefits may change from time to time. All Services shall be subject to all of the limitations contained in this Agreement. You understand that The Practice does not provide medical services to a Patient during periods of a Patient's hospitalization. Your medical care shall continue to be provided by the hospital-based physicians during the term of your hospitalization.

2. Membership Fee. You agree to pay to Practice the Membership Fee specified in your Membership Application, as valuable consideration for the provision of Program Benefits. The Membership Fee covers only the Program Benefits described on the Membership Benefits Sheet, and both the amount of the Membership Fee and the terms of the Membership Benefits Sheet may be changed in Practice's sole discretion at any time with 30 days notice.

3. Patient Acknowledgments and Conditions of Participation. You acknowledge and understand that Program Benefits are unique and provided with certain specific limitations and conditions, as follows:

A. You understand and acknowledge that any medical and healthcare services that are covered and reimbursable by your insurer are separate and distinct from and independent of the Program Benefits. Program Benefits are not covered health care services or supplies and are not reimbursable under any private health insurance policy, private health plan or government program, including, but not limited to, Medicare, in which you may be enrolled (sometimes

referred to herein as "your insurer"). You understand and acknowledge that Program Benefits convey value and benefits that you do not already receive under any such health insurance policy, plan or government program, including, but not limited to, Medicare, in which you are enrolled. To the extent any one or more Program Benefits are considered covered and reimbursable benefits, the Membership Fee is consideration for the remaining items of the Program Benefits.

B. The list of Program Benefits offered under the Program may be amended or modified by the Practice at any time and for any reason, including without limitation to the extent necessary to reflect any change in interpretation or terms of coverage and benefits of any private health insurance policy, private health plan or government program, including, but not limited to, Medicare, in which you are enrolled.

C. Neither you nor the Practice may, and shall not, bill or seek reimbursement from your insurer for any Program Benefits.

D. Practice may also provide medical service(s) to you that are covered or reimbursable from your insurer (including Medicare, as applicable). In such case, Practice may bill and seek reimbursement from such payor(s) under the terms and conditions of your enrollment agreement with such payor(s). You understand and acknowledge that any covered and reimbursable services are separate and distinct from and independent of the Program Benefits. Practice employs physician assistants, nurse practitioners, and registered nurses who, from time to time, may provide medical services to you within the scope of their licensure and under the supervision of the Doctor.

E. Practice may also seek reimbursement from you as permitted under your enrollment agreement with such payor(s) (e.g. deductibles, coinsurance or copays). The Membership Fee does not affect the co-payments, co-insurance, or deductibles that you are required to pay pursuant to the terms of your health or other insurance coverage. You will be financially responsible for any co-payments, co-insurance, or deductible amounts required by your insurer.

F. The Doctor may from time to time, due to emergency situations, like medical emergencies and natural disasters, not be available at the times referred to in the Membership Benefits Sheet, and you acknowledge such possibilities. During the Doctor's planned absence for vacations, continuing medical education, illness, emergencies, or days off, the Doctor will make arrangements with another Provider and will inform you about how to reach the Provider.

G. This Agreement is not a substitute for health insurance or other health plan coverage (such as membership in an HMO). You acknowledge that you would need to obtain or keep in full force patient and/or family health insurance policy(ies) or plans in order to cover your general healthcare costs. You acknowledge that this Agreement is not a contract that provides health insurance for you, and this Agreement is not intended to replace any existing or future health insurance or heath plan coverage that you may carry for yourself or your family.

4. Renewals and Termination. The Membership Fee covers a period of one (1) year (the "Term"). At the end of the first one (1) year period (the "**Initial Term**"), this Agreement will renew for successive one (1) year periods (each a "**Renewal Term**") and you will be billed for the next Renewal Term according to the billing preferences you have provided to the Practice, unless this Agreement is earlier terminated according to the terms herein. Either you or the Practice may terminate your participation in the Program

and this Agreement at any time upon thirty (30) days' advance written notice. If your participation is terminated for any reason other than at the end of the Initial Term or a Renewal Term, you will be entitled to a prorated refund of any unused portion of your Membership Fee. Such prorated refund will be based on the number of days you are enrolled in the Program during the period covered by your most recent Membership Fee payment. Upon Practice's receipt of this Agreement and the Membership Fee, Practice shall have the option, in its sole and absolute discretion, not to accept this Agreement and to return your payment to you.

5. Practice Location and Home Visits. The Practice maintains an office at 2150 Main St Suite 3, Cambria, CA 93428. When medically necessary, your Doctor is available to visit your home. Note that a home visit may or may not be a covered service under your insurance, whether a private insurance company, or a federally-funded health care program such as Medicare. For medical services that are not covered by your insurance, you acknowledge that the Practice will bill you directly for the uncovered service. As an example, a home visit that is not medically necessary will likely not be covered by your insurance, and would be billed directly to you.

6. HSA/FSA/HRA. You agree that your Doctor does not provide tax advice. If you use a tax-favored vehicle to pay for or to reimburse medical expenses, such as a Health Savings Account (HSA), Medical Savings Account (MSA), Flexible Spending Arrangement (FSA), or Health Reimbursement Arrangement (HRA), you are advised to check with your tax advisor regarding the deductibility of Membership Fees.

