IH² Membership Understanding

Dear Valued Member:

The IH² team are looking forward to serving you and being a part of your Concierge Medical Care Team. The following Understanding between you and "Nur Ventures, PLLC dba Integrative Health & Heart (IH² and all affiliates) describes and summarizes the terms and conditions of your participation in IH². Upon your signature and payment, the Understanding document is effective for one year (Understanding Term). After execution, a copy of the Understanding will be provided to you. Should any questions arise, please contact our office at **214.945.3621**.

IH² will be available to you for medical services and advise twenty-four (24) hours a day, seven (7) days per week, including holidays and be an advocate for you in the healthcare system. Your physician, Dr. N. S. Chowdhury, will assist you in formulating, monitoring and help you reach your health and wellness goals.

IH² reserves the right to make changes to these services at any time in response to regulatory requirements, market conditions, and medical developments. If such change becomes necessary, IH² will send you an updated version from time to time reflecting the necessary changes.

DEFINITIONS – It is important that this Understanding be clear and unambiguous to both parties. Therefore, we will attempt to use certain terms in the same way throughout this Understanding. These terms are as follows:

- "Understanding" shall mean this Client Retainer Agreement.
- "IH²" or Integrative Health and Heart" shall include any physician, nurse practitioner, or physician assistant employed or retained by Nur S. Chowdhury, MD, Nur Ventures, PLLC or Integrative Health and Heart.
- "Member" shall mean all of the rights, privileges, duties, and obligations you undertake by agreeing to participate in the Practice.
- "Membership Fee" shall mean the fee charged to Members in return for their access to the services listed.
- "Member Level" shall mean the combinations of Members described later in this Understanding which are used to calculate the Membership Fee.
- "Member Year" shall mean the one-year period beginning on the first day of the month immediately after the date you sign this Understanding and payment is credited.
- "Practice" shall mean "IH2"or "Integrative Health and Heart" as described in detail in the Understanding.
- "You" or "Your" shall mean any and all Members as defined above.

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Your Rights & Responsibilities

Your enrollment is voluntary, and you acknowledge that IH² has not induced you to participate in this Practice. Even though you may be suffering from an urgent or emergent medical condition and request evaluation and treatment on the day you sign this Understanding, it was with your full consent.

Private health insurance and other third party payment programs will not pay for your Membership Fee, and by entering into this Understanding you agree not to seek reimbursement for your Membership Fee from any private health insurance or other third party payment program.

Some of the services you will receive from the Practice may constitute medical, clinical, diagnostic or therapeutic services that are **NOT** covered by your private health insurance or other third party payment program. Your private health insurance or other third party payment program may not reimburse you for some of the screening or diagnostic testing, laboratory tests, and other services you will receive in connection with your annual comprehensive physical exam, if performed. You are financially responsible for any unpaid balance with laboratory and diagnostic affiliates of IH².

We are a non-participating entity for all governmental programs, including but not limited to Medicare and Medicaid. It shall be a breach of this Understanding for Member to submit any request for reimbursement to Medicare or any government program for services provided hereunder.

This program is not intended as a replacement of any health insurance or similar benefits program maintained by any third party payor, such as Medicare, BlueCross/BlueShield or United Healthcare, and does not affect any applicable co-payments, co-insurance, or deductible thereunder (which you must continue to pay under the terms of such insurance or such program). This Understanding is a service agreement, and not a contract of insurance.

Membership Fees

Your participation in the Practice begins immediately after you sign and date this Understanding and payment is received and lasts for one calendar year.

Payment Terms & Termination of Membership

The monthly Membership Fee is payable by cash, check, or credit card (Visa, Master Card), with a requested commitment for three months (90 days) before terminating this Understanding with a 30 day written/text/emailed/verbal notice. Cash payments will require a credit card or ACH account on file. In the event of non-payment, the registered account will be drafted five (5) days after the payment due date. Annual payments can be processed as well as automatic bank checking account drafts. Membership Fees are subject to change at the time of renewal and you will be notified in advance. Your Membership will renew automatically annually. One to two months before the end of your Membership Year, you will receive a communication (email or letter sent to the address that you designate outlining any changes). If you do not wish to renew or you wish to withdraw your membership after the initial 90 days and before the date you wish to withdraw from Membership, please notify us in writing one month or 30 days before the end of your

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current Membership Year. If an annual Membership Fee has been paid and you wish to withdraw your Membership prior to the end of the Membership year, we regret that we are unable to refund the balance.

