

EAGLE DIRECT PRIMARY CARE
Daniel G. Orr, M.D.
134 Pottstown Pike
Chester Springs, PA 19425
610-458-8881

Dear Patient:

This agreement (the “Agreement”) specifies the terms and conditions under which you, the undersigned patient may participate in the Eagle Direct Primary Care Practice. (the “Practice”). This Agreement will become effective on the date of your signature on this Agreement (the “Effective Date”).

1. Practice Services. The annual fee paid by you to Dr. Orr encompasses the majority of services already provided by Dr. Orr (“Services”), including, but not limited to the following:

- Annual wellness/physical examination
- Unlimited sick and follow-up visits
- Chronic condition management
- Electrocardiogram, pulmonology function testing, and audiograms
- Flu Shots
- Limited in office laboratory testing such as urinalysis, strep
- Repair of lacerations
- Minor in-office surgery, cryotherapy
- Psychopharmacology and supportive therapy
- Completion of forms for physicals

You will be entitled to unlimited visits during the year.

2. Excluded Services. You will be responsible for payment of the following Excluded Services, for which Dr. Orr will charge you at his cost:

- Vaccines other than flu shots
- Attorney letters or completion of forms other than for physicals
- Services provided outside of the Practice offices.

3. Limited Practice. Dr. Orr limits his practice size to provide conveniences, such as same-day or next-day appointments that start on time, unhurried visits, 24/7 availability via cell phone, and enhanced coordination of specialist care.

4. No Co-Payments. Other than the annual fee, **you will not be required to pay any co-payments, co-insurance or deductibles at the time of the visit.** The annual fee covers all the Services. You will only be responsible for payment of those Excluded Services. Dr. Orr will **not**

seek reimbursement from any insurer or other third-party payor for the Services nor will he submit any claims on your behalf to your insurance plan. But, you will receive a bill for services performed (up to the annual fee) for you to seek payment from your insurance company or HSA, or to go toward your deductible.

5. Renewals and Termination. The Annual Fee covers a period of one (1) year (the “Term”). Failure to pay the renewal Annual Fee prior to the annual anniversary of the Effective Date shall result in termination of your participation in the Practice. If you leave the program and then reenroll at a later date, you will be required to sign up for a new one-year contract at that time.

6. Entire Agreement. This Agreement does not constitute an insurance policy or an agreement to provide insurance. Rather it is a contract for personal services. You agree to the terms of this Agreement, all of which are contained herein. There are no promises or representations except as set forth in this Agreement.

7. Notices. Any communication required or permitted to be sent under this Agreement shall be in writing and sent via U.S. mail Dr. Orr at the address listed on this letterhead. Any change in address shall be communicated in accordance with the provisions of this section.

18. Billing. Initial payments are processed at the time of your enrollment in the Practice. Subsequent payments will be billed to you.

10. Governing Law. This Agreement shall be governed by and construed in accordance with the law of the Commonwealth of Pennsylvania without regard to Pennsylvania’s choice of law provision.

If you agree to the terms of this Agreement, please sign and date this Agreement where indicated below.

Sincerely,

Daniel G. Orr, M.D.

Accepted and agreed upon by:

Date: _____

Patient Enrollment Form

EAGLE DIRECT PRIMARY CARE

Please Print All Information

PATIENT NAME Mr. Mrs. Ms. Dr. Gender Male Female

First Name _____ Middle Initial _____

Last Name _____

Street Address _____

City _____ State _____ Zip _____

Phone: Home (____) _____ Office (____) _____ Cell (____) _____

Date of Birth _____

E-mail Address _____

ENROLL ADDITIONAL MEMBERS IN HOUSEHOLD:

Additional Adult #2

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: Male Female

Alternate Phone (if different from above) (____ - _____)

Child #1

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: Male Female

Alternate Phone (if different from above) (____ - _____)

Child #2

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: Male Female

Alternate Phone (if different from above) (____ - _____)

To register more children, attach an additional Patient Enrollment form with their information.

PAYMENT OPTIONS

Payment in full using Cash or Check	1141.65	<input type="checkbox"/>
Payment in full under 21 Cash/Check	610.55	<input type="checkbox"/>
3 payments per month in (July/August/Sept)	400.60 mo.	<input type="checkbox"/>
3 payments per month (if under 21) (July/August/Sept)	214.15 mo.	<input type="checkbox"/>
Payment in full using a credit card	1204.70/642.50	<input type="checkbox"/>

PATIENT SIGNATURE _____ **Date** _____