FRANK MAZZONE, M.D.
PREMIER CONCIERGE MEDICINE

Patient Agreement Form

I wish to enroll in Dr. Frank Mazzone's Personalized Care Medical Practice beginning on _____.

I agree to pay the annual enrollment fee of ☐ $3,100 for an individual OR ☐ $6,000 for a married couple in full by check or credit card.

OR

I agree to pay the annual enrollment fee quarterly of ☐ $800 for an individual each quarter OR ☐ $1,550 for a married couple each quarter on _____, _____, _____, and _____ by credit card. I agree to have a credit card on file with the Practice and have the quarterly payment charged at the beginning of each quarter.

I understand that the annual enrollment fee covers my primary care visits with Dr. Frank Mazzone for the 1-year period of _____ to _____. I also understand that this agreement will automatically renew for successive one-year terms unless I notify the practice before the annual renewal date.

I have read and understand this Agreement, the Patient Invitation Letter, and the Frequently Asked Questions. I understand that if I choose to discontinue membership in the Practice or if I pass away, I will receive a pro-rated refund of my annual enrollment fee (calculated by unused months) within 30 days if I have not had my annual Executive Physical. I also understand that no refund will be given if I choose to discontinue membership in the Practice or pass away after I have had my annual Executive Physical.

_____/_____/_____
Signature Printed Name Date

_____/_____/_____
Signature Printed Name Date

Please charge my credit card for the entire annual enrollment fee of ☐ $3,100 for an individual OR ☐ $6,000 for a married couple **OR** the first of my quarterly payments of ☐ $800 for an individual OR ☐ $1,550 for a married couple.

_____/_____/_____
Credit Card Number Expiration Date Security Code

_____
Billing Address

_____
Email Address

_____/_____
Signature Date