PRESTIGE Regenerative Medicine

NON-PELLET HRT MEMBERSHIP PROGRAM AGREEMENT

This document outlines the terms and conditions of the Prestige Regenerative Medicine (PRM) Non-Pellet Hormone Replacement Therapy Membership Program, referred to hereinafter as "Program."

INCLUSIONS:

SPECIALIZED MEDICAL EXPERTISE: Our medical providers have received highly specialized training in hormone replacement therapy. Though hormone management is offered by some general primary care practices, Prestige Regenerative Medicine providers follow unique and specialized protocols in this field of medicine.
PRESCRIPTIONS: This Membership includes the prescription of hormone replacement therapy to the patient's preferred pharmacy. The patient is solely responsible for the cost of all hormones and medications. PRM will make reasonable efforts to obtain insurance authorization / approvals for patients, but it is important to understand that insurance companies often deny coverage for hormone replacement therapy. In that case, online coupon services such as GoodRx.com can offer substantial savings to the patient. Any other related prescriptions requested by the patient can be prescribed to their pharmacy of choice and the cost of these additional medications will be the responsibility of the patient.
LABS: Also included in this Membership is the necessary standard labs ordered up to twice per year by our medical team through our lab partner, Quest Laboratory.
PROVIDER CONSULTS FOR LAB REVIEWS: This Membership also includes a consultation annually with a Prestige Regenerative Medicine provider for interpretation of lab results, revision of treatment, and other medical questions. A minimum of one consultation per year is required to maintain prescriptions.
MEDICAL GUIDANCE: This Membership includes exclusive access to our patient portal, Onpatient, for submitting questions and receiving PRM staff guidance. Patient questions can also be directed to our front office staff via our office phone. If your question must be answered directly by a provider, our staff will schedule a courtesy 15-minute phone consult with a provider up to once per quarter of each calendar year.

EXCLUSIONS (ADDITIONAL FEES):

MEDICATION COSTS: As mentioned above, the patient is responsible for pharmacy costs.
ADDITIONAL LABS: In addition to our standard labs prescribed up to twice per year, PRM providers may feel that additional lab work is necessary for specialized care. These additional labs are the financial responsibility of the patient. For female patients, PRM strongly recommends the specialized DUTCH test (Dried Urine Test of Comprehensive Hormones), offered by Precision Analytical. This valuable test not only shows hormone levels but delineates a patient's metabolic pathways for health optimization. The test can typically be ordered after the first 2-3 months of therapy and then every 8-12 months thereafter. The test is done in the comfort and convenience of the patient's home and does not require a blood draw.
ADDITIONAL PROVIDER CONSULTS: If a patient's questions require more time than the inclusions mentioned above, the patient may schedule a longer consultation with their provider (in clinic or phone consult), billed according to the published fee schedule based on consult length.

FEES AND PROGRAM TERM:

The fee for this Membership is **$95 per month. Membership is a three (3) month minimum commitment, as this is the minimum amount of time needed to properly administer treatment, test hormone levels, and make any necessary adjustments to patient's prescription. Memberships will continue to auto-renew unless the patient gives notification by phone or in writing of the desire to cancel.** There is no cancellation

fee, provided that the patient has fulfilled the initial three (3) month agreement. The patient will provide secondary payment account information in the event of a default on the primary account.

CANCELLATION OF MEMBERSHIP:

If a member chooses to cancel membership before the minimum 3-month commitment, the patient will be charged the remainder of the balance for the 3-month term and no further payment will be due. If a member chooses to cancel after the minimum 3-month agreement, this can be done in writing or verbally at any time with no cancellation fee. Once a patient cancels their membership, the patient is classified as inactive. PRM is unable to provide medical advice, order labs, or prescribe medication for inactive patients. After 12 months of inactivity, if a patient chooses to begin treatment with PRM, the inactive patient will need to schedule a new patient consult to re-establish care.

PATIENT ALSO AGREES TO THE FOLLOWING:

By providing my email address and/or mobile phone number I consent to receive emails and/or text messages regarding my payment activity. I agree to pay according to the payment schedule above and I hereby attest that I am the owner of the bank account(s) or credit/debit card(s) referenced herein. Furthermore, should any payment obligation as called for in this agreement become more than sixty (60) days late PRM shall have the right to declare me in "default" and the entire remaining balance shall become immediately due and payable, and PRM reserves the right to debit either my primary or secondary payment account for the full balance owed. I understand that should a default occur, I will be obligated to pay PRM for additional charges incurred by PRM related to the costs of collection, including but not limited to collection agency fees, court costs, and attorney fees.

To the extent that I request additional products or services or modifications to my existing Payment Plan Agreement, I will make payment for such products and services in accordance with this agreement.

My signature indicates that I agree with the terms and conditions herein.

Printed Name:______________________________ **Date________________**

DAYTIME PHONE NUMBER:___________________________________

EMAIL ADDRESS:_______________________________________

Signature:_____________________________

PRM Staff Signature: _______________________________

Membership Payment Information

Monthly Recurring Charge Amount: ________   Date of First Payment: ___________

PRIMARY PAYMENT METHOD:

☐ Debit / Credit Card   CIRCLE TYPE OF CARD: VISA MASTERCARD AMEX DISCOVER

(*V-Code: _______) * last 3 numbers on back of card by signature line or 4 digits on front for AMEX

CREDIT CARD #: ____ EXP. DATE: Month____ Year ____

NAME AS IT APPEARS ON CARD:____________________________

BILLING ADDRESS:______________________________CITY, STATE, ZIP CODE:______________________

☐ Checking/ Savings Account

Account Type: Checking   Savings   Bank Name:_______________________________

Routing Number:_________________________ Account Number:____________________________

BILLING ADDRESS:______________________________CITY, STATE, ZIP CODE:______________________

SECONDARY PAYMENT METHOD:

☐ Debit / Credit Card   CIRCLE TYPE OF CARD: VISA MASTERCARD AMEX DISCOVER

(*V-Code: _______) * last 3 numbers on back of card by signature line or 4 digits on front for AMEX

CREDIT CARD #: ____ EXP. DATE: Month____ Year ____

NAME AS IT APPEARS ON CARD:____________________________

BILLING ADDRESS:______________________________CITY, STATE, ZIP CODE:______________________

☐ Checking/ Savings Account

Account Type: Checking   Savings   Bank Name:_______________________________________

Routing Number:_________________________ Account Number:____________________________

BILLING ADDRESS:______________________________CITY, STATE, ZIP CODE:______________________

I authorize Prestige Regenerative Medicine to charge my payment method for the above amount as outlined by my signed agreement.

_____________________________   _______________

Patient's Signature   Date