Changes In The Practice

It may be necessary for IH² to change the Practice substantially or make adjustments if market conditions change. You will be notified at the address you provided if this occurs. If you cancel your Membership within thirty (30) days of this notice of a change in adjustments, we will cancel your Membership at the end of that month, and you will have no further obligation to pay the Membership Fee.

IH² Promise

IH² promises to you to enhance the Doctor/Patient relationship and thus provide quality medical care. If you feel that this is not accomplished and IH² is not suitable for you, please notify us immediately and we will make every effort to transfer your medical care to a qualified medical practitioner of your choosing.

Electronic Communications/Privacy

If you wish to communicate electronically with the Practice, you acknowledge that email, text messaging, and video conference is not a secure medium for sending or receiving potentially sensitive personal health information. Although the Practice will take steps to keep your communications with the Practice and its respective employees, agents and representatives, confidential and secure, the confidentiality of electronic communications cannot be assured or guaranteed.

Medical Care NOT an Insurance Policy

The Practice is not a health insurance benefit plan. You, your private health insurance or other third party payment program, or both will continue to be financially responsible for all services you receive that are not specifically covered by this Understanding. You acknowledge and agree that the Membership Fee does not constitute payment (in whole or in part) for any medical, clinical, diagnostic, or therapeutic services or for any items that are covered (in whole or in part), by any payors providing any benefits to you. Specifically excluded from services provided under this Understanding are diagnostic testing, procedures performed by IH², treatment by any other physician group, medications, hospitalizations and any services not described herein. The Practice is also **NOT** a substitute for **EMERGENCY MEDICAL CARE**. Call 911 in the event of a medical emergency.

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Mediation/Arbitration

Any dispute arising from this Understanding shall be resolved through non-binding mediation, and, if mediation is unsuccessful, BINDING ARBITRATION under the auspices of the American Health Lawyers Association Alternative Dispute Resolution Service.

Assignment

You may not assign this Understanding or any of the rights, duties, privileges, or obligations which arise under it to any other party. Any attempt to do so will be null, void, and of no legal effect.

Governing Law

This Agreement shall be subject to and governed by the laws of the State of Texas.

I / We (Please circle one) understand and agree to all the terms of the Practice described above.

Participant(s)

Signature: _____ Date: _____

Print Name: _____

Signature: _____ Date: _____

Print Name: _____

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Payment Authorization

RESPONSIBLE PARTY

Name: _____

Date of birth:_____Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Membership Type: _____ Payment Fee: _____

Payment Terms (Please initial):

____ I am electing to pay **monthly** by credit card or ACH debit. I understand that by my signature below, I am authorizing Integrative Health and Heart to charge the monthly Membership Fee for the option I have chosen on the _____ day of every month of my Membership Year, after the initial 90 day payment is made in full.

Credit Card Authorization

Name as Appears on Credit Card: _____

Billing Address: _____

City: _____ State: _____ Zip Code:_____

Credit Card Number: _____

Expiration Date:_____ CVV Security Code (On Back of Card): _____

OR Debit Bank Account Authorization

Banking Institution Name: _____

Account Type (Circle One): Checking or Savings

Bank Account #: _____

Bank Transit (Routing) #: _____

I hereby authorize Nur S. Chowdhury MD, dba Integrative Health and Heart to charge this credit card or bank account for the Participation Fee and Payment Terms as indicated above.

_____ _____

Signature Date

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Participant Information Form

Please Print All Information.

Primary Participant:

Name: _____

Date of Birth:_____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Pharmacy/#: _____

Please circle preferred method of contact:

E-Mail Address: _____

Cell Phone: _____

Work Telephone: _____

Spouse/Emergency Contact of Primary Participant:

Name: _____

Date of Birth:_____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Pharmacy/#: _____

Please circle preferred method of contact:

E-Mail Address: _____

Cell Phone: _____

Work Telephone: _____

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Dependents Covered By This Agreement:

Name: ____

Date of Birth:________________________ Social Security Number: ___________________________

Address: ____

City: ____________________________ State: __________ Zip Code: ___________________

Home or Cell Telephone: ____

Name: ____

Date of Birth:________________________ Social Security Number: ___________________________

Address: ____

City: ____________________________ State: __________ Zip Code: ___________________

Home or Cell Telephone: ____

Name: ____

Date of Birth:________________________ Social Security Number: ___________________________

Address: ____

City: ____________________________ State: __________ Zip Code: ___________________

Home or Cell Telephone: ____

Name: ____

Date of Birth:________________________ Social Security Number: ___________________________

Address: ____

City: ____________________________ State: __________ Zip Code: ___________________

Home or Cell Telephone: ____