Skurcenski
PRIMARY CARE

RETAINER PRACTICE AGREEMENT

Welcome to the Skurcenski Primary Care LLC's Medical Practice (the "Practice"). This Retainer Practice Agreement describes the Practice and summarizes the terms and conditions of your participation. If you have any questions, please contact us at 717-919-1845 or *contact@skurcenskiprimarycare.com*. Otherwise, please sign and date this Agreement, provide the information requested below, and return the Agreement to us at **Skurcenski Primary Care, 645 N. 12th Street, Suite 300, Lemoyne, Pennsylvania, 17043.**

A. Practice Services

This Agreement is designed to create an understanding whereby you, the patient, engage the Skurcenski Primary Care in a retainer relationship in which the physicians of Skurcenski Primary Care (Dr. Alison Skurcenski) and the Skurcenski Primary Care 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 an annual fee by you, the Practice will provide you with the following services:

- Dr. Skurcenski 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. Skurcenski will see you at your home.
- Same day or next-day acute care appointments.
- Twenty-four (24) hour per day, seven (7) days per week telephone access to Dr. Skurcenski. In the event that Dr. Skurcenski is unavailable due to vacation, etc., arrangements will be made to provide patients with access to another doctor who will cover Dr. Skurcenski's call for the period she unavailable.
- Electronic access to your medical record.
- Access to our office by e-mail. Please note that an e-mail communication cannot be guaranteed to be entirely secure or confidential and it is not always read in a short time period after it is sent. The telephone should be used for urgent communications. **In emergencies call 911.**

B. Participation Fees

The term of this Agreement is (1) one year. The annual participation fee for the Practice is $3,000.00 and is payable, in full, by the due date and validated upon your signing and returning this Agreement. It may be paid by cash, check (which should be made out Skurcenski Primary Care, LLC), or credit card (please complete the credit card authorization below). Skurcenski Primary Care prefers the annual participation fee be paid in full annually, however arrangements may be made at the Practice's discretion, for patients who desire to split the annual participation fee into bi-annual or quarterly payments.

You may cancel your participation at any time. If you wish to cancel, please notify us by e-mail at *contact@skurcenskiprimarycare.com* or by letter addressed to Skurcenski Primary Care, LLC, 645 North 12th Street, Suite 300, Lemoyne, Pennsylvania, 17043. 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. We may cancel your participation at any time. In the event that we cancel your participation, you will receive thirty (30) days notice of the cancellation via standard U.S. postal service and by certified mail. 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.

There is no penalty if you wish to cancel your participation or do not wish to renew your participation in the Practice.

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

C. Participation Renewal

We will renew your participation automatically each year. You will receive a reminder letter, sent to the below address, sixty (60) days before this Agreement expires. If you do not wish to renew, please notify us by email at *contact@skurcenskiprimarycare.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.

D. 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.

E. Health Insurance

Dr. Skurcenski does not participate with any health insurance carriers and has opted out of Medicare. Dr. Skurcenski's opt out period expires on January 2, 2024. Neither Dr. Skurcenski, nor Skurcenski Primary Care LLC process or submit any claims to health insurance carriers or to Medicare. Your retainer fee encompasses the above-noted office visits and services. Upon

request, superbills (an itemized statement of services provided) can be provided for services performed. However, the superbills may not meet the requirements of insurance carriers. We cannot guarantee whether and to what extent your commercial health insurance carrier will reimburse you. We encourage patients to contact your commercial health insurance carrier for non-participation rules and reimbursement rates. You may not submit claims to Medicare for reimbursement. If you have Medicare coverage, you will also be required to sign a Medicare Private Contract which explains both of our obligations regarding Medicare. The Practice does not include hospitalization, specialty health care, x-rays, laboratory work, prescription drugs, emergency room visits, or mental health care. You should maintain health insurance coverage for these services.

The Practice is not a health insurance nor is it a health benefit plan.

F. Hospital Care

Dr. Skurcenski does not admit or attend to patients in the hospital. Hospital care is not a component of the Practice nor is it included in this Agreement.

G. Miscellaneous

1. Successors and Assigns. All rights and liabilities herein given to, or imposed upon Skurcenski Primary Care, LLC, or Dr. Alison Skurcenski shall extend to and bind the several and respective successors and assigns of Skurcenski Primary Care, LLC and/or Dr. Skurcenski. This agreement is between you and Skurcenski Primary Care, LLC. You may not assign to another person the services which we have agreed to provide you.

2. Severability. Each provision contained in this Agreement shall be construed as being independent of each other provision contained in this Agreement and non-compliance with any one provision shall not be deemed to excuse compliance with any or all other provisions. If any provision of this Agreement is determined by a judicial or administrative tribunal of proper jurisdiction to be invalid or unenforceable, the provision shall be severed and the balance of this Agreement shall remain in full force and effect.

3. Entire Agreement and Modification. This writing contains the entire agreement between the parties, and no modification of this Agreement shall be binding unless the modification is made in writing and signed by the parties.

4. Governing Law. This Agreement shall be governed by, construed under, and enforced in accordance with the laws of the Commonwealth of Pennsylvania.

By: _____ Date: _____

Dr. Alison Skurcenski, M.D.

I wish to participate in the Skurcenski Primary Care LLC's Medical Practice. I understand and agree to all of the terms of the Practice described above.

Your Signature: _____ Date: _____

Your Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____ E-mail: _____

Emergency Contact: _____ Relationship: _____

Telephone Number(s): _____

Credit Card Authorization

Name as it appears on the credit card: _____

Billing Address: _____

Card Type: _____

Card Number: _____ Expiration Date: _____

I hereby authorize Skurcenski Primary Care, LLC to charge this credit card for annual retainer practice enrollment fees.

Signature: _____ Date: _____