CONTRACT BETWEEN ADULT MED HOUSE-CALL PHYSICIANS AND PATIENT

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This agreement is made between Laurie F. Draughon, M.D., whose principle place of business is 231 Market Place, Suite 115, San Ramon, CA 94583 and _____, who resides at _____.

Dr. Draughon will perform medical and medically-related services, pertaining to her specialty in internal medicine. In return for these services, the undersigned patient agrees to provide payment to physician in the amount set forth in the "Fee Schedule".

By signing this contract, _____ agrees, and understands the following:

_____ Patient agrees to be fully responsible, whether through insurance or otherwise, for payment of all services, and understands that Medicare or other insurance may not reimburse you for part or all of these services.

_____ Patient understands that if the address given to Medicare by patient is not in the same county as the physical address of the patient, then the patient will be responsible for the difference between what Medicare would approve for Contra Costa/Alameda County and the county of residence Medicare has on file.

_____ Patient understands that Medi-Gap plans do not, and other supplemental insurance plans may not, make payment for the services not reimbursed by Medicare or the primary insurance company. *This is patient's responsibility.*

_____ Patient understands that *travel, liaison, and concierge services* are not covered by Medicare or other insurances, and are solely the responsibility of the patient. Patient understands that if patient expires before the end of the fee quarter, there will be no refund for that quarter.

_____ Patient agrees to allow the physician to inform and discuss your medical situation with the following, at any time, unless specifically requested by you at a later date not to.
Familymembers:

_____

_____
Friends or other people in your life you want to have this information:

_____

Patient has read and signed the fee schedule pertaining to them, the patient information sheet, and the privacy notice.

Executed at _____, California on _____ (date)

Physician signature: _____ print name: _____

Patient signature: _____ print name: _____