Member Name (child) ____________________

Date of Birth: ____________________ M / F

www.iconpediatrics.com

MEMBERSHIP AGREEMENT

I have engaged ICON Pediatrics, LLC and its physician, Eddie Hamilton, M.D. to provide primary care services for my child (as named above) for a period of one year from the membership acceptance date. As used in this Agreement, the term "Service Year" refers to the 1-year period beginning on the membership acceptance date, as well as every 1- year period after that.

This membership fee will cover basic services of well child visits consistent with the American Academy of Pediatrics' periodicity schedule, recommended vaccines, and **unlimited** acute care and/or sick visits. The membership does not cover certain specialized services and procedure such as the Cogmed Working Memory Training for students with ADD/ADHD. Each specialized service will be designed for individual patient needs.

We are out of network with all insurances but are happy to assist you in filing your insurance. We encourage you to carry insurance for emergency hospital stays, x-rays and labs.

FOR PATIENT MEMBERSHIP DURING THE SERVICE YEAR, I AGREE TO PAY ICON PEDIATRICS:

- ☐ $1200.00/year – First Child (age 18 or younger)
- ☐ $600.00/year - Any additional child (age 18 or younger)

METHOD OF PAYMENT:

☐ Credit/Debit Card ☐ Cash ☐ Check Check number ____________________

Full amount payable upon acceptance date. (a 5% discount will be given)

- ☐ Annual Payment — 50% due upon acceptance date, and the remaining 50% due in 6 months.
- ☐ Semiannual Payment — 25% due upon acceptance date, and 3 equal payments at 3-month intervals.
- ☐ Quarterly Payment — 10% due upon acceptance date, and 11 equal payments at 1-month intervals
- ☐ Monthly Payment

I authorize ICON Pediatrics to charge my credit/debit card according to the payment plan indicated above.

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

____________________ Credit Card Number ____________ Exp. Date ________ Verification Code ____________________ Cardholder Signature

GUARANTOR SIGNATURE: Please print name and date and sign form below

I acknowledge that either ICON Pediatrics or I can terminate this Agreement with a 30 day written notice. If I terminate, I understand that my Annual Fee may be forfeited, and this will be determined on a case-by case basis. If ICON Pediatrics terminates, I will receive a refund of the prorated portion of the paid Annual Fee, based on the number of days that have elapsed in the Service Year. Such refund will be paid to me within 30 days after termination.

I understand that this Agreement will automatically renew upon expiration of the previous of the Service Year. The terms of this Agreement will apply to all such subsequent Service Years, unless ICON Pediatrics and I agree otherwise, and in writing.

____________________ Signature ____________________ Printed Name ____________ Date

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