Ann Giedd, PLLC, d/b/a Concierge Care N.P.
Patient Agreement

CCNP provides both functional medicine and primary care medical services to patients, and employs Ann Giedd, DNPc (the "Provider") for the purpose of providing the services defined in this Agreement. You desire to receive, in exchange for a fee, certain Primary Care medical services, Functional Medicine services and non-medical services (collectively the "Services") from CCNP as part of and by virtue of this Agreement. The purpose of this Agreement is to set forth the terms and conditions of how the Services shall be furnished to you by CCNP. You and CCNP therefore agree as follows:

1. Services Provided:
   - 1.1 Primary Care Medical Services. CCNP will provide you with the Primary Care Medical Services described in this Section. As used in this Agreement, the term "Primary Care Medical Services" means only those primary care medical services that the Provider is permitted to perform under the laws of the State of New Hampshire and that are consistent with her training and experience as a primary care Provider. Generally, such services encompass health promotion, disease prevention, diagnosis, care, and treatment of patients during health and all stages of illness, with a focus on preventive care.
     - 1.1.1 Annual In-Depth Wellness Examination. Payment of your Patient Fee includes an annual in-depth wellness physical examination and evaluation ("Wellness Evaluation") to be provided by the Provider at no additional charge. As part of the Wellness Evaluation, the Provider will administer a panel of laboratory tests and then develop a personalized written health, exercise, and dietary health plan for you to follow. As used in this Agreement, the term "Wellness Evaluation" means a physical examination and wellness evaluation provided to you not in connection with any illness or injury.
     - 1.1.2 EXCLUSIONS: Your Patient Fee DOES NOT COVER, and you may incur additional out-of-pocket costs for: hospitalization, surgical procedures, vaccines, medications, Stem Cells, Botox, X-rays, CT scans. MRIs, any diagnostic testing or lab work, pathology (pap smears, biopsies, etc.), emergency room visits, prenatal care, and other services not typically rendered by Primary Care Providers in their medical offices. You or your medical insurance carrier will be responsible for payment of all medical costs excluded under this Agreement or otherwise not covered by your Patient Fee.
     - 1.1.3 Not all conditions can be treated by CCNP, and at times, additional medical care may be required. CCNP is not a chronic pain clinic. We only prescribe acute pain medication if warranted to established patients.
   - 1.2 Functional Medicine Services. CCNP will provide you with the Functional Medicine Services described in this Section. As used in this Agreement, the term "Functional Medicine Services" means only those Functional Medicine services that the Provider is permitted to perform under the laws of the State of New Hampshire and that are consistent with her training and experience as a Functional Medical Specialist. Generally, such services encompass diagnosis of the root cause of medical problems and treatment using holistic methods such as supplements and guidance on living a healthy lifestyle using food, exercise and stress management.
     - 1.2.1 EXCLUSIONS: Your Patient Fee DOES NOT COVER, and you may incur additional out-of-pocket costs for: hospitalization, surgical procedures, vaccines, medications, Stem Cells, Botox, X-rays, CT scans, MRIs, any diagnostic testing or lab work, pathology (pap smears,

biopsies, etc.), emergency room visits, prenatal care, and other services not typically rendered by Functional Medicine Providers in their medical offices. You or your medical insurance carrier will be responsible for payment of all medical costs excluded under this Agreement or otherwise not covered by your Patient Fee.

1.3 Non-Medical Services. Payment of the Patient Fee will enable you to receive the following non-medical services and benefits usually not covered by insurance:

1.3.1 You will have access to the Provider twenty-four hours per day, seven-days per week via email, text and phone. The Provider will make every attempt to respond within 24 hours of your request; however, there may be periods where the Provider is not available due to vacation, illness or emergencies. The provider will make every effort to respond during these times and may have another Provider or a Nurse respond when possible. If a substitute Provider is used, they will be available to you to the same extent as the Provider, although the substitute Provider may be contacted through an answering service rather than directly.

