GracePointe Healthcare PLLC
Modern medicine the old fashioned way

Basic Smart Care Plan*

_____ $89 enrollment fee ($69 for existing patients) plus $49 per month for 12 months, with automatic bank draft (ACH). (This payment option does not include Comprehensive Screening Exam***.)

or

_____ $588 paid in full (12 months) – enrollment fee will be waived. Includes *FREE Comprehensive Screening Exam**** with basic labs/diagnostic tests*, plus PSA or PAP Test and EKG. ($275 value).

For a fee of $588 or $49 per month for 12 months (the "Base Fee"), our Basic Smart Care Plan allows you to be scheduled for routine office visits *with no office visit fee* ($69 savings), which will include any necessary basic lab work/diagnostic tests** each visit. Also includes (i) *free prescription refills* ($25 savings), (ii) *free phone consults* ($50 savings), and (iii) *Housecalls at $100* ($100 savings). (Non-basic lab work, retail products, medications, supplements or immunizations are charged at standard rates.)

I _____, agree to pay the $89 or $69 enrollment fee plus $49 per month starting on today's date for the Basic Smart Care Plan or $588 in full (enrollment fee waived) as noted above. This prepaid plan entitles me to discounted fees on services at GracePointe Healthcare, as set forth herein. I will still be responsible for other services not discounted as specifically mentioned above. At the end of one year, I may renew this contract but the fees and terms may change, at GracePointe Healthcare's sole discretion. I understand that:

- **If I receive services under this agreement and either fail to make a monthly payment or fail to make payment for the full annual fee, I will be responsible for all charges for services I incurred at the standard non-discounted rate as well as an early termination fee of $250.**
- **I will owe a $35.00 fee for any checks or ACH withdrawals that have insufficient funds.**
- **Payment for anything not covered under the Smart Care Plan is due at time of service.**
- **24 hours notice is required for appointment cancellations and there is a $49 charge if less than 24 hours notice is given or if I fail to show up for the appointment.**
- **All amounts paid for the Smart Care Plan are nonrefundable.**

I understand that this is intended to be a legally binding contract that becomes binding when executed by the undersigned and accepted by GracePointe. This agreement (together with any Addendums executed in connection herewith) is the final agreement between the parties and no other agreements, written or verbal, are binding. Unless the parties have executed a Family Coverage Addendum, this agreement covers only the undersigned and may not be assigned or transferred. I have read, understand and agree to the terms and conditions of this agreement.

Signed_____ Date_____

* Our Smart Care Plans are private one year contracts between GracePointe Healthcare and the patient, which are executed after payment has been made and initial services rendered. At present, insurance will not reimburse for the prepaid plans and this is not a type of insurance, it is only a prepaid discount plan. GracePointe Healthcare makes no guarantees regarding reimbursement by insurance companies and does not file insurance claims or sign insurance contracts. Medicare and Medicaid patients are not permitted to file claims per government regulations.

**Basic labs/diagnostic tests include: CBC, CMP, Lipid Panel, Urinalysis and vital signs.

***Free Comprehensive Screening Exam includes: » PSA or PAP Test and EKG. » Height, Weight, BMI, Pulse, Blood Pressure, Temperature, Pulse Oximetry, etc. » Health Risk Factors: Diet, Exercise, Safety, Alcohol, Contraception, etc. » Disease Prevention: Stroke, Coronary Disease, Cancer, Illness, etc. » Physical Exam » Health Maintenance: Review immunizations, etc. » Recommendations/Referrals

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Family Coverage Addendum

I, the undersigned primary patient, agree that this Family Coverage Addendum amends the agreement entered into between myself and GracePointe Healthcare PLLC (the "Agreement") regarding GracePointe Healthcare's Smart Care Plan (whether a Basic or Premium Plan). The purpose of this Addendum is to add the following members of my immediate family to the Agreement ("immediate family" being limited to my spouse and children under the age of 18 years).

	Name	**Relationship and Birthdate**	
1.	_____	_____	10% Discount: $529 in full or $44 a month
2.	_____	_____	20% Discount: $470 in full or $39 a month
3.	_____	_____	30% Discount: $411 in full or $34 a month
4.	_____	_____	40% Discount: $352 in full or $29 a month
5.	_____	_____	50% Discount: $294 in full or $24 a month
6.	_____	_____	60% Discount: $235 in full or $19 a month
7.	_____	_____	70% Discount: $176 in full or $14 a month

I agree that the Base Fee for the first family member listed above shall be the same as my Base Fee under the Agreement, minus a 10% discount. If there is more than one family member listed above, the second person shall receive a 20% discount off the Base Fee, the third person shall receive a 30% discount, and so on (up to 100%). Otherwise, the Plan's terms and conditions set forth in the Agreement shall be the same for each such person as they are for me, including charges other than the Base Fee, which shall not receive any additional discounts.

