George Liakeas, MD

Castle Connolly
PRIVATE HEALTH PARTNERS, LLC

MEMBERSHIP AGREEMENT

This Membership Agreement (the "Agreement"), between you and **LIAKEAS CCPHP, LLC** (the "Company'), sets forth the terms of your membership in the Company's "Membership Program." The Agreement includes the Membership Handbook (the "Handbook"), accessible at ccphp.net/liakeasccphp/member-handbook, which should be read carefully because it includes important information about the terms of your Membership, including the details of the "Enhancements" that are referenced below.

1. **The Role of the Company.** The Company works closely with your chosen physician, Dr. George Liakeas (your "Physician") and your Physician's medical practice, Lexington Medical Associates, PC (the "Practice") to provide you with, or arrange to make available, the services and amenities listed in the Handbook (collectively, the "Enhancements"), which are designed to enhance your healthcare experience. To be clear, the Enhancements are not professional services and do not include items or services that are covered by health insurance plans**.** All professional services are provided by your Physician and the Practice. The Company does not engage in the practice of medicine or provide any diagnostic, therapeutic or clinical services; and no act or service required or permitted of the Company by any provision of this Agreement is intended, or should be construed, as constituting the practice of medicine under New York law.

2. **You and Your Physician.** Your Physician will be your primary treating physician for your internal medicine and related services needs, and the Company has arranged for your Physician to generally be available to provide professional services to you and assist the Company in providing the Enhancements to you. Your Physician may not be available from time to time due to illness, continuing medical education obligations, customary vacation periods or similar reasons. During any such unavailability, your Physician will designate a covering physician or other licensed medical professional to attend to your medical needs. Nothing in this Agreement should be deemed or construed, and nothing herein is intended, to influence or affect your Physician's or any covering practitioner's independent clinical judgment as it relates to your care. Your Physician and all covering practitioners retain full and free discretion to exercise their professional medical judgment on your behalf.

3. **Membership Fee/Not Covered by Health Insurance.** By signing on to this Agreement and becoming a Member, you agree to the terms of this Agreement and you agree to pay the Company the annual Membership Fee set forth below. The Membership Fee pays the Company for providing you the Enhancements. It does not cover or pay for any professional services provided by your Physician or the Practice.

   Because all professional services are performed by your Physician and the Practice, the Practice will separately bill you or your health insurance plan for their professional services. The Practice currently participates with several health insurance plans, including Medicare, and where applicable, accepts payment from those plans as payment in full for professional services, subject to applicable deductibles, copayments and coinsurance.

You agree not to submit to your health insurer or health plan any bill, invoice or claim for reimbursement or payment with respect to the Membership Fee. You also agree that this Agreement is a service contract and not a contract of insurance. You acknowledge that you may, however, in your discretion, submit the Membership Fee for reimbursement to any flexible spending account, health reimbursement account, or medical savings account of your employer in which you participate, but that the Company makes no representation that any part of the Membership Fee will qualify to be reimbursed from any such account.

Your annual Membership Fee is **$_____**. You may pay the Membership Fee in one annual payment, two (bi-annual) payments, four quarterly payments or monthly payments. Single annual payments or bi-annual payments can be made to the Company by check or credit card. If you select to pay your Membership Fee through quarterly installments, those payments can only be made to the Company by credit card. If you select to pay your Membership Fee through monthly installments, those payments can only be made to the Company through ACH (Automated Clearing House). You will select your method and timing of payment in the Payment Information section of this Agreement, below. Certain processing fees, as outlined in the Payment Information section, will apply.

The Company reserves the right to change the Membership Fee at the start of any Renewal Year (defined below), following at least thirty (30) days' advance written notice.

4. **Term and Termination.** The initial term of this Agreement will begin on the "Effective Date," which is the date on which your Membership Services begin pursuant to this Agreement, as confirmed by the Company following its receipt of a copy of the Agreement executed by you and your Membership Fee; provided that upon the Company's receipt of the executed Agreement and the Membership Fee, the Company retains the option, in its sole discretion, not to confirm the effectiveness of this Agreement (e.g., due to limitations on the number of Members) and to return your Membership Fee payment to you.

   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.

   Unless the Agreement is sooner terminated, the Company will bill you for any Renewal Year before the beginning of that year. You agree to pay the Membership Fee for each Renewal Year (or pay the initial installment for that year, as applicable) within thirty (30) days following invoicing. Failure to pay the invoiced amount in a timely manner may result in termination of this Agreement.

   Either party may also terminate this Agreement at any time for any reason upon thirty (30) days' prior written notice to the other party, delivered in the manner set forth in Section 4 of

the Additional Terms section of the Handbook. If you terminate this Agreement, you will be refunded the pro-rata portion of any paid portion of your annual Membership Fee, minus an administrative fee of two hundred dollars ($200) ("Administrative Fee"). Except as provided below, if the Company terminates this Agreement, you will be refunded the pro-rata portion of any paid portion of your annual Membership Fee, and no Administrative Fee will be due. Any pro-rated refund will be based on the number of days remaining in your Membership term (or payment period, as applicable). In the event of your death, this Agreement will immediately terminate. However, in the event that your Physician becomes unavailable for an extended period of time, the Company may seek to identify a replacement Physician as your Physician (at least temporarily) and not terminate this Agreement, in which case you will be entitled to terminate the Agreement and obtain a pro-rated refund as provided above.

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George Liakeas, MD

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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.

Member Signature: _____
Member Printed Name: _____
Date: _____

Agreed/Accepted:
LIAKEAS CCPHP, LLC
By: _____
Its: _____

Effective Date: _____

Member Information

Name: _____
DOB: _____
Address 1: _____
Address 2 (e.g., apt.): _____
City, State, Zip: _____
Phone: _____
Email: _____

Payment Information

☐ Check [Annual or Bi-annual payment ONLY]

☐ Credit Card

___ Annual payment* ___ Semi-Annual payment** ___ Quarterly payment***

Name on card: _____

Card number: _____

Security Code: _____

Exp. date: _____

* Paid once annually, with no processing cost.
** Paid semi-Annually with a 2.5% processing cost applied to each payment. Semi-annual installments will be charged automatically to the credit card on file during each year that you are a Member.
*** Paid quarterly with a 5% processing cost applied to each payment. Quarterly installments will be charged automatically to the credit card on file during each year that you are a Member.

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AUTHORIZATION FOR DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I,_____ , hereby authorize the disclosure of my protected health information by George Liakeas, M.D. and Lexington Medical Associates, PC (together, for this purpose, the "Practice") to Liakeas CCPHP, LLC (the "Company"), a company with which the Practice works to help carry out Practice administrative and related functions, and to deliver certain Enhancements which are described in a Membership Agreement between me and the Company. I further authorize the disclosure of my protected health information by the Company as necessary to enable the Company to carry out those functions. 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; although I understand that any Company re-disclosure is anticipated, unless otherwise required by law, to be for the limited purpose of carrying out the functions described above.

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 or the Company took before it received my notice of revocation. In any event, the authorization will expire upon termination of my Membership Agreement with the Company, provided that I provide notice of such termination to the Practice.

The address and phone number of the Practice is: Lexington Medical Associates, PC.
139 East 57th Street
New York, NY 10022
Phone: (212) 750-5088
Fax: (212) 750-6118

_____
Signature of Patient or Personal Representative

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

_____