MITCHELL KARL, M.D., P.A.

MEMBERSHIP AGREEMENT – MEDICAL PROGRAM

This membership agreement ("the agreement") specifies the terms and conditions under which you, the undersigned ("You" and/or "the Patient") may participate in the special medical program provided by MITCHELL KARL, M.D., P.A. ("the practice"). This membership agreement ("the agreement") is made as of the date set forth on the signature page hereof by and between, MITCHELL KARL, M.D., P.A. ("the practice") and the patient identified on the signature page ("You and/or Patient").

Term

For each term (defined below) that You elect to participate in the program, You must pay the agreed upon annual membership fee. Payment may be made by cash, check, or credit card deemed acceptable to the Practice and will be processed on or before the effective date. This fee may not be altered by either party once agreed to during the one-year term but may change after the completion of each one-year term at the renewal date. Any change in the fee will be agreed to by both parties.

Program

The program is designed to enable me as Your MITCHELL KARL, M.D., P.A. physician to have more time to devote to You as my patient. This program is especially suited to patients who wish me to fulfill some or all of the role of their primary care internist while continuing to provide the highest quality preventative, diagnostic, and therapeutic cardiology services within the broader spectrum of their primary care needs. The program is intended to be exclusive and limited to about half that of the traditional memberships of most other similar programs.

MITCHELL KARL, M.D., P.A. agrees to arrange its practice so as to be able to afford to You the care and attention described in this Agreement. In general, MITCHELL KARL, M.D., P.A. will not accept patients other than those who have entered into the Agreement to be part of the program.

Services

Payment for the annual fee entitles You to the following services (collectively "the services") to be furnished by the Practice:

1. In general, Your MITCHELL KARL, M.D., P.A. physician shall be available twenty four hours per day, seven days per week via some form of telephone or electronic communication. During the absence of Your MITCHELL KARL, M.D., P.A. physician, a local physician will be available, with availability based on their daily office schedule. You understand that the MITCHELL KARL, M.D., P.A. program does not transfer to another physician during the absence of Your MITCHELL KARL, M.D., P.A. physician. Any charges incurred by evaluation and/or treatment by another physician, physician's office, urgent care center or emergency room will be responsible by You as defined by Your insurance plan, including, but not limited to, co-payments.
2. In general, Your MITCHELL KARL, M.D., P.A. physician will agree to see You in his office the same day or the next business day after You call for an appointment, when possible. When medically necessary, preferred morning or evening office hours and select weekend hours may be available if member need arises. House-calls are also available based on Your request and the healthcare provider's reasonable impression of its medical necessity. Said house-calls will be provided at a time (morning or evening) agreeable to You and Your

MITCHELL KARL, M.D., P.A. physician. These house-calls may be provided by an RN, MD, or both, depending upon the nature of the illness, for an additional fee of 600 dollars for the physician and the nurse if required.

3. You are responsible for the cost of in-office procedures, medications, and/or administration fees not included with the Program. You are responsible for any payment that results from the balance billing of services to Your insurance company, from outside laboratory, radiographic, or specialist visits. On each anniversary date of this agreement, MITCHELL KARL, M.D., P.A. may change its fee schedule by sending You a notice enclosing a revised fee schedule.

MITCHELL KARL, M.D., P.A. agrees to provide the non-clinical services described in this section with the objective of making Your healthcare experience with MITCHELL KARL, M.D., P.A. as convenient and effective as possible.

1. MITCHELL KARL, M.D., P.A. staff will assist You in scheduling appointments with Your MITCHELL KARL, M.D., P.A. physician, specialist, and providers of ancillary services to whom he refers You on a basis that is as convenient for your schedule as possible. MITCHELL KARL, M.D., P.A. will facilitate the provision to You the results of consultations with specialists and ancillary service providers. Please keep in mind, Your MITCHELL KARL, M.D., P.A. physician does not refer to specialist or for ancillary services based on Your insurance.
2. MITCHELL KARL, M.D., P.A. will maintain a website through which You can access information about the Practice.
3. MITCHELL KARL, M.D., P.A. will respond to any questions or concerns You have regarding the provision by MITCHELL KARL, M.D., P.A. of medical services in accordance with the Agreement.
4. MITCHELL KARL, M.D., P.A. reserves the right to request reimbursement from Your insurance plan for any house call, hospital care, telemedicine, telephone, or other virtual visit.
5. MITCHELL KARL, M.D., P.A. will provide You with access to general wellness information and reminders on a periodic basis.