1.3.2 If you are experiencing a life-threatening or emergency medical situation, you should NOT call the Provider, but instead you should CALL 911 IMMEDIATELY.

1.3.3 Telemedicine appointments with the Provider may be conducted using Telemedicine via an application on your computer or phone. It is the Patient's responsibility to provide the equipment and the internet connection that enables this technology on the Patient's end of the connection.

2. Patient Fees and Payment:

2.1 In exchange for the Services provided for in this Agreement, you agree to pay an annual patient fee ("Patient Fee") to CCNP in the amount specified on the attached Schedule "A". You may elect to pay your Patient Fee annually, semi-annually or quarterly. You will designate your selected payment plan on Schedule "A". Patient Fee payments not received by their due date will cause your rights under this Agreement to be suspended until such payment is received by Provider.

2.2 The annual Patient Fee covers a period of one (1) year starting on the Effective Date of this Agreement. The fee schedule is subject to change in subsequent years. Patients will be notified upon renewal of the annual Patient Fee and any fee increases and may elect to not renew Agreement without penalty. Either party shall have the absolute and unconditional right to terminate this Agreement for any reason by giving 30 days' prior written notice to the other party. Additionally, CCNP may terminate this Agreement immediately upon your failure to pay the Patient Fee or for abusive or fraudulent behavior, by giving you written notice of termination. Your initial Patient Fee payment must be made prior to your first visit. The Patient Fee is paid in addition to and not in exchange for any copayments, deductibles, or coinsurances.

2.3 CCNP reserves the right to assess a returned check fee in the amount of $35.00 for any returned or declined check. If this occurs, the Patient will no longer be eligible to remit payment by check.

2.4 CCNP will notify you of the renewal fee prior to the one (1) year anniversary of the Effective Date (the "Anniversary Date"). Unless terminated as set forth above, at the expiration of the initial one-year period (and each succeeding one-year period), this Agreement shall automatically renew for successive one-year periods upon your payment of the Patient Fee. Failure to pay all or a portion of the Patient Fee by the Anniversary Date shall result in automatic termination of this Agreement.

2.5 If this Agreement is terminated by either party upon written notice, you will be entitled to a pro-rated refund of any unused portion of your Patient Fee, provided that the first half of your Patient Fee shall be non-refundable upon termination. Such prorated refunds will be based on the number of days during the 1-year term of the Agreement during which you have been a Patient and the completion of the plan's number of visits.

3. Insurance; Patient Responsibility for Other Medical Coverage. You or your insurance company shall be responsible for paying any medical, clinical, diagnostic, or therapeutic services or items provided to you outside of CCNP. This Agreement is not a substitute for health insurance or other health plan coverage. You acknowledge that the Provider has advised you to keep in full force (or to purchase) health insurance policy(ies) or plans in order to cover you and your family for healthcare costs not covered under this Agreement. This Agreement does not affect any applicable copayments, coinsurance, or deductibles thereunder, which you must continue to pay under the terms of such health insurance plan. It is the responsibility of the Patient to pay deductibles, co-pays, and coinsurances associated with any charges from outside health care providers, facilities, and/or entities.

4. Assignment. You may not assign this Agreement, or any of the rights and benefits provided in this Agreement, without prior written consent from CCNP. Any attempt to assign this Agreement without such consent shall be null, void, and of no legal effect. CCNP may assign this Agreement to any entity that is a successor to CCNP, provided that Ann Giedd, DNPc will continue to serve as the Provider hereunder.

5. Notices. Any written communication required or permitted to be sent to the other party under this Agreement shall be in writing sent via certified mail, return receipt requested, to the address set forth in this Agreement, or by hand delivery or delivery by Fed Ex or similar delivery service. Any changes in address shall be communicated to CCNP in accordance with this section.

6. Amendment. No modification or amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties hereto. Notwithstanding the foregoing, CCNP may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending you written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by CCNP, except that you shall initial any such change at CCNP's request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

7. Severability. If for any reason any provision of this Agreement shall be deemed by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with Applicable Law in its modified form, and that provision shall then be enforceable.