7. E-mail and other Electronic Communications; Privacy. Practice shall make available to you a "patient portal" (the "Portal"), a HIPAA-compliant program for electronic storage and transmission of your medical information. This Portal includes the ability to email your Doctor directly. Practice encourages you to use only the Portal for the electronic transmission of your protected health information. The Portal provides encrypted messaging, which is more secure than "regular" email or text message. By **entering into this agreement, you consent to Practice communicating with you, including sending your protected health information to you:**

A. **Electronically, via the secured messaging system available through the Portal; and**

B. **Electronically, via the "preferred e-mail address" and/or "preferred mobile phone" number specified in your Membership Application;**

You should be aware that neither e-mail nor electronic text messaging systems are secure media for sending and receiving potentially sensitive personal health information. You should limit your modes of communication with Practice to telephone calls, in-person visits and messages via the Portal. If you send e-mail and / or text communications to your Doctor and/or Practice, your Doctor and Practice will take steps to keep your communications confidential and secure. However, the confidentiality of e-mail and / or text communications cannot be assured or guaranteed. Note that if your Doctor and/or Practice need to send you a communication that contains protected health information, your Doctor and/or Practice may choose not to respond via a means of communication that is not appropriately secure. Rather, you will receive a notification via your "preferred e-mail address" that a message is available to you via the patient Portal. E-mail and text are also not good media for urgent or time-sensitive communications. If a communication is time-sensitive, you must communicate with Practice by telephone or in person. At the discretion of your

Doctor and/or as required by law, your e-mail and / or text communications and communications via the Portal may become part of your permanent medical record.

7. **Entire Agreement.** This Agreement, including all exhibits and attachments, constitutes the entire agreement between the parties and no other agreements, oral or written, have been entered into with respect to the subject matter of this Agreement. This Agreement supersedes all prior agreements, negotiations, and communications of whatever type, whether written or oral, between the parties hereto with respect to the subject matter of this Agreement.

8. **Notices.** Any notices required or permitted to be sent under this Agreement shall be in writing and sent to the party to be so notified via certified mail, return receipt requested, or provided via hand delivery, to the mailing addresses set forth in your Membership Application. Any change in address shall be communicated in accordance with the provisions of this Section.

9. **Governing Law; Arbitration.** This Agreement shall be governed by, construed and enforced under the laws of the state of California. Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by JAMS under its Comprehensive Arbitration Rules and Procedures. The number of arbitrators shall be one. The place of arbitration shall be Los Angeles, California. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

10. **Assignment.** Except as expressly provided herein, neither Party shall have the right to assign any rights and responsibilities under this Agreement. Notwithstanding the above, Practice shall have the right to assign all of the rights and responsibilities to an entity wholly owned by the Doctor.

11. **Severability.** The provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the parties.

12. **Amendment.** This Agreement may be amended at any time by mutual agreement of the parties without additional consideration, provided that before any amendment shall become effective, it shall be reduced to writing and signed by the parties.

13. **Waiver.** No delay or omission by either party to exercise any right or remedy under this Agreement shall be construed to be either acquiescence or the waiver of the ability to exercise any right or remedy in the future. Any waiver of any terms and conditions hereof must be in writing, and signed by the parties hereto. A waiver of any term or condition hereof shall not be construed as a future waiver of the same or any other term or condition hereof.

14. **Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument. An electronic signature on this Agreement shall be deemed to be an original.

////**SIGNATURES NEXT PAGE**/////

COASTAL PINES
MEDICAL GROUP

ACCEPTANCE SIGNATURES

By signing below, each signatory represents that he or she fully understands and freely covenants to accept the rights and obligations under this Membership Agreement. If the attached Membership Application is accepted by Practice and credit card information is provided, Patient authorizes practice to charge the indicated card for sums due to Practice under this Agreement and in accordance with its terms.

MEMBER:	**PRACTICE:**
Patient Name: _____ (please print)	Coastal Pines Medical Group
Signature: _____	Signature: _____
Date: _____	By: Richard David Griffith, its President
If signed by someone other than Patient, please indicate the name of the signer and the capacity in which they sign for Patient:	Date: _____
Signatory Name: _____ (please print)	
Capacity: _____	
Date: _____	

COASTAL PINES
MEDICAL GROUP

Membership Application

COASTAL PINES MEDICAL GROUP

2150 Main St, Suite 3, CAMBRIA, CA 93428

Membership Type

- □ Individual ($100/mo or $1000/yr)
- □ HomeBound ($200/mo or $2,000/yr)
- □ Family (2 patients) ($150/mo or ($1,500/yr)
- □ Family (3 patients) ($175/mo or $1750/yr)
- □ Family (4 patients) ($200/mo or $2,000/yr)

Please complete application for each family member.

Member Information

Member last name | Member first name | ____ Initial | ___/___/____ Date of birth

Address | City | State | Zip Code

Home phone | Mobile phone | E-mail address

☐ **Billing Address** (if not to Member) [] N/A

Please complete this Section if mail should be directed to a person other than Member, such as a guardian, conservator, or person having power of attorney for Member's healthcare decisions ("Guardian"). If you complete this section, all mail will be directed to this address.

Billing last name | Billing first name | Initial

Address | City | State | Zip Code

Home phone | Mobile phone | E-mail address

Credit Card Billing Information

- □ Check if same as Member Information
- □ Check if same as Billing Address Information

Type of card: □ Visa □ M/C _Credit card number | Expiration | Security code

If paying by check, please make checks payable to: Coastal Pines Medical Group.
mail to: 2150 Main St, Suite3., Cambria, CA 93428