Email communications

Communications between You and MITCHELL KARL, M.D., P.A., via e-mail shall be governed by then-current Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy policies and procedures. Notwithstanding the foregoing, You shall not use e-mail for communication regarding emergencies or other time-sensitive issues. You shall not use e-mail for private or sensitive matters. You authorize the Practice to communicate with You via e-mail regarding your Protected Health Information ("PHI") as that term is defined in HIPAA and its implementing regulations. Such e-mail communications shall become part of Your and/or the Patient's permanent medical record. Neither MITCHELL KARL, M.D., P.A. ("the Practice) nor any MITCHELL KARL, M.D., P.A. physician shall be liable to any member of the Program for any loss, cost, injury, or expense caused by or resulting from: (i) failure or delay in response to You due to technical failures, including, but not limited to, technical failures attributable to MITCHELL KARL, M.D., P.A. or its physician's electronic messaging software, failure of MITCHELL KARL, M.D., P.A. or its physician to properly address e-mail messages, failure of MITCHELL KARL, M.D., P.A. or its physician's computers or computer network, or faulty telephone or cable data transmission; or (ii) any interception of e-mail communications by a third party.

Text (SMS) message communications

Communications between You and MITCHELL KARL, M.D., P.A. via text (SMS) message, ("Text"), will be utilized unless a written request has been received by You noting otherwise. Notwithstanding the foregoing, You shall not Text for communication regarding emergencies or other time-sensitive issues. You shall not use Text for private or sensitive matters. You authorize the Practice to communicate with You via Text regarding your Protected Health Information ("PHI") as that term is defined in HIPAA and its implementing regulations. Such Text communications shall become part of Your and/or the Patient's permanent medical record. Neither MITCHELL KARL, M.D., P.A. ("the Practice) nor any MITCHELL KARL, M.D., P.A. physician shall be liable to any member of the Program for any loss, cost, injury, or expense caused by or resulting from: (i) failure or delay in response to You due to technical failures, including, but not limited to, technical failures attributable to MITCHELL KARL, M.D., P.A. or its physician's electronic messaging software, failure of MITCHELL KARL, M.D., P.A. or its physician to properly address Text messages, failure of MITCHELL KARL, M.D., P.A. or its physician's cellular telephone(s), computers or computer network, or faulty telephone or cable data transmission; or (ii) any interception of Text communications by a third party.

*** Definitions: For the purposes of this subsection, "healthcare profession" is a licensed physician, nurse practitioner, physician's assistant, registered nurse, or medical assistant selected by the practice.

EXCESS USE:

The practice reserves the right to bill an additional 25 dollars per text/ phone/ or email encounter if the total of these encounters exceeds 24 in one year.

RENEWALS AND TERMINATION

1. The annual Membership fee covers a period of one calendar year from the time of the effective date. With the consent of MITCHELL KARL, M.D., P.A., You may elect to renew Your membership for an additional year. Failure to pay the renewal fee on or before the renewal date will result in termination of the membership in this program. Either party may terminate this agreement at any time upon 15 days' written notice. If You terminate the agreement at any time for any reason during the calendar year, You will forfeit all paid fees to that point. If the Practice terminates this agreement during the period that has been paid for by You, then MITCHELL KARL, M.D., P.A. shall refund You the prorated unused portion of the fee paid. You understand that MITCHELL KARL, M.D., P.A. may change the Membership fee at any time by sending you a new Membership fee schedule (any revised Membership fee schedule will be applicable at Your next annual renewal date).
2. If You elect to terminate your participation in the Program, You understand that You will need to select a new primary care physician and/or cardiologist before the time at which Your termination is effective. If You notify MITCHELL KARL, M.D., P.A. of the name of your new primary care physician and/or cardiologist physician, with Your written authorization, MITCHELL KARL, M.D., P.A. will provide for the transfer to Your new primary care physician and/or cardiologist of the medical records then maintained by MITCHELL KARL, M.D., P.A. on a date that is no later than 14 days following the date of Your termination.
3. You understand that you will be responsible for obtaining and maintaining Your own health insurance.

