



Choice Care

by

Marcy Zwelling, M D

Private Medical Services

This Membership Agreement (the 'Agreement') describes the services and amenities provided by Dr. Zwelling-Aamot and her staff in the *Choice Care*<sup>TM</sup> Internal Medicine Program (the "Program"), explains how you may participate in the Program, and summarizes the terms and conditions of your membership. By electing to participate in the Program, you are deciding to make your health and well-being a top priority.

*Choice Care*<sup>TM</sup>: Dr. Zwelling-Aamot will provide the following services for you while you are a participant in the program:

- Small and intimate practice size
- Minimal waiting for appointments
- Unhurried visits made at a time that is convenient for you and your busy schedule
- Dr. Zwelling's contact information by personal phone, fax or e-mail
- Lifestyle consultations
- Scheduled telephone visits
- Enhanced coordination with specialists
- Prescription facilitation

**Membership:** For those services and amenities, you will pay the annual membership fee to *Choice Care*<sup>TM</sup> each year that you are a patient in the Program. The annual fee is \$1800 if paid in advance and in full. If paid over time, the fee is \$475 quarterly due on the 15<sup>th</sup> of the preceding month. Monthly payments require a credit card on file. If you have children between the ages of 16-18, we will see them regularly during the course of the year as needed for an additional \$500.00 per child for office visits only.

Family Plan for 2: \$3500

Family Plan for 3: \$5100

Family Plan for 4: \$6600

**Corporate Membership:** By contract

***THESE RATES APPLY ONLY IF PAID IN FULL AT THE WHEN  
THE MEMBER SIGNS THE CONTRACT***

After paying your fee in full, Dr. Z will not accept any other direct payment from a *Choice Care*<sup>TM</sup> member for that 12 month period excepting for medication or laboratory services if you choose to purchase those thru our office rather than thru your insurer.

Those patients who choose to NOT provide us with a credit card # must assume full responsibility for their timely payment. There will be a \$25 late fee for those payments received more than 30 days late. If a credit card is declined, there will be a \$25 charge. Similarly, there will be a \$25 charge for all returned checks.

Marcy Zwelling, MD 3771 Katella Avenue Ave., Suite #108 Los Alamitos, Ca. 90720 592-596-7584 (P) 562-596-4360 (F)

All members not paying in full when signing this contract will receive a statement within 15-20 days of the contract's completion with a payment schedule. Payments received after the 15<sup>th</sup> of the month are considered late. Credit card charges will be processed between the 10<sup>th</sup> and the 15<sup>th</sup> of the month.

**Limited Services:** Due to Medicare regulations, we bill them directly and we accept assignment. We are not contracted with any insurance company but we will provide you with a superbill upon request.

If you belong to an HMO, we will forward your authorization thru the PCP documented on your card. Be advised that you may have to visit this PCP in order to get your HMO benefits. This is the decision of your insurance carrier.

As an additional benefit, pneumococcal, influenza, and tetanus vaccinations are included in the yearly membership assessment. All other vaccination costs (travel) must be paid at the time of service. Other elective vaccinations must also be paid in full at the time of inoculation.

Lab costs when billed to this office on your behalf are due at the time of service.

**How to become a member:** You may become a member in the Program by completing and returning the attached Authorization Form, together with your check or payment instructions. For new Choice Care Members, the period of your participation in the Program is one year, beginning on the date you sign the member agreement. For those continuing to participate, renewal of your contract will be continuous. **THERE WILL BE NO BREAK IN THE CONTRACT PERIOD.**

**Cancellations and Refunds:** The term of Agreement shall be for one (1) year commencing on the effective agreement date. Either Physician or Patient shall have the right to terminate this Agreement at any time provided that Physician or Patient, as the case may be, provides the other with 30 days prior written notice of such termination. In the case of event of termination, the patient shall be entitled to a prorated refund of \$800. \$1000 will not be refunded after the agreement is signed provided that a patient has been a member of Choice are for one or more months. In the event of a patient's death, if that patient has not received substantial care over the contracted time period, the family may request a refund. Patients participating with a participating dependant child shall not be entitled to any refund of the fee paid for such child or children.

**Miscellaneous:** This Agreement, and the attached Authorization Form, represents the entire agreement between you and Dr. Zwelling-Aamot regarding the subject matter of these documents, and supersedes and replaces all prior and contemporaneous agreements and understandings, whether oral or written, and b) may not be modified or amended, except by a subsequent written instrument executed by you and Dr. Zwelling-Aamot. This Agreement shall be governed by, and construed in accordance with, California law.

**Election to Participate:** If you wish to participate, then please complete the Authorization Form, accompanied by your check or payment instructions, and return it to Dr. Marcy Zwelling-Aamot, 3771 Katella Ave, Suite 108, Los Alamitos, CA 90720. Please keep this Participation Agreement with your records.

**Thank you for your interest in Dr. Marcy Zwelling- Aamot/Choice Care™. We consider this a serious partnership to ensure that you receive the very best personalized health care.**

(562) 596-7584 phone \* (562) 596-4360 fax  
[Marcy@z-doc.com](mailto:Marcy@z-doc.com) \* [www.z-doc.com](http://www.z-doc.com)  
3771 Katella Avenue, Suite #108, Los Alamitos,



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**Patient(s) Information** – (please print)

**Contract Start Date:**

**Contract End Date:**

**Name**

Phone \_\_\_\_\_

Street Address \_\_\_\_\_ E-mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Participating Dependents/ Family Members:**

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

**Agreement to Participate:** I elect to participate in the Choice Care Program, and agree to all of the terms and conditions described in the Participation Agreement.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Payment information:** Please choose one of the following payment methods:

**Monthly /Quarterly.** Please provide MC, Visa or Bank Debit card with Visa/MC logo for automatic payment

**Check.** Please make check payable to Marcy Zwelling-Aamot, M.D. and return with this form

	<b>Annual</b>	<b>Quarterly</b>	<b>Monthly</b>
<b>One person</b>	____(\$1800)	____(\$475)	____(\$175)
Family of 2	____(\$3500)	____(\$950)	____(\$350)
<b>Family of 3</b>	____(\$5100)	____(\$1425)	____(\$525)
Family of 4	____(\$6600)	____(\$1900)	____(\$700)
<b>College Student</b>	____(\$900)		

**Authorization For Credit Card Payment** – Automatic payment of monthly/quarterly fee by credit card

I authorize Marcy Zwelling-Aamot, M.D., to automatically charge my monthly/quarterly fee to the credit card indicated below. This authorization will remain in effect until Dr. Zwelling-Aamot, M.D. has received written notice from me of its termination in a reasonable time to act on it.

VISA MC Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Is your Visa or MasterCard linked to your checking account? Yes No

Name as it appears on card: \_\_\_\_\_

**Cardholder Signature** \_\_\_\_\_

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Please mail your completed Authorization Form, and check or payment information to:

**Marcy Zwelling-Aamot, M.D., 3771 Katella Avenue, Suite 108, Los Alamitos, CA 90720**