Kennestone Internal Medicine Associates, P.C.
David M. Lahasky, M.D.

Retainer Agreement

This Retainer Agreement (the "Agreement") is entered into as of the _____ day of _____, 20___, and effective as of the _____ day of _____, 20___, between you the undersigned Patient ("You") and Kennestone Internal Medicine Associates, P.C. (the "Practice") under which the Practice will make certain health and wellness services, amenities and enhanced services available to you which are not otherwise covered by commercial insurance, managed care, Medicare and/or other third party payers. By voluntarily entering into this Agreement and remitting the Annual Retainer Fee (as set forth below), you may participate in the Practice's Concierge Medical Services Program (the "Program") for a period of twelve (12) months beginning on the Effective Date.

1. **The Program:** The Program's Annual Retainer Fee covers the following services and amenities provided by David M. Lahasky, M.D. as set forth below:

   - Annual Health Assessment, more comprehensive than covered by third-party payers (including Medicare) as set forth in Exhibit A
   - Enhanced appointment availability (usually the same business day, but no later than the next business day)
   - Personal appointment reminders
   - Reduced wait times for a physician appointment
   - Increased physician appointment time
   - Physician availability after hours by cell phone[1]
   - Secure e-mail communications
   - Coordination of specialist care and hospital services

   The amenities include both non-healthcare service amenities and healthcare related services usually not covered by insurance. Other service amenities may be offered from time to time and these may be subject to limitations.

2. **Annual Retainer Fee:**

   Individual $1,500 per year[2]

   You may elect to pay the Annual Retainer Fee on an annual or on a quarterly basis in advance of each quarter. If you elect to pay on a quarterly basis, each fee installment ($375 per quarter per individual) will be automatically charged to your credit card on or following the first day of each quarter as set

Patient's Initials: _____

forth in the attached Exhibit B. We offer a 10% family discount when more than one individual living in the same household is enrolled in the Program.

3. **Renewals and Termination:** The term of this Agreement shall be one (1) year from the Effective Date and shall automatically renew for every one (1) year period thereafter unless either party gives written notice of non-renewal at least thirty (30) days prior to the anniversary date of the Agreement. The terms and conditions of this Agreement may be changed with written notification to You. Failure to pay renewal of the annual membership fee prior to the anniversary of the Effective Date may result in termination of your membership in the Program.[3] Either You or the Practice may terminate this Agreement with thirty (30) days written notice to the other party. If this Agreement is terminated after your Annual Health Assessment, the Annual Retainer Fee is nonrefundable. If terminated prior to your Annual Health Assessment, the Annual Retainer Fee is refundable on a prorated basis.[4]

4. **Medical Care Services Excluded from Annual Retainer Fee:** Neither the Practice nor Dr. Lahasky will seek reimbursement for the Annual Retainer Fee from any insurer, Medicare or other third-party payer for services provided that are included in the Annual Retainer Fee. You are solely financially responsible for payment of the Annual Retainer Fee and agree not to submit the Annual Retainer Fee to Medicare or your private insurance carrier, except for reimbursement from your health savings account ("HSA"), medical savings account ("MSA") or Flexible Benefits Account ("FBA"). Except for services provided as part of the Annual Health Assessment or provided as personal services, You and/or your insurer shall be financially liable for all other covered services provided by the Practice and/or Dr. Lahasky and You or your insurer, as the case may be, will be billed for these other services.

5. **Co-Payments:** You remain financially responsible for all co-payments, co-insurance and/or deductibles as defined by the terms of your insurance coverage for provision of covered services.

6. **Non-Participating Provider:** If You have insurance with which Dr. Lahasky or the Practice does not participate, the Practice will file a claim with your insurance company as a courtesy only with respect to services that are provided other than as part of the Annual Health Assessment or as personal services. Under such circumstances, You will be responsible for an office visit charge.

7. **E-Mail Communications/Privacy:** You acknowledge that traditional e-mail is not a secure way for sending or receiving personal health information. If You choose to send confidential personal health information by non-secure e-mail, You specifically authorize Dr. Lahasky or the Practice to reply with personally identifiable protected health information. Dr. Lahasky will have

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sole discretion as to whether or not to reply to any e-mail communication and whether or not to open e-mail attachments. E-mails may become part of your medical record. You also acknowledge You will not use e-mail to seek an urgent appointment, ask questions about an urgent issue, or for any other time sensitive issue. If You have time sensitive issues, You must contact Dr. Lahasky or the Practice by telephone or in person at his office.

8. **Amendments and Waivers:** This Agreement may only be revoked, altered, amended or modified by the written agreement of both parties hereto. No waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach of the same provision or of any other covenants or conditions.

9. **Section Headings:** Any section, section title or caption contained in this Agreement is for convenience only and in no way defines, limits or describes the scope or intent of this Agreement or any of the provisions hereof.

10. **Invalid Provisions:** The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

11. **Entire Agreement:** This Agreement constitutes the entire understanding of the parties with respect to the subject matter outlined in this Agreement. The undersigned agrees to the terms and conditions of this Agreement and acknowledges there are no promises or representations except as specifically listed in this Agreement.

12. **Notices:** Notice from one party to the other shall be in writing and shall be deemed to have been duly given when delivered in person or sent via U.S. mail to the addresses listed in this Agreement.

13. **Governing Law:** This Agreement shall be governed by and construed in accordance with the laws of the State of Georgia.

I _____, agree to the terms and conditions herein.
Patient Printed Name

I acknowledge that I understand the "Program", that this is not an insurance product and that I have been advised that I will need to continue my own health insurance. I have read and agree to the terms of the Practice's payment policies.

_____ _____

Patient Signature Date

Acknowledged and accepted by the Practice:

Kennestone Internal Medicine Associates, P.C.

_____ _____

By: David M. Lahasky, M.D., CFO Date

[1] With reasonable exceptions, i.e. limited cell phone or pager coverage/reception, dead batteries, electrical outages, etc.

[2] Annual Retainer Fee payment is due on enrollment and may be made by credit card or check made payable to Kennestone Internal Medicine Associates, P.C. Quarterly payments are by credit card only. You must pre-authorize a credit card charge for the quarterly payment at time of enrollment in the Program.

[3] If terminating from the Program, you must sign a HIPAA compliant request to have your records transferred to your new physician. One copy of your records will be provided to your physician at no charge. Any additional copies of your records will be charged for at then current rates.

[4] Your failure to renew in the Program will be taken as your decision to immediately establish yourself with a new physician. Dr. Lahasky will provide emergency care only for thirty (30) days after your termination from the Program. After this time, Dr. Lahasky will no longer be responsible for any aspect of your medical care and you should see your new physician for all medical issues. You and/or your insurance company, as the case may be, will be responsible for any charges incurred for emergency care provided during this time.