PATIENT AGREEMENT

PHILIP G. HUFF, MD

NORTH FULTON INTERNAL MEDICINE GROUP, PC

I have engaged **North Fulton Internal Medicine Group, PC** (**NFIMG**) and its physician, Philip G. Huff, MD, to provide primary care services to me/us for a period of one year beginning on July 1, 2009. As used in this Agreement, the term "Service Year" refers to the 1-year period beginning on July 1, 2009 as well as every 1-year period after that, to the extent I renew the Agreement as provided below.

✓ FOR PATIENT MEMBERSHIP DURING THE SERVICE YEAR, I AGREE TO PAY:

- ❑ $1,800/year = Individual (age 45 and over as of 7/1/09)
- ❑ $3,200/year = Adult Couple (age 45 and over as of 7/1/09)
- ❑ $1,400/year = Individual (age 44 and under as of 7/1/09)
- ❑ $2,500/year = Adult Couple (age 44 and under as of 7/1/09)
- ❑ No charge for dependent children of member (age 18-25 as of 7/1/09)*

**Annual exam not included. Office visits will be filed to insurance and payment will be the member's responsibility.*

✓ METHOD OF PAYMENT:

❑ **Personal check enclosed.** *Please make check payable: North Fulton Internal Medicine Group, PC*
(Full annual payment only. Semiannual payments must be made by credit card.)

_____ **Check Number** _____**Amount**

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

- ❑ **I will pay annually.** Please charge my credit card for the full amount.
- ❑ **I will pay semiannually.** Please charge one-half now, and the balance on or about January 1, 2010.

I hereby authorize NFIMG to charge my credit card an amount equal to the annual fee(s) I have indicated above.

_____ / _____ / _____
Cardholder Signature *Card #* *Exp. Date*

_____ / _____ / _____
Cardholder Billing Street Address *Billing Zip Code* *Card Security Code*

✓ PATIENT(S): *Please PRINT & SIGN* *(Additional names may be indicated on reverse side)*

I acknowledge that *NFIMG* or I can terminate this Agreement upon 30 days written notice. If I terminate, the Annual Fee may be pro-rated or forfeited, to be determined on a case-by-case basis. However, if the annual wellness exam has been completed, there will be no refund. If *NFIMG* terminates, I will receive a refund of the prorated portion of the paid Annual Fee, based on the number of days that have elapsed in the Service Year.

I may renew this Agreement for subsequent Service Years by paying the Annual Fee for the applicable service year as determined by *NFIMG*. The terms of this Agreement will apply to all such subsequent Service Years, unless *NFIMG* and I agree otherwise, in writing.

_____/ _____/ _____
Signature **Printed Name** **Date**

_____/ _____/ _____
Signature **Printed Name** **Date**

PLEASE SIGN & RETURN BY JUNE 15TH WITH YOUR INDICATED PAYMENT IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.

----------Tear Here----------Tear Here----------

PATIENT DECLINATION

I acknowledge that, effective July 1, 2009, I will no longer consider myself a patient under the care of Philip G. Huff, MD. If I choose not to join Dr. Huff's new practice, but would like to remain with North Fulton Internal Medical Group, my records will remain where they are and no further action is required by me. I understand I may select another physician of my choice to continue my care and that Dr. Huff's staff will assist me during the transition, upon my request. Additionally, upon receipt of my signed authorization, my medical records will be transferred to my new physician and a reasonable fee may be charged.

I further understand that if I have not contacted Dr. Huff's office to request transitional support or assistance in obtaining continued medical care elsewhere by July 1, 2009, his office may assume I have satisfactorily obtained medical care elsewhere and am no longer a patient of Philip G. Huff, MD.

PATIENT(S): ***(Additional names may be indicated on Reverse Side)***

_____/ _____/ _____
Signature **Printed Name** **Date**

_____/ _____/ _____
Signature **Printed Name** **Date**

PLEASE SIGN & RETURN BY JUNE 15TH IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.