PHILIP G. HUFF, MD
NORTH FULTON INTERNAL MEDICINE GROUP, PC

PATIENT AGREEMENT

I have engaged **North Fulton Internal Medicine Group, PC** (**NFIMG**) and its physician, Philip G. Huff, MD, to provide non-covered primary care services to me/us for a period of one year beginning _____. 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, 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 date of enrollment)
- ❑ $3,200/year = Adult Couple (age 45 and over as of date of enrollment)
- ❑ $1,400/year = Individual (age 44 and under as of date of enrollment)
- ❑ $2,500/year = Adult Couple (age 44 and under as of date of enrollment)
- ❑ No charge for dependent children of member (age 18-25 as of date of enrollment)*

**Annual exam not included. Office visits will be filed to insurance and payment will be the member's responsibility.*
(Note: The Annual Membership Fee above is for non-covered services only.)

✓ 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 six months from date of enrollment.

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/Security Code*

_____/_____/ _____
Cardholder Billing Street Address *Billing Zip Code* *Cardholder Daytime or Cell Phone Number*

✓ 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, and the amount may be determined by whether the annual comprehensive wellness evaluation has been completed. 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 WITH YOUR INDICATED PAYMENT IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.

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