Membership Acknowledgement Agreement

This Membership Acknowledgement Agreement is made and entered into as of the date set forth below, next to the signatures, by and between the patient, or guardian of patient, ("Patient") and Houston Area Pediatric Neurology.

The patient(s) identified below desires unique services and benefits to be provided by Houston Area Pediatric Neurology that are not covered or otherwise not reimbursable under a private health insurance policy or plan, in which Patient is enrolled (the "Membership Benefits and Services").

In addition to items covered by insurance and expected of any physician, Houston Area Pediatric Neurology agrees to provide to Patient enhanced access to the Physician and to limit patient enrollment in this Membership Benefits and Services.

In consideration of the applicable Membership Benefits and Services, Patient agrees to pay to Physician the following on a monthly basis:

$50/month (or $600/year) per family
(includes all immediate family members)

The "Membership Fee" is NOT due on the first patient appointment date nor due on the date this form is signed. The "Membership Fee" is for a 12-month period ("Term") ending one year from the time of first payment. First payment will be due on the SECOND PATIENT APPOINTMENT visit. The amount is guaranteed for such contract year, but may be increased upon annual renewal. The Membership Fee is non-refundable and is due monthly or before each anniversary thereafter (if paid as a lump sum) as a condition for continuing as a Patient of the Physician.

Patient has financial responsibility to pay for medical services that are provided at regular office visits that are not part of Membership Benefits and Services. The Practice will bill Patient's insurance for services performed, but Patient shall remain financially responsible for all charges incurred, including applicable deductibles and co-payments required.

Patient acknowledges and understands that Membership Benefits and Services are unique and are provided with certain specific limitations and conditions, as follows:

1. The applicable Membership Benefits and Services are not covered and otherwise not reimbursable under any private health insurance policy or plan in which Patient is enrolled. Accordingly, Patient understands and acknowledges that Membership Benefits and Services convey value and benefits that Patient does not already receive under any private health insurance policy, private health plan or government program in which Patient is enrolled.

2. The Membership Benefits and Services may be amended or modified to the extent necessary to reflect any change in interpretation or terms of coverage and benefits of any private health insurance policy or plan.

3. Physician may also provide service(s) to Patient that are covered or reimbursable from a private health insurance policy or plan in which Patient is enrolled. In such case, Physician may bill and seek reimbursement from patient's private health insurance policy or plan under the terms and conditions of Patient's enrollment agreement with such payor(s). Physician may also seek reimbursement from Patient as permitted under Patient's enrollment agreement with such payor(s) (*e.g.*, deductible, coinsurance or copays). Patient understands and acknowledges that any covered and reimbursable services are separate and distinct from and independent of the applicable Membership Benefits and Services provided herein.

This Agreement shall automatically expire at the end of the existing Term unless Patient renews the Agreement and pays the Annual Fee for the next Term. Physician may terminate this Agreement at any time during any Term of this Agreement, by providing Patient at least thirty (30) days' notice of such termination.

By signing below, Patient and Physician represent that they fully understand and freely covenant to accept the rights and obligations under this Membership Acknowledgement Agreement.

Date: _____

Name of Patient: _____

Signature of Patient or Guardian:_____

Printed Name of Guardian: _____

Date Signed: _____

Additional patient(s): (if applicable): _____

NOTICE OF ACCEPTANCE:

Houston Area Pediatric Neurology acknowledges receipt of this agreement.

_____ _____

Representative of Houston Area Pediatric Neurology **Date**