

Rockville Concierge Doctors
Aimee Seidman, M.D., FACP & Marcia Goldmark, M.D.

2010 Retainer Fee Schedule

Please note your preferred method of payment. **Note: this is a one year commitment.**

If your payments are late, please note that you will need to pay retroactively in order to be seen by the doctors again. We will assess a \$50 late fee after a one week grace period, unless other arrangements have been made.

- Personal check, made payable to Aimee Seidman M.D., P.C. (**\$75.00 return ck fee**)
- Credit Card (MasterCard, VISA)
(Circle type of card used).

By agreeing to pay with your credit card, you are authorizing us to automatically run your credit card when you're scheduled fee is due.

Card # _____ Expiration _____

CVV _____ (This 3 digit number is located on the back of your Credit card)

Please check your preferred schedule of payment.

- Paid annually in full. *One payment of \$1,850 [Total \$1,850].* Deduct 15% for one additional family member (\$1572.50).
- Paid semi-annually, one-half of the retainer fee, and one-half of the retainer fee six months later. *Two payments of \$950 [Total \$1900.00].* This schedule requires use of credit card. For second member of family, the total fee would be \$1615.00 (two payments of \$807.50)

Note: Each child of an adult member 16 years old through their 25th birthday are charged at *half* the adult rate. All other terms applying to adults apply to children. Children under the age of 16 are not seen. All individuals under age 21 must have at least one parent in the practice. A family member is defined as parents, children, siblings, and relatives living together.

Print Name _____

Address _____

City _____ State _____ Zip _____ Phone _____

Signature _____ Date _____

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Retainer Contract

I _____ (**patient name**) voluntarily agree to participate in the retainer practice model of Aimee Seidman, M.D., P.C. and Marcia Goldmark, M.D.. I understand that I will pay \$ _____ in _____ installments as a retainer fee. The fee includes all medical services appropriate to a primary care and geriatrics practice, including a comprehensive annual history and physical examination; electrocardiograms, vascular studies of the lower extremities, influenza vaccinations, pneumovax when indicated, tetanus and tuberculosis screening tests where appropriate. As used in this Agreement, the term "Medical Services" shall mean those medical services that the physician herself is permitted to perform under the laws of the State of Maryland, and that are consistent with her training and experience as a specialist in Internal Medicine. Routine lab work that is done for your annual history and physical will be included in the cost of the retainer fee. During other office visits, lab work will be billed to your insurance company, as will all radiological studies (x-rays, CT scans, MRIs, mammograms, sonograms, bone density studies, etc.). I understand that my doctor will be considered "**out-of-network**" by all insurance companies, and therefore the payment for these **tests** is subject to their reimbursement schedule. Our Doctor's do not accept any insurance nor do we file claims on the patient's behalf. It is the responsibility of the patient to file claims to their prospective insurance companies for any reimbursement that may or may not be due to them.

This fee also includes 24 hour a day, seven days a week access to your doctor, day or night (except during vacation or emergency, during which, Drs. Seidman and Goldmark will be covering for one another); same or next day appointments for urgent needs, timely appointments for physicals, and house calls in emergencies within a 20 minute radius of our office. I will be able to contact my doctor by cell phone, email, fax, or answering service. Email and fax will be reserved for non-urgent problems.

In addition, my doctor will be in close contact with any subspecialists I may need to be referred to. Almost all physicians practice the traditional medicine utilizing insurance. **I fully understand that I need to maintain my health insurance** and I acknowledge that the physician has advised me to obtain or keep in full force my health insurance policies in order to cover for healthcare costs not within the definition of Medical Services under this Agreement, and to prevent gaps in health coverage. I acknowledge that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that I may carry for myself and family.

I may terminate this Agreement at the end of the contract year. The parties agree that any dispute or disagreement under this Agreement shall be resolved as we may amicably agree, and if we cannot agree then in accordance with the rules and procedures of the American Arbitration Association then in effect in the State of Maryland. The decision of the arbitrator shall be binding on the parties and may be reduced to judgment in the State of Maryland.

Signature _____ Date _____