Patient Agreement

Jeffrey R. Zohner, MD

Patient Name(s) ______________________________

Address ______________________________

City, State Zip code ______________________________

❑ Annual Fee $2,000 = Individual
❑ Annual Fee $3,600 = Adult Couple

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 _______________. 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** ○ **Discover** ○ **American Express**

- ❑ **I will pay annually.** I understand the full annual fee will be charged upon receipt of this form and the full annual fee will be charged automatically at 12 month intervals, continually, from my renewal date.
- ❑ **I will pay semiannually.** I understand one-half of the annual fee will be charged upon receipt of this form and one-half of the annual fee will be charged automatically at 6 month intervals, continually, from my renewal date..
- ❑ **I will pay quarterly.** I understand one-quarter of the annual fee will be charged upon receipt of this form and one-quarter of the annual fee will be charged automatically at 3 month intervals, continually, from my renewal date.

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 (Patient #1) / **Printed Name (Patient #1)** / **D.O.B.** / **E-mail Address (Patient #1)**

______________________ / ______________________ / __________ / ______________________
Signature (Patient #2) / **Printed Name (Patient #2)** / **D.O.B.** / **E-mail Address (Patient #2)**

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

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