MEDICAL CARE SERVICES EXCLUDED FROM THE ANNUAL FEE

The annual fee covers the aforementioned services only. You and/or the insurer as applicable will be financially responsible for payment including co-payments and deductibles for all medical care services received by You. MITCHELL KARL, M.D., P.A. will bill You and/or the insurer as applicable for those medical services provided to You and/or the Patient.

NO INSURANCE COVERAGE

The annual fee covers the services which are of a special and unique nature and are not services reimbursable by any third party payer including Medicare and/or Medicaid programs. You agree that You will not seek reimbursement of the annual fee for any of the aforementioned special services from any third party or expect MITCHELL KARL, M.D., P.A. to submit claims for the annual fee for special services to any insurance company or third party payer.

ASSIGNMENT MODIFICATION OF THE AGREEMENT

This agreement may not be assigned by You and/or the patient without the MITCHELL KARL, M.D., P.A. prior written approval. Modifications to this agreement will only be effective if in writing and signed or initialed by both parties. This includes any change in the program fee.

1. **ENTIRE AGREEMENT**

Each of the undersigned agrees to the terms of this agreement. There are no promises or representations except as set forth in this agreement.

2. **NOTICES**

Any notice required under this agreement must be sent in writing via facsimile or certified mail return receipt requested to the addresses provided by the party to whom the notice is sent.

3. **CONFIDENTIALITY**

The parties hereunto agree to maintain confidentiality as to the terms of this agreement and hereby agree to keep the terms confidential among the parties unless required to disclose such terms by subpoena or court order. Notwithstanding the foregoing, the parties may disclose the terms when necessary to enforce the terms of this agreement.

4. **REPRESENTATION**

Prior or subsequent to executing this agreement, the prospective member is welcome to retain an attorney or similar adviser to assist with understanding the rights and obligations set forth in this agreement. Neither the practice nor its advisers will represent the member with respect to this agreement.

5. **SEVERABILITY**

Should any part, clause, provision, or condition of this agreement be held by a court of competent jurisdiction to be void, invalid, or inoperative, the parties agree that such invalidity shall not affect any other part, clause, provision, or condition herein and that

the remainder of this agreement shall be effective as though such void part, clause, provision, or condition had not been contained herein.

6. GOVERNING LAW

This agreement will be governed by and construed in accordance with Florida law without giving effect to its choice of law provisions. The venue will be in Palm Beach County, Florida

Member Signature	Date
Member Printed Name	Date of Birth
Mitchell Karl, M.D., P.A.	Date

MITCHELL KARL, M.D., F.A.C.C., P.A.

880 NORTH WEST 13TH STREET, SUITE 1-B
BOCA RATON, FLORIDA 33486
PHONE: 561-392-9214

CONCIERGE MEMBERSHIP FORM

PATIENT INFORMATION

PATIENT NAME(S): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PAYMENT INFORMATION

☐VISA ☐MASTERCARD ☐DISCOVER ☐ CHECK

NAME ON CREDIT CARD: _____

CARD NUMBER: _____ SECURITY CODE:_____

EXPIRATION DATE: _____

O GOLD MEMBERSHIP ($5,000)

O PLATINUM MEMBERSHIP ($10,000)

TERMS OF PAYMENT

Your yearly membership renewal with Mitchell Karl, M.D. will start August, 2022.

Payment will appear as charge from Mitchell Karl, M.D., P.A.

This form does not serve as patient-physician relationship and does not entitle the party to medical advice or care by Mitchell Karl, M.D. until after membership agreement is signed and returned by member(s).