I understand that this Addendum amends the Agreement only with regard to the terms herein described. Where the terms and conditions of this Addendum conflict with the terms and conditions of the Agreement, this Addendum shall control. Otherwise, the terms of the Agreement are hereby ratified, affirmed and approved.

Signed_____ **Date**_____

For any Spouse listed above:

I agree that I am being added as a party to the Agreement, and that such Agreement, together with this Addendum and any other Addendums executed in connection with the Agreement, shall be binding upon me as if I was a signatory thereto.

Signed_____ **Date**_____

AUTHORIZATION AGREEMENT FOR DIRECT DEBIT (ACH DEBITS)

Gracepointe Healthcare PLLC COMPANY TAX ID NUMBER _____

I (we) hereby authorize **Gracepointe Healthcare PLLC** herein called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) [ ] CHECKING [ ] SAVINGS account indicated below and the depository named below, herein called DEPOSITORY, to debit and/or credit the same to such account.

DEPOSITORY BANK _____ BRANCH _____

CITY _____ STATE _____

ROUTING NUMBER _____ ACCT NUMBER _____

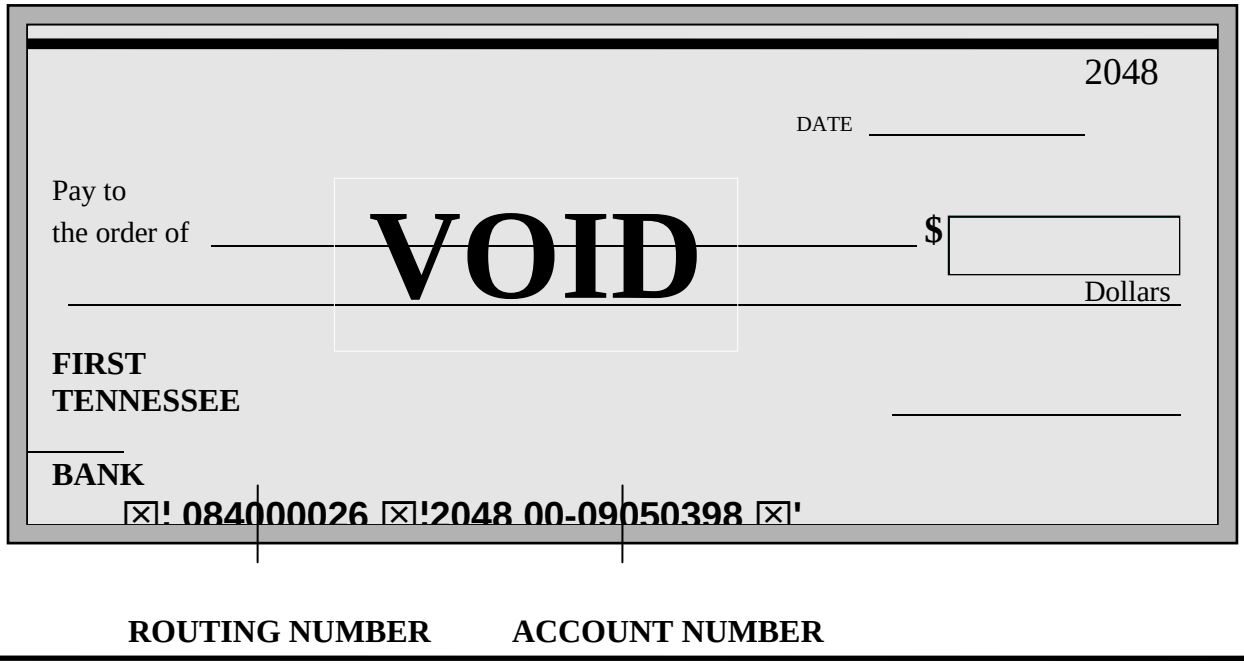
This authorization is to remain in full force and effect until the COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY BANK a reasonable opportunity to act on it.

NAME(S) _____ _____
(PLEASE PRINT) (PLEASE PRINT)

SIGNED _____ SIGNED _____ Date

Please staple to this form a voided check to verify bank account information for deposits into a Checking Account or a deposit slip for deposits into a Savings Account.

FIRST TENNESSEE BANK



ROUTING NUMBER **ACCOUNT NUMBER**