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. Annual Fee. The annual fee for each adult can be found on the last page of this document**.** The annual fee may be paid in full or in three equal installments over the first three months of this Agreement. There will be a discount of 5% if paying the annual fee in full by cash or check. To pay by credit card, please provide the office with your credit card information. This fee is subject to change at the end of each enrollment year, you will be informed of any fee change sixty (60) days prior to the end of the annual agreement.

5. 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. However, 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.

6. 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 re-enroll at a later date, you will be required to sign up for a new one-year contract at that time.

7. 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.

9. 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.

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 below.

Sincerely,

Daniel G. Orr, M.D.

Accepted and agreed upon by:

_____

Date: _____

EAGLE DIRECT PRIMARY CARE Patient Enrollment Form

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) (____) _____

PAYMENT OPTIONS

Payment in full using Cash or Check	$ 1425	☐
3 consecutive monthly payments	$ 500 / mo.	☐
Payment in full using a credit card	$ 1500	☐

PATIENT SIGNATURE _____

Date _____