WELL PRIMARY CARE, LLC
PATIENT AGREEMENT
Ann Marie Johnson, MD

This Patient Agreement is entered into by the undersigned, Well Primary Care, LLC (the "Practice") and Ann Marie Johnson, M.D. ("Dr. Johnson") for the purpose of the undersigned obtaining primary care medical services from Dr. Johnson and the Practice. I understand that these primary care medical services are offered subject to the following terms and conditions:

1. Effective Date: This Patient Agreement (the "Agreement") will commence on _____ and will be for an initial period of one (1) month. Thereafter, this Agreement will automatically renew each month unless it is terminated in writing by either me or by Dr. Johnson in accordance with Section 7 below or if I fail to make two consecutive payments of the Monthly Fee by the Due Date.

2. Covered Services: Dr. Johnson and the Practice will provide those standard primary care medical services listed on Exhibit A as requested by me or as deemed necessary by Dr. Johnson and in accordance with the established standard of care for internal medicine physicians ("Covered Services"). All of the Covered Services listed on Exhibit A are included in the Monthly Fee and no additional fees, such as co-payments or deductibles will be charged for Covered Services provided to me. I understand that certain Additional Services (listed on Exhibit B) will not be covered by the Monthly Fee and will be billed to me at the Practice's standard rates.

3. NonParticipation in Medicare and Insurance Plans: I understand that the Practice and Dr. Johnson do not participate or contract with any insurance plans and that Dr. Johnson has opted out of the Medicare program. I will be personally responsible for payment of all Monthly Fees and for any Additional Services not covered by the Monthly Fee. The Practice will not submit any claim forms to my insurance plan for any Covered Service or Additional Services provided to me.

I may, at any point, elect to obtain medical care from a health care provider who participates with my insurance plan or who has not opted out of the Medicare program, rather than receiving medical care from Dr. Johnson.

4. Medicare Part B Beneficiaries: If I am a Medicare Part B beneficiary, or if I will become a Medicare Part B beneficiary at any time during the term of this Agreement, I also agree to enter into the Private Contract as required by the Medicare program. Under the terms of the Private Contact, I cannot submit any bills for Additional Services to the Medicare Program for reimbursement and that any Medicare supplemental insurance may not cover services not paid for by Medicare.

5. Submission of Charges to Insurance Plans: Certain commercial insurance plans will allow patients to submit claims for services provided by out of network providers. At my request, the Practice will provide me with a bill for any Services that I can submit to my insurance plan in accordance with the plan's rules.

6. Monthly Fees. The Practice will automatically bill me every month for the Monthly Fee and for the cost of any Additional Services that I request. I agree to authorize such payments to be automatically charged to my credit card or deducted from my bank account. Such payments are due by the first of each month.

7. Termination of this Agreement: This Agreement may be terminated at any time by either me or the Practice upon providing sixty (60) days prior written notice of termination. In addition, this Agreement will automatically terminate if I fail to pay the Monthly Fees for two (2) months in a row. In the event that Dr. Johnson should terminate this Agreement, the Practice will assist me in finding another primary care physician to take over my care at the end of the 60 day notice period. I understand that if I elect to leave the Practice, my medical records will be forwarded to my new physician upon completion of a written record release from me. A $15.00 fee will be charged to me for the cost of copying the records.

8. Entire Agreement. This Agreement does not constitute an insurance policy or an agreement to provide insurance. Rather it is a contract for personal services. I agree to the terms of this Agreement, all of which are contained herein. There are no promises or representations except as set forth in this Agreement.

9. Notices. Any communication required or permitted to be sent under this Agreement shall be in writing and sent via U.S. mail to Dr. Johnson at the address listed on this letterhead. Any change in address shall be communicated in accordance with the provisions of this section.

10. Governing Law. This Agreement shall be governed by and construed in accordance with the law of the State of Delaware without regard to Delaware's choice of law provision.

_____ _____

Patient Name (please print) Ann Marie Johnson, MD
Well Primary Care, LLC

_____ _____

Patient Signature Date

_____

Date

If the Patient is a minor, the Patient's parent or legal guardian must sign below indicating the parent or guardian's acceptance of the above terms and agreement to pay the Monthly Fee on behalf of the Patient:

_____

Signature of Parent/Guardian

Exhibit A

Well Primary Care Services and Fees

Covered Services Included in the Monthly Fee	
Annual Comprehensive Exam	Included
Work, Sports and DOT Physicals	Included
Preoperative Evaluations	Included
Cervical Cancer Screening (Pap)	Included*
Office visits other than annual exam	Included, up to 6 per year
EKG	Included
Minor skin and other procedures (skin tag removal, ear flushing, wound care)	Included*
In-office Laboratory testing (urine/pregnancy)	Included
Specimen collection (blood, urine)	Included*
B12 shots	Included
Coordination of specialist care	Included

*Patients are responsible for laboratory charges for tests sent out from the office, but the laboratory will submit a claim to the patient's insurance plan.

EXHIBIT B

Additional Services Not Included in the Monthly Fee

In-office Pharmacy (limited to certain medications)	Cost plus administration fee
Flu Shots	Cost plus administration fee
Additional office visits over 6	$ 50
Home Visits (Middletown only/physician's discretion)	$ 75
Medical Record Request	$ 15