_____ _____ _____

Signature of Payee Print name Date

Please return completed form to: *880 N.W. 13st, Suite 1B, Boca Raton, FL, 33486,*
or by fax (*561-394-4250*) or by email (*drkarlcares@gmail.com*).

PATIENT INFORMATION RECORD

Allergies:_____ Age:_____

Patient's Legal Name: _____ Today's Date: _____
First M.I. Last

Address: _____
Street City State Zip

Phone #'s – Daytime:_____ Evening:_____ Emergency: _____ Cell:_____

Where do you prefer to receive calls?: ❑ Home Number ❑ Work Number ❑ Cell Number ❑ In Writing
❑ OK leave message with detailed info ❑ Leave message with call-back number only

Patient's Date of Birth:_____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partner Religion: _____ Primary Language: _____

Ethnicity: _____ Race: _____

Social Security No.:_____ – _____ – _____ Referred By: _____

Responsible Party: _____ Telephone: (___)- _____
First M.I. Last

Address: _____
Street City State Zip

Responsible Party Social Security No.:_____ – _____ – _____ Date of Birth: _____

Employer:_____ Telephone: (___)- _____

Address: _____
Street City State Zip

Next of Kin: _____ Relationship:_____ Telephone: Res:(___)-_____ Work:(___)- _____

I. INSURANCE INFORMATION:

Is Your Insurance a: ❑ PPO ❑ HMO ❑ Medicare ❑ Medicaid ❑ Other:_____

II. IS PATIENT'S CONDITION RELATED TO:

Employment (Current or Previous): ❑ Yes ❑ No Auto Accident: ❑ Yes ❑ No Other Accident: ❑ Yes ❑ No

PRIMARY

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Group Number:_____ Medicare/Policy Number: _____

Name of Insured:_____ Insured's Date of Birth:_____

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): _____

SECONDARY

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Group Number:_____ Medicare/Policy Number: _____

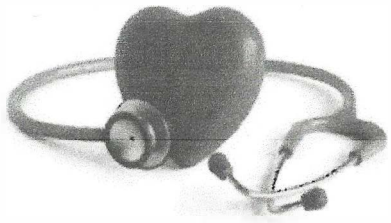
Name of Insured:_____ Insured's Date of Birth:_____

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): _____

**** FOR OFFICE USE ONLY ****

Identification Presented: ❑ Passport ❑ Driver's License ❑ State I.D. ❑ Insurance Card



Dr. Mitchell Karl, M.D., F.A.C.C.

PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** ____ / ____ / ____

PLEASE PROVIDE FAMILY OR CAREGIVERS BELOW SO OUR OFFICE MAY SHARE YOUR PROTECTED HEALTH INFORMATION (PHI)		
Name	**Relation**	**Telephone**

Patient Signature: _____ **Date:** ____ / ____ / ____

Witness Signature: _____ **Date:** ____ / ____ / ____

MEDICARE AND MEDICAID SIGNATURE AUTHORIZATION

Medicare and Medicaid patient certification – patient certification authorization to release information and payment request. I certify that the information given by me in applying for under TITLE XVIII and/or TITLE XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services. I request that this authorization apply to all claims, present and future. I understand that I am responsible for my health insurance deductible and coinsurance.

Date: _____

Print Patient's/Beneficiary's Name : _____

Patient's/Beneficiary's Signature: _____

****

COMMERCIAL INSURANCE, MANAGED CARE MEMBERS AND SECONDARY PAYOR AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf. I assign the benefits payable for physician services to MITCHELL KARL M.D.,P.A. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment of any balance not paid by my insurance company.

Date: _____

Print Patient's/Insured's Name: _____

Patient's/Insured's Signature: _____

PATIENT HISTORY FORM

PATIENT NAME: **DATE:**

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review.

