DIRECT PRIMARY CARE MEMBERSHIP AGREEMENT

This DIRECT PRIMARY CARE MEMBERSHIP AGREEMENT (this "Membership Agreement") is made this ____day of ____, 20 ____ by and between Tree of Life Wellness, LLC, an Michigan limited liability company, located at 3830 Packard St, Suite 230, Ann Arbor, MI 48108 (the "Practice") and _____ ("Patient") and included minors:_____ ("Patient")

1. MEMBERSHIP. Patient hereby agrees to enroll as a member in the Practice's direct primary care membership program ("Membership Program") beginning on the Effective Date set forth above. By being a member of the program, Patient shall be eligible to receive certain basic medical services described on Exhibit A ("Covered Services"), attached hereto and made a part hereof, and shall be subject to the conditions and limitations described therein. Membership in the Practice's Membership Program includes only the Covered Services specifically described in Exhibit A. The Practice may add or discontinue Covered Services at any time, as it may choose in its sole discretion. The Practice shall provide at least sixty (60) days' advance written notice upon any change to the Covered Services listed in Exhibit A.

All patients are required to be seen in clinic at least once per year to maintain active patient status. Additionally, one well visit annually is required for individuals 40+ due to increased need for screening evaluations.

2. MEMBERSHIP FEES. Membership Fees shall be due on the 1st of each month following the Effective Date, is billed in arrears and will cover the Patient's membership for that month (e.g. if the sign-up date is May 15th, patient's membership is effective on May 15th and the Membership Fee for the month of May is due on June 1). Membership Fees shall be pro-rated for the first month only if a new patient signs up after the first of the month. Any fees or charges that are not included in the Membership Fee (i.e. fees for non-covered services) shall be due at the time of service., for example, an appointment outside of those including in patient's plan. For purposes of this Membership Agreement,

A. NONPAYMENT. In the event that the Patient is unable to pay the monthly Membership Fee in full and on time, the Practice may, in its sole discretion, terminate this Membership Agreement in accordance with section 5A. It is the Patient's responsibility to maintain a correct and up-to-date credit/debit card number on file.

B. CHANGES TO MEMBERSHIP FEE SCHEDULE. The Practice may amend the Membership Fee Schedule at any time, as it may determine in its sole discretion, upon providing Patient at least 60 days' advance written notice.

3. NON-COVERED SERVICES. Patient understands and acknowledges that Patient is responsible for any charges incurred for health care services performed outside of the physical office space location as set forth above, including, but not limited to, emergency room visits, hospital and specialist care, and imaging and lab tests performed by third parties. Patient shall also be responsible for any charges incurred for health care services provided by the Practice but not specifically described on Exhibit A.

The Practice strongly encourages the Patient to maintain health insurance during the term of this Membership Agreement to cover services that are not provided under this Membership Agreement. Patient should purchase health insurance to cover, at a minimum unpredictable and catastrophic expenses.

4. INSURANCE. Patient acknowledges and understands that this Membership Agreement or Membership in the Practice does not provide comprehensive health insurance coverage, nor is it a contract of insurance. Patient acknowledges that patient has contacted Patients' insurance health

insurance company to discuss any limitations or restrictions that may be imposed upon patient by signing the agreement for self pay status attached hereto and incorporated by reference herein.

A. INSURANCE CLAIMS. Patient acknowledges and understands that the Practice is not a participating provider in any Medicaid or private health care plan. Patient acknowledges and understands that the Practice will not bill insurance carriers on Patient's behalf for Covered Services provided to Patient and the Practice will not bill any health care plan of which the Patient may be a subscriber or beneficiary for Membership Fees due and owing to the Practice under this Membership Agreement. Membership Fees may not be submitted to insurance companies for reimbursement.