8. Arbitration of Disputes. All disputes arising out of this Agreement shall be submitted to arbitration in the county in which the Provider is located, pursuant to the rules of the American Arbitration Association then in existence in New Hampshire. The decision in arbitration shall be conclusive and binding on the parties and may be reduced to judgment in any court of competent jurisdiction. The parties expressly waive their right to trial in any court.

9. Relationship of Parties. You and the Provider intend and agree that the Provider, in performing her duties under this Agreement, is an independent contractor, as defined by the guidelines promulgated by the United States Internal Revenue Service and/or the United States Department of Labor, and the Provider shall have exclusive control of her work and the manner in which it is performed.

10. Legal Effect. You acknowledge that this Agreement is a legal document and creates certain rights and responsibilities. You also acknowledge that you have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

11. Acceptance by Provider. This Agreement shall be effective on the date provided above, provided that your Patient Fee payment has been received. CCNP is not obligated to accept this Agreement or payment,

and may, in its sole discretion, elect not to do so, based on limitation on the number of Patients and other restrictions deemed appropriate by CCNP.

12. Miscellaneous Provisions. This Agreement shall be governed by and construed in accordance with the internal, substantive laws of the State of New Hampshire, sets forth the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement. Patient has read and fully understands all of the provisions of this Agreement.

By signing below, the undersigned Patient acknowledges that he or she has read and understood this Agreement and is signing this Agreement freely and voluntarily.

PATIENT

Signature: _____

Print Name: _____

Date: _____

ANN GIEDD, PLLC d/b/a Concierge CareNP

By: _____
Ann Giedd, DNPc

Date: _____

You may receive a copy of this Patient Agreement upon request.

Schedule A

Functional Medicine Retainer Rates

Plan Type	* Paid in Full	Semi Annual	Quarterly	Monthly
	1 Payment of	2 Payments of	4 Payments of	12 Payments of
12 Month Retainer	$1,200	$720	$375	$130
** Spouse Add-On	$900	$550	$280	$100
*** Child Add-On (per child)	$700	$400	215	$75

Primary Care Retainer Rates

(in addition to the Functional Medicine Rates)

	* Paid in Full	Semi Annual	Quarterly	Monthly
Patient	1 Payment of	2 Payments of	4 Payments of	12 Payments of
12 Month Retainer	$1,500	$900	$470	$160
** Spouse Add-On	$1,000	$600	$310	$110
*** Child Add-On (per child)	$800	$465	$250	$100

***** Discounted pricing is available if the retainer fee may be paid in full at the start of the retainer period.
****** Both spouses must be retained in the same plan to be eligible for the Spouse discount.
******* To be eligible for the Child rate at least one parent must have the same retainer plan.

1. Please select a Patient plan type (check one):

   ☐ Functional Medicine

   ☐ Both Functional Medicine and Primary Care

2. How will you pay the total Patient fee (check one)?

   ☐ Annually (1 lump sum payment)

   ☐ Semi-annually (2 equal installments)

   ☐ Quarterly (4 equal installments)

   ☐ Monthly (12 equal installments)

3. Select a method of payment (check one):

   ☐ Check* (please make checks payable to: Concierge Care N.P.)

   ☐ Credit/Debit Card **

   ☐ Cash

   ***** Checks should be made payable to Concierge Care NP. They may be mailed to P.O. Box 183, Eaton NH 03832.

   ****** To pay by Credit/Debit Card, you must complete the Credit Card Authorization form (Schedule B).

Schedule B

Credit Card Authorization Form

I agree to pay Concierge Care NP using the credit card below. I may change this credit card by notifying Concierge Care NP in writing within 5 days of the scheduled payment date.

Name on Card: _____

Credit Card #: _____

Expiration Date: _____

CVV: _____

I authorize Concierge Care NP to charge the credit card above according to the following schedule:

Amount	**Date**
_____	_____
_____	_____
_____	_____

_____ _____ _____

Printed Name Signature Date