MEMBERSHIP AGREEMENT

Align MD_Rajeev Khanna MD CONCIERGE CARE

PLEASE COMPLETE & RETURN FORM

PHONE (703) 785-5289

TERMS OF AGREEMENT

I/we have engaged Align MD_Rajeev Khanna MD CONCIERGE CARE(Company) to provide non-covered, non-clinical amenities and benefits to me/us for an initial minimum period of one year beginning on my/our Start Date.

- **Renewal:** I/we understand that this Agreement will renew automatically following the end of each one-year period unless I/we provide Company a written notice of non-renewal.
- **Fees:** I/we further understand that I/we will be required to pay the yearly membership fee for the non-covered services, amenities and benefits for a minimum of one year.
- **Start Date:** As used in this Agreement, the term "Start Date" refers to the one-year period beginning on the date of enrollment, as well as every one-year renewal period thereafter.
- **Payment Schedule:** I/we understand that the first payment of my/our annual fee will be charged upon enrollment and the balance will be charged according to my/our terms selected after the Start Date, continuously, while this Agreement remains in effect.

MEMBERSHIP FEES

FOR MEMBERSHIP DURING THE SERVICE YEAR, I AGREE TO PAY THE COMPANY:

[ ] **$2,800/year** = First Individual (Additional family members in the same household may receive a 10% discount)

ACKNOWLEDGEMENT This Agreement is for non-covered, non-clinical amenities and benefits as described in the Highlights & Details document. I/we have read and understand this Agreement as well as the Highlights & Details and Frequently Asked Questions documents that are considered a part of this Agreement. Unless the Agreement is terminated as provided in the first paragraph above, it will automatically renew for subsequent Service Years under the same payment terms unless I/we notify Company otherwise (or Company notifies me/us) within 30 days prior to the next payment due date. Concierge membership fees are subject to change.

COMMUNICATION AUTHORIZATION I/we authorize my/our physician(s) and/or their billing company to send emails regarding my/our membership, enrollment, invoices, upcoming and past due payments, and receipts.

MEMBER INFORMATION

MEMBER #1

Name (Print): _____

Signature: _____

D.O.B.: _____ **Gender:** _____

Email: _____

Cell Phone: _____

MEMBER #2

Name (Print): _____

Signature: _____

D.O.B.: _____ **Gender:** _____

Email: _____

Cell Phone: _____

HOUSEHOLD INFORMATION

Home Address: _____

ZIP Code: _____

HOW DID YOU HEAR ABOUT THE PRACTICE? [ ] Current Patient [ ] Patient Referral [ ] Internet Search [ ] Insurance Provider [ ] Physician Referral [ ] Print Ads [ ] Other: _____

METHOD & TERMS OF PAYMENT

I authorize the Company to automatically charge my bank account/card the amount(s) indicated above.

SELECT PAYMENT METHOD: [ ] **ACH** (Electronic bank transfer). *Please note we are unable to accept checks.* [ ] **Credit Card** (Your card will be charged Align MD, LLC)

SELECT PAYMENT :

[ ] **I will pay annually.** I understand that the full annual fee will be charged upon enrollment and the full annual fee will be charged automatically at 12-month intervals from my Service Year, continually, while this Agreement remains in effect.

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PAYMENT DETAILS

IF PAYING BY ACH BANK TRANSFER:

Bank Account Number: _____

Routing Number: _____

Cardholder Signature: _____

IF PAYING BY CREDIT/DEBIT CARD:

Card Number: _____

Expiration Date: _____ **Security Code:** _____

Billing Address (if different): _____ **ZIP Code:** _____

Cardholder Daytime Phone Number: _____

Cardholder Signature: _____