B. TAX-ADVANTAGED MEDICAL SAVINGS ACCOUNTS. The Practice cannot guarantee that the Membership Fees described in Section 2 constitute eligible medical expenses that are payable or reimbursable using a tax-advantaged savings account such as a health savings account ("HSA"), medical savings account ("MSA"), flexible spending arrangement ("FSA"), health reimbursement arrangement ("HRA"), or other health plans similar thereto (collectively referred to as a "tax-advantaged savings account"). Every health plan is uniquely different. Patient should consult with their health benefits advisor regarding whether Membership Fees may be paid using funds contained in Patient's tax-advantaged savings account, as may be applicable.

C. HEALTH PLANS. Because the Practice is not a participating provider in any Medicaid or private health care plan, third party payers may not count the Membership Fees incurred pursuant to this Membership Agreement toward any deductible Patient may have under a health plan. Patient should consult with their health benefits advisor regarding whether Membership Fees may be counted toward the Patient's deductible under a health plan, as may be applicable.

5. TERMINATION OF AGREEMENT. Termination of this Membership Agreement shall cause the termination of Patient's membership in the Membership Program described herein.

A. TERMINATION BY PRACTICE. The Practice may terminate this Membership Agreement at any time and for any reason upon providing Patient advance written notice. Termination will be effective starting five business days after notification. Upon termination, the Practice shall comply with all rules and regulations of the State of Michigan Medical Board regarding the provision of emergent care for 30 days after termination and cooperate in the transfer of Patient's medical records to the Patient's new primary care physician, upon the Patient's written request and direction.

B. TERMINATION BY PATIENT. Patient may terminate this Membership Agreement at any time and for any reason, upon providing advance written notice to Practice. Such termination shall be effective on the last day of the then-current calendar month. Membership Fees shall not be pro-rated for any terminal month. Monthly Membership Fees will continue to accrue until Patient's written notice of termination is received by Practice at its office location set forth above.

6. REINSTATEMENT. In the event Patient terminates this Membership Agreement after the Effective Date hereof, Patient shall be ineligible for membership for a period of six (6) months following the effective date of termination, unless Patient pays a fee in the amount of five hundred dollars ($500.00) ("Reinstatement Fee"). Practice reserves the right to deny reinstatement.

7. INDEMNIFICATION. Patient agrees to indemnify and to hold the Practice and its members, officers, directors, agents, and employees harmless from and against all demands, claims, actions or causes of action, assessments, losses, damages, liabilities, costs and expenses, including interest, penalties, attorney fees, etc. which are imposed upon or incurred by the Practice as a result of the Patient's breach of any of Patient's obligations under this Agreement.

8. ENTIRE AGREEMENT. This Membership Agreement constitutes the entire understanding between the parties hereto relating to the matters herein contained and shall not be modified or amended except in a writing signed by both parties hereto.

9. WAIVER. The waiver of either the Practice or Patient of a breach of any provisions of this Membership Agreement must be in writing and signed by the waiving party to be effective and shall not operate or be construed as a waiver of any subsequent breach by either the Practice or Patient.

10. CHANGE OF LAW. If there is a change of any law, regulation or rule, federal, state or local, which affects this Membership Agreement, any terms or conditions incorporated by reference in this Membership Agreement, the activities of the Practice under this Membership Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and the Practice reasonably believes in good faith that the change will have a substantial adverse effect on the Practice's rights, obligations or operations associated with this Membership Agreement, then the Practice may, upon written notice, require the Patient to enter into good faith negotiations to renegotiate the terms of this Membership Agreement. If the parties are unable to reach an agreement concerning the modification of this Membership Agreement within ten (10) days after the effective date of change, then the Practice may immediately terminate this Membership Agreement upon providing written notice to Patient.

11. GOVERNING LAW. This Agreement and the rights and obligations of the Practice and Patient hereunder shall be construed and enforced pursuant to the laws of the State of Michigan.

12. ASSIGNMENT/BINDING EFFECT. This Membership Agreement shall be binding upon and shall inure to the benefit of both the Practice and Patient and their respective successors, heirs and legal representatives. Neither this Membership Agreement, nor any rights hereunder, may be assigned by the Patient without the written consent of the Practice.

IN WITNESS WHEREOF, the parties have caused this Membership Agreement to be effective on the Effective Date first above written.