1 CONSTITUTIONAL SYMPTOMS

Good general health lately	NO	YES
Recent weight change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

2 INTEGUMENTARY (SKIN & BREAST)

Rash or itching	NO	YES
Change in skin color	NO	YES
Change in hair or nails	NO	YES
Varicose veins	NO	YES
Breast pain	NO	YES
Breast lump	NO	YES
Breast discharge	NO	YES

3 NEUROLOGICAL

Frequent or recurring headaches	NO	YES
Light headed or dizzy	NO	YES
Convulsions or seizures	NO	YES
Numbness or tingling sensations	NO	YES
Tremors	NO	YES
Paralysis	NO	YES
Stroke	NO	YES
Head injury	NO	YES

4 HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts	NO	YES
Bleeding or bruising tendency	NO	YES
Anemia	NO	YES
Phlebitis	NO	YES
Past transfusion	NO	YES
Enlarged glands	NO	YES

5 PSYCHIATRIC

Memory loss or confusion	NO	YES
Nervousness	NO	YES
Depression	NO	YES
Insomnia	NO	YES

6 ENDOCRINE

Glandular or hormone problem	NO	YES
Thyroid disease	NO	YES
Diabetes (insulin or non insulin - circle one)	NO	YES
	NO	YES
Excessive thirst or urination	NO	YES
Skin becoming dryer	NO	YES
Change in hat or glove size	NO	YES

12 GENITOURINARY

Frequent urination	NO	YES
Burning or painful urination	NO	YES
Blood in urine	NO	YES
Incontinence or dribbling	NO	YES
Kidney stones	NO	YES
Sexual difficulty	NO	YES
Male: testicle pain	NO	YES

7 EYES, EARS, NOSE, MOUTH

Hearing loss or ringing	NO	YES
Earaches or drainage	NO	YES
Chronic sinus problem or rhinitis	NO	YES
Nose bleeds	NO	YES
Mouth Sores	NO	YES
Bleeding gums	NO	YES
Sore throat or voice change	NO	YES
Swollen glands in neck	NO	YES

8 CARDIOVASCULAR

Heart trouble	NO	YES
Chest pain or angina pectoris	NO	YES
Palpitation	NO	YES
Shortness of breath with walking	NO	YES
Swelling of feet, ankles or hands	NO	YES

9 RESPIRATORY

Chronic or frequent coughs	NO	YES
Spitting up blood	NO	YES
Shortness of breath	NO	YES
Asthma or wheezing	NO	YES

10 MUSCULOSKELETAL

Joint pain	NO	YES
Joint stiffness or swelling	NO	YES
Weakness of muscles or joints	NO	YES
Muscle pain or cramps	NO	YES
Back pain	NO	YES
Cold extremities	NO	YES
Difficulty in walking	NO	YES
Sports injury	NO	YES

11 GASTROINTESTINAL

Loss of appetite	NO	YES
Change in bowel movements	NO	YES
Nausea or vomiting	NO	YES
Frequent diarrhea	NO	YES
Constipation	NO	YES
Rectal bleeding or blood in stool	NO	YES
Abdominal pain	NO	YES
Peptic ulcer (stomach or duodenal)	NO	YES

12 GENITOURINARY - FEMALE

Pain with periods	NO	YES
Use douche	NO	YES
Irregular periods	NO	YES
Vaginal discharge	NO	YES

Age at the onset of menstruation

Number of days menstruation lasts

Date of last pap smear

Date of last menstrual period

List all pregnancies with dates, weights, and problems (Please include miscarriages, terminations, and pre-term)

ALLERGIC / IMMUNOLOGIC: History of reaction to

Medication: NO YES Other: NO YES
List: List:

Past Medical History

Previous Hospitalizations / Surgeries / Serious Injuries

Pharmacy Name & Phone Number

Medications

Please include name, dosage, and frequency

Patient Social History:

Marital status	□ Single	□ Married	□ Separated	□ Divorce	□ Widowed
Use of alcohol	□ Never	□ Rarely	□ Moderate	□ Daily	
Use of tobacco	□ Never	□ Previously but quit	□ Current packs per day:		
Use of drugs	□ Never	□ Type / Frequency			
Exposure to	□ Fumes	□ Dust	□ Solvents	□ Air-borne Particles	□ Noise
History of domestic violence	□ Verbal	□ Physical	□ Other		

Family Medical History

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Siblings			
Spouse			
Children			