RETAINER AGREEMENT FOR ROUTINE INTEGRATED FUNCTIONAL MEDICINE SERVICES

PARTIES: ROBIN FLECK, MD (PHYSICIAN) AND _____ ___(PATIENT) agree to the terms and conditions of this Agreement.

TERM: Care shall begin on the date this Agreement is signed by both parties and initial retainer fee of $300 is paid and monthly subscription payments of $300 shall continue for one year. Patient agrees that physician is hereby authorized to debit patient's bank account by automatic ACH withdrawal each month. Thereafter this Agreement may be renewed for an additional term of one year by the payment of $300 each month by ACH debit.

LICENSURE: During the term of this Agreement, Physician shall maintain an active Texas Medical License as required by law. Physician shall also maintain current state and federal DEA certificates.

SERVICES: The following services shall be encompassed by this Agreement.

A. Location of care: Care shall be provided in Physician 's office located at 23321 FM 244, Iola, TX and by telephone or email by appointment.
B. Time of service: Weekdays by appointment as set by Physician between 9 am and 3 pm CST.
C. Contact information: Patient may contact Physician by text message (830-383-0735) requesting additional discussion or with questions related to treatment. Physician will contact Patient by telephone during business hours within 24-48 hours after text message.
D. Routine Integrated Functional Medicine Services: Physician will evaluate Patient with routine consultations, laboratory evaluation, imaging and related discussions and recommend and prescribe diet and lifestyle modifications, bio identical hormone supplementation and homeopathic prescriptions as indicated, all tailored to the Patient's specific needs to improve Patient's symptoms. Physician will clinically supervise Patient's progress and after Patient's symptoms are relieved and hormonal levels are optimized, Patient is expected to remain on the prescribed regimen. Any deviation from the prescribed regimen should only be pursued after discussion with Physician. Patient hereby holds Physician harmless from poor outcomes due to noncompliance with the Physician-recommended regimens.
This Retainer fee does not include the cost of laboratory evaluations, imaging studies or prescription drugs or OTC supplements which shall be borne by Patient.

INSURANCE: Neither Patient nor Physician shall submit a bill to an insurer for the services provided Patient under this Agreement.
Patient understands and acknowledges that Physician does not accept any form of insurance for the services rendered under this Agreement and that the Physician does not participate in the Medicare or Medicaid, Tricare or VA Health insurance programs.
Physician and Patient understand and acknowledge that the provision of services under this Agreement constitutes the establishment of a direct relationship between Patient and Physician without influence by guidelines, restriction or contract established by any health insurance company, health maintenance organization or hospital service organization or the Medicare or Medicaid, Tricare or VA Health insurance programs. Physician and Patient understand and acknowledge that this Agreement does not provide health insurance coverage, including the minimal essential coverage required by applicable federal law. This Agreement is not a substitute for health insurance. It provides only the services described herein. It is recommended that health care insurance be obtained to cover medical services by any other provider patient seeks to employ.

If you are eligible for Medicare, or during the term of the Agreement become eligible for Medicare you will sign the agreement entitled “Medicare Opt Out Agreement.”

TERMINATION: This Agreement will terminate upon the death of either Patient or Physician. Patient may terminate this Agreement for any reason by providing 30 days’ written notice to Physician. Refunds will not be provided for consultations already provided to Patient.
Physician may terminate this Agreement for any reason with 30 day’s written notice to Patient.

NOTICES: All notices, requests, demands and other communications required under this Agreement shall be in writing. If Patient wishes to send email or text message communication to and to receive email or text message communication from Physician, Patient must sign a separate affidavit permitting the use of electronic communications. Patient understands that neither email nor text message are a secure medium for sending or receiving potentially sensitive personal health information and Patient acknowledges that his/her emails or text message will become part of his/her medical record. In the event that a breach of privacy occurs while sending/receiving email or text messages, Patient agrees to indemnify and hold harmless the Physician.

MODIFICATIONS: This Agreement may not be modified except in a written document signed by both parties.

DATED this _____day of _____, 20__.

by

Phthisic _ _____

Patient_____

Email address_____