Tree of Life Wellness PLC, a Michigan limited liability company

Patient Name *[Please Print]*	Selected Plan

_____ {Initials} I acknowledge that I have read and understand the fee schedule and agree to book and pay for appointments outside of the included number of visits in my selected plan.

_____ {initials} I acknowledge that, if minors are listed above, that all portions of the contract apply to each minor

_____

Patient and Guardian Signature

Start date_____

End Date (one year from start) _____

COVERED SERVICES

In clinic or telehealth appointments as available. See your specific plan options for number of covered visits.

Brief calls, emails, portal messages requiring less than 5 minutes of time.

Appointment types include wellness exams, acute and chronic disease management, and covered procedures (listed below).

Lab orders, specialists referrals, imaging testing orders, therapy referrals and medication refills

I reserve the right to indicate the need for an appointment.

- **OFFICE CARE AND MINOR PROCEDURES INCLUDED, AS MEDICALLY INDICATED (and during a scheduled appointment that applies to allotted number of appointments based on plan)**
    - Ear wax removal
    - Rapid flu and strep testing
    - Pap smears *
    - Rapid strep test
    - Stitches for cuts/wound care
    - Skin biopsies *
    - 1-2 page paperwork

EXCEPTIONS TO ABOVE:

*Patient will be responsible for the laboratory fee.

Forms of more than 2 pages (for example, but not limited to, disability, FMLA, attorney correspondence) may require an appointment.

EXCLUDED SERVICES:

Anything not specifically listed as a Covered Service shall be a non-covered service.

Any health care services not performed on or within the premises of Tree of Life Wellness, LLC, including emergency room visits, hospital stays, specialist care, imaging and labs, etc.

- Durable medical equipment (braces, splints, etc.).
- Any care delivered by providers not affiliated with the Practice.

EXHIBIT B: FEE SCHEDULE

	Option A	Option B	Option C
Children 0-2 years	40 (55 if parent is not a patient)	30 (40 if parent is not a patient)	Not available
Individuals 2-18 years	55	40	20
Adults 18+	85	45	25

Option A – Includes 4 (30minute) appointments in one month, 36 total appointments in one year

Option B – Includes one in-clinic visit and three (30 minute) in-clinic or video visits per year, additional appointments will be billed at $30 per 30-minute visit. (will be prorated/projected for 15 minute, 45 minute and 60 minute visits as needed)

Option C - includes one in-clinic visit per year, additional appointments will be billed at $50 per 30-minute visit (will be prorated/projected for 15 minute, 45 minute and 60 minute visits as needed)

Non primary care / pay per-visit- $100 for a 30 minute urgent concern, $150 for a 45 minute Integrative consultation

- This is NOT primary care. You cannot make these appointments if you require ongoing care including medication refills, screening tests, etc.
- This does not include ANY communication outside of visits – no email, texts, message or phone follow ups. All questions, paperwork and follow up must be completed in the time allowed.

Available discounts include:

- 10% Discount per person for those in the same household (only applied toward monthly fee, does not include additional visit fees)
- 2.5% Discount total to pay for full year in advance (only applied toward 12 months of monthly fee, does not include additional visit fees)

Credit Card Payment Authorization

❑ - **Recurring Charge** – You authorize regularly scheduled charges to your Credit Card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your Credit Card Statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 60 days prior to the payment being collected.

I _____ authorize Tree of Life Wellness to charge my Credit Card below for $_____ beginning on _____ (Date) and repeated on the 1st of every Month.

Goods / Services Rendered: Medical Care Services

❑ - **One (1) Time Charge** – You authorize the merchant below to make a one-time charge to your Credit Card listed below, per visit that exceeds your contract allowance.

By signing this form, you give us permission to debit your account for

I _____ authorize Tree of Life Wellness to charge my Credit

Card indicated below

Goods / Services Rendered: Medical Care Services

Billing Details

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Credit Card Information

❑ - Visa ❑ - MasterCard ❑ - AMEX ❑ - Discover

Credit card information to be added securely via phone

Individual's Signature _____ Date _____