

**Acknowledgement of Services**

1. I understand that I am participating as a patient/client with ACCESS MD, an Internal Medicine based practice. ACCESS MD is not a health benefit or health insurance program, and the Access MD Fee does not include payment for clinical services, or reimbursement for clinical services provided to me. For clinical services, all third-party insurance (including Medicare), cost-sharing and co-payment rules for service and billing apply.
2. I acknowledge and agree that the healthcare services provided to me under this program are subject to the coverage and payment terms of my healthcare benefit plan, whether I have coverage obtained through an employer plan, or an individual plan.
3. I understand that Diana K. Hashimi, M.D. is a board-certified physician who will serve as my physician contact in Access MD.
4. I understand that I will receive results from the health screening exams, physical exams, laboratory and diagnostic testing. I understand that it is my sole responsibility to follow up on these results with an Access MD physician or other physician of my choosing. Access MD will provide ample time to discuss and advise on the results but final decision for treatment is mine.
5. I understand and agree that I am solely responsible for the follow-up care with physician specialist. Access MD, their respective staff and affiliates, and the physicians providing services under this program are in no way responsible for such follow up care.
6. **The Access MD Fee will provide only for services that are not covered by third party insurers (including Medicare):**

* **Private and personalized health assessment in a serene, unhurried atmosphere**
* **Includes a Cardiac Calcium Score and other advanced screening test as indicated**
* **Customized fitness and wellness plan**
* **No waiting and dedicated time with your doctor**
* **USB drive containing your health information, upon request**
* **Prompt research information on medical questions**

1. Should a provision of this acknowledgement or portion thereof be found invalid or void as against public policy by any court of competent jurisdiction, the remainder of this agreement shall nonetheless remain in full force and effect.
2. I agree to pay an annual fee for Access MD in the amount of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “Access MD Fee”). I understand that I will receive a receipt for the Access MD Fee but not an itemized bill for these services. I further understand that these services are outside of my health insurance coverage and that my health insurer will not cover the services included in the Access MD Fee, or reimburse me for any portion of the Access MD Fee.
3. The initial term of this Agreement shall be one (1) year from the Effective Date (“Initial Term”). This agreement shall automatically renew on an annual basis thereafter, unless either party provides written notice of termination at least thirty (30) days prior to the end of the term.
4. **I acknowledge that I have read and understand this acknowledgement and have been given the opportunity to ask any questions, and have received and understand all of the information provided.**

In witness where of, I have signed this Acknowledgement:

**Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**