Patient Agreement

Jeffrey R. Zohner, MD

Annual Fee $1,800 = Individual Adult

I have engaged Jeffrey R. Zohner, MD, LLC and its physician, **Jeffrey R. Zohner, MD** (***JRZMD***) to provide a personalized preventive care program to me/us for a period of one year beginning ________________, 2013. I understand that a yearly fee is assessed to pay for these non-covered services and benefits. As used in this Agreement, the term "Service Year" refers to the 1-year period beginning on the date above as well as every 1-year period after that, unless I/we choose not to renew the Agreement as provided below.

✓ **METHOD OF PAYMENT:**

❑ **Personal check enclosed.** *Please make check payable to* ***Jeffrey R. Zohner, MD***
(Full annual payment only. No semiannual or quarterly option for payment by check.)

__________ Check Number __________Amount

❑ **Credit Card** ➔ ○ MasterCard ○ Visa ○American Express ○ Discover

❑ **I will pay annually.** Please charge my credit card now for the full amount.

❑ **I will pay semiannually.** Please charge one-half now, and the balance on or about six months from date of enrollment.

❑ **I will pay quarterly.** Please charge one-quarter now. The remaining three quarters will be charged one-quarter at a time at three month intervals from date of enrollment.

I hereby authorize *JRZMD* to charge my annual fee to my credit card under the terms I have indicated above.

___________________________________/_______________________________________/_______________/___________
Cardholder Signature *Card #* *Exp. Date* *Security Code*

____/___________/____
Cardholder Billing Address *Billing Zip Code* *Cardholder Daytime or Cell Phone Number*

✓ **PATIENT(S): PLEASE PRINT & SIGN YOUR NAME(S)!**

I may renew this Agreement for subsequent Service Years by paying the Annual Fee for the applicable Service Year. I have read and understand this Agreement. I acknowledge that this Agreement will automatically be renewed and will continue for future Service Years unless I notify *JRZMD* of my intention to terminate. I acknowledge that either I or *JRZMD* may terminate this Agreement at any time upon 30 days *written notice*. If either party terminates this Agreement, the Annual Fee may be pro-rated or forfeited. However, if the annual Comprehensive Wellness Evaluation has been completed, there will be no refund. The terms of this Agreement will apply to all such subsequent Service Years, unless *JRZMD* and I agree otherwise, in writing.

___________________________________/___________________________________/________/_________________________
Signature **Printed Name** **Date** **E-mail Address**

___________________________________/___________________________________/________/_________________________
Signature **Printed Name** **Date** **E-mail Address**

PLEASE SIGN & RETURN WITH YOUR INDICATED PAYMENT BY YOUR RENEWAL DATE
IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.

© 2012 Specialdocs Consultants, Inc.