D.C. MEDICAL CARE LLC

Dana Cernea, M.D.

D.C. SELECT CARE SERVICES AGREEMENT

This *D.C. SELECT CARE SERVICES* Agreement ("Agreement") sets forth the terms under which Dana Cernea, MD (the "Physician") and DC Medical Care, LLC (the "Practice") offers to provide medical services, counseling and advice to selected patients.

The relationship between doctor and patient is grounded in mutual trust and confidence. This Agreement confirms the terms and conditions of our engagement, so that hereafter our time and energies may be focused exclusively on providing the best medical care to you. Please contact us directly with any questions regarding this Agreement.

1. **Patient**. The person signing this Agreement (the "Patient") retains the Practice to provide services (as described below), and the Practice agrees to provide such Services, subject to the terms hereof,

2. **Services.** As used herein, the term "Services" includes those services offered by the Practice, as more fully described in attached D.C. SELECT CARE SERVICES Handbook.

3. **Term/Renewal**.
   (a) **Term**. The term of this Agreement shall commence and terminate on the dates set forth on the signature page (the "Term").
   (b) **Renewal**. Unless this Agreement is otherwise terminated as provided herein, the initial term of this Agreement will be for one (1) year, commencing on the Effective Date (the "Initial Year"), and the Agreement will automatically renew for successive one (1) year periods (each, a "Renewal Year"), unless either party notifies the other party in writing, not less than thirty (30) days' prior to the expiration of the Initial Year or a Renewal Year (as applicable) of that party's desire not to renew this Agreement.

4. **D.C Select Care Fee/Not Covered by Health Insurance.** The initial annual fee is $2,00 at any point in the calendar year. The D.C Select fee is payable annually. The initial term fee is required at the time of signage. Patient understands that this fee is subject to change by the Practice. Any revised fee will be effective at Patient's next annual renewal date. The fee pays for providing enhanced services set forth in the handbook. The Patient agrees not to submit to their health insurer any invoice for reimbursement or payment with respect to the D.C Select Services fee. However, patient should be aware that they may submit the fee for reimbursement to any flexible spending account (FSA/HSA), or medical savings account established by an employer. The Practice makes no representation that the Patient will qualify to be reimbursed from any such account. This Agreement is a service contract and not a contract of insurance.

5. **Health Insurance** – The Patient understands that he is responsible to maintain commercial health insurance or Medicare coverage at all times and that D.C. Select Care Services is not a substitute thereof. This is an enhancement, and does not cover or pay for any medical services provided to you by the Physician or the Practice. All medical services performed by the Physician and the Practice will be separately billed to the Patient's health insurance plan. The Practice currently participates with most health insurance plans, including Medicare, accepts payment from those plans as payment in full

for professional services, subject to applicable deductibles, copayments and coinsurance. The Patient will still be responsible for all deductibles copayments and coinsurance as per legal statutes governing delivery of medical care.

6. **Physician / Coverage**. The Physician will be the primary treating physician for all Internal Medicine and related service needs. The Physician may not be available from time to time, due to continuing medical education obligations, vacations or similar reasons. During such periods there will be a designated coverage physician or other licensed medical professional, to attend to any medical need that needs immediate attention.

***D.C. SELECT CARE SERVICES* Fees**

Initial contract year: Current date/Renewal date _____

___ $2,000 per person

___ $3,000 per person for emergency acceptance into service due to serious illness at doctor's discretion

The Agreement will automatically renew for successive one year periods, unless either party notifies the other party in writing, no less than thirty (30) days prior to expiration of the initial year or a renewal year (as applicable), of that parties desire not to renew this Agreement. The Practice will bill the Patient for any renewal year before the beginning of that year, and the Patient agrees to pay within 30 days following invoicing. In exceptional circumstances (e.g. patient moving out of state) a provision can be made, at the discretion of the Practice, to refund a prorated amount of the fee to the Patient.

By signing below, I hereby acknowledge and agree that I have read and understand this Agreement, including the Handbook, and that I agree to all terms contained therein.

Agreed:

Member Signature: _____

Member Printed Name: _____

Date: _____

Accepted:

DC Medical Care, LLC

_____

Dana Cernea, M.D.

Effective Date: _____

Member Information

Name: _____

Birthday (DOB): _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Payment Information [Annual payments ONLY]

___ Check

___ Credit Card

Name on card: _____

Card number: _____

Security Code: _____

Exp. date: _____

PLEASE COMPLETE AND SIGN THESE LAST TWO PAGES.
FORMS AND PAYMENTS TO BE SENT TO THE ADDRESS BELOW.

HIPPA AUTHORIZATION OF PROTECTED HEALTH INFORMATION

I,_____ , hereby authorize the disclosure of my protected health information by Dana Cernea, M.D. and DC Medical Care, LLC (together, for this purpose, the "Practice"). I further authorize the disclosure of my protected health information by the Practice as necessary. I authorize the Practice to interact on my behalf with specialists, hospitals, and other medical entities as well as family members if needed. For purposes of this document, protected health information means any and all information relating to healthcare services provided to me by the Practice including, but not limited to, information relating to healthcare services provided to me prior to this date and information received by the Practice in connection with my care.

I understand that I am not required to electronically sign this authorization/consent in order to receive treatment, and I understand that information disclosed pursuant to this authorization/consent may be re-disclosed by the recipient and no longer protected by privacy regulations, unless otherwise required by law, to be for the limited purpose of carrying out the functions of medical care. I also understand that this authorization will remain in effect until I provide a written notice of revocation to the Practice, and that I may revoke this authorization at any time by sending written notice to the address below. The revocation will be effective immediately upon the Practice's receipt of my written notice, although the revocation will not affect any actions the Practice took before it received my notice of revocation. In any event, the authorization will expire upon termination of my Agreement, provided that I provide notice of such termination to the Practice.

The address and phone number of the Practice is:

Dana Cernea, M.D.
DC Medical Care, LLC
PO Box 1778
Englewood Cliffs, NJ 07632
Phone: (201) 475-9421
Fax: (201) 475-1555

_____
Signature of Patient or Personal Representative

_____
Printed Name of Personal Representative (if applicable) and relationship to patient