COLUMBIA EYE ASSOCIATES

PREFERRED MEMBERSHIP PATIENT AGREEMENT

This Preferred Membership Patient Agreement ("Agreement") is entered into by and between the Practice, Columbia Eye Associates PC (2440 M St NW Suite 516, Washington DC, 20037), and the Patient signing this Agreement.

1. **Preferred Membership Services**
   The Practice agrees to provide the following preferred-level services to the Patient during the term of this Agreement:

   - Priority and same/next-business day scheduling for urgent eye issues.
   - Extended consultation times with the ophthalmologist for a more thorough discussion of your eye needs.
   - Direct physician communication via phone, text, or email and Telehealth visits available via FaceTime.
   - Personalized care planning, especially for chronic ocular diseases (e.g., chronic dry eye disease, blepharitis, glaucoma, macular degeneration).

   These services are offered in addition to the standard medical services covered by the Patient's insurance.

2. **Fees and Payment**
   - **Annual Preferred Membership Fee**: $950 for an individual and $650 for each additional member in the same household.
   - *Membership fee includes annual refraction for glasses and contacts, no show/cancellation fees (3), facilities fees for emergency visits (4) and in-office procedures (2), and DMV form completion with a* ***value over $1,130*** *annually.*
   - Fee may be paid in full at the start or in biannual or quarterly installments with a credit card on file.
   - This fee covers only the services listed above, that are services Medicare, Medicaid and private insurance do not cover. This Agreement is **not** health insurance, a prepaid medical services plan, nor a substitute for health insurance.
   - The Preferred Membership Fee is **non-refundable, except upon early termination by the Practice.**

3. **Insurance & Third-Party Payments**
   - The Practice **does not bill** any private insurance, Medicare, or Medicaid for Preferred Membership Fees or services provided under this Agreement.
   - Patients are responsible for all charges outside the scope of this Agreement.

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- You are encouraged to maintain private insurance as any services outside this Agreement (e.g., surgeries, hospitalizations, or diagnostic imaging) may be billed separately and may be eligible for insurance reimbursement depending on the patient's coverage.

4. Term & Termination

- This Agreement is valid for a 12-month term from the Effective Date. It will renew each year automatically unless you give us notice by mail or email within 30 days prior to the renewal date. The Practice will email you a renewal notice each year at least sixty days prior to the annual automatic renewal date.
- Either party may terminate this Agreement with 30 days written notice via mail or email to office@columbiaeyedc.net for any reason.
- If the Physician terminates the agreement, a prorated refund of the membership fee will be provided. No refund is available if a patient terminates this Agreement before the end of its term.
- If you choose to discontinue your membership and you later wish to re-enroll, the Practice reserves the right to decline re-enrollment or require you to pay a re-enrollment fee that is equivalent to the months of absent payments while you were not enrolled as a member, not to exceed twelve (12 months).

5. Limitations of Care

- This is **not** an emergency service. In life-threatening or urgent eye emergencies after hours, patients should go to the nearest emergency department or call 911.
- The Practice provides ophthalmologic care only. General medical care must be maintained through the Patient's primary care physician or other providers.

6. Patient Responsibilities The Patient agrees to:

- Notify the Practice of changes to contact information or medical status.
- Respect the time and policies of the Practice to maintain a collaborative relationship.
- Timely pay the annual fees and other payments due.

7. Confidentiality & Communication

- The Practice complies with all HIPAA privacy standards.
- The Patient consents to email and may consent to text communication for convenience by initialing below. Communications by email or text, by their nature cannot be guaranteed to be secure or confidential. If you initiate a conversation in which you disclose personal health information on any of these platforms, then you authorize the Practice to communicate with you regarding all protected health information in the same format.

8. Governing Law and Other Provisions

This Agreement shall be governed by and construed in accordance with the laws of the District of Columbia. No amendment or variation of the terms of this Agreement shall be valid unless mutually agreed to in writing. This Agreement is personal to you and may not be assigned by you. It is possible that we will need to delegate certain duties under this Agreement and you consent to such delegation. If we elect to assign this Agreement we will provide you with notice as referenced herein. This Agreement constitutes the entire agreement between us and supersedes any and all other oral or written agreements, representations, negotiations, and understandings. In the event that any provision of this Agreement is held to be illegal or unenforceable for any reason, the unenforceability of that provision shall not affect the remainder of this Agreement, which shall remain in full force and effect in accordance with its terms and modified to be conforming to law or interpreted as though the offending provision had not existed. If this Agreement is held to be invalid or unenforceable for any reason, and if we are therefore required to refund all or any portion of the Fees paid by you, you agree to pay the Practice an amount equal to the fair market value of the Services actually rendered to you during the period of time for which the refunded fees were paid, commensurate with prevailing rates in our practice area. No waiver or delay of action with regard to a breach of any provision of this Agreement will be construed to be a waiver of this Agreement.

SIGNATURE

By signing below, the Patient acknowledges that they have read, understood, and agreed to the terms of this Preferred Membership Patient Agreement.

Patient Full Name (Printed): _____

Patient Signature: _____ **Date:** _____

Patient Date of Birth: _____ / _____ / _____
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Please initial below to
CONSENT FOR TEXT MESSAGING

_____ I consent to receive messages, i.e. conversational, customer care, appointment reminders, information about Practice specials etc. from Columbia Eye Associates. I understand that I may opt out at any time by replying “STOP” to any message; Message & data rates may apply; Messaging frequency may vary.

CREDIT CARD AUTHORIZATION FOR PREFERRED MEMBERSHIP

By completing the information below, you authorize **Columbia Eye Associates** to charge your credit card for the annual preferred membership fee or any other agreed-upon charges related to your care, as outlined in this agreement. You are required to keep a valid form of payment on file for electronic payments, and if the form of payment provided expires or otherwise becomes invalid, you agree to promptly provide updated payment information. In the event there are costs associated with invalid payment information, such charges will be applied to your account.

This information will be securely stored and used only for payment purposes authorized by you.

I agree to pay:

☐ Annual Fee for Single Person**: $950**

☐ Annual Fee for Additional Members in Household: **$650 each**

# of persons _____

My payment will be made:

☐ Annually ☐ Biannually ☐ Quarterly

Credit Card Information

Cardholder Name (as appears on card): _____

Billing Address: Street: _____

City: _____ State: _____ ZIP: _____

Credit Card Type:

☐ Discover ☐ American Express ☐ MasterCard ☐ Visa

Card Number _____ _____ _____ _____ Expiration Date: ____ / ____

CVV (3 or 4 digits): _____

AUTHORIZATION

I, the undersigned, authorize **Columbia Eye Associates** to charge my credit card for the services described in this agreement. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the practice of any changes to my card information.

Cardholder Signature: _____ **Date:** _____