Ellen F Bunch MD
National Board of Physicians & Surgeons
The Healthcare You Need, The Attention & Privacy You Deserve
928-777-8880 • Fax 928-777-8884
1456 W. Gurley Street • Prescott, AZ 86305
info@ellenbunchmd.com • www.ellenbunchmd.com

Hello !

I hope you find the following informative and refreshing. After reading the particulars on Dr. Bunch's amazing concierge/boutique/direct Primary Care practice, please give me a call so I can schedule your personal meeting with Dr. Bunch.

As I am sure you will agree, your primary health care experiences today are rushed, overwhelmed and slow to respond. You deserve a relationship with an MD who engages fully in your health and is available when you need her. A doctor who focuses on **prevention** and **wellness**, not just on **disease management**. Dr. Bunch's **concierge practice** is *refreshingly different* from conventional practices in Prescott; and **YES**, she is accepting new patients.

Unlike conventional medical practices these days, Dr. Bunch gives you a doctor-patient interaction from the 'good old days' with the benefits of modern-day variety of heath care and treatment options. It has been said that Dr. Bunch's Concierge Family Care practice is what everyone is looking for in a doctor-patient relationship. For an all-inclusive annual fee, you get a doctor who takes the time to **listen completely** to her patients and design a health care strategy specifically for you.

But you may ask, Why the fee? From her years taking care of people, Dr. Bunch has learned that to provide better long-term care, it is important to eliminate the high overhead of complex billing and reimbursement systems. As well as 3rd-party mandates that make little sense but consume more and more of your doctor's time away from you. By charging an affordable annual fee, Dr. Bunch can focus only on you, the patient. In fact, Dr. Bunch established her Personal Care Concierge practice in January 2005 and removed as many obstacles as possible between her and her patients; *insurance companies included*. Dr. Bunch felt insurer's ability to more or less force a particular treatment on you based on a diagnosis-driven-pre-determined reimbursement schedule an unacceptable intrusion into true patient care.

Professionally, Dr. Bunch received her MD from the University of Arizona College of Medicine in Tucson, AZ. And to add the full complement of all of our health capability, Dr. Bunch is also fellowship trained in **Integrative Medicine**; also from the **Arizona Center for Integrative Medicine**, University of Arizona. To clarify, Integrative Medicine is a relatively new way of providing care for you through utilization of **all available healthcare options**. Including lifestyle modifications, dietary supplements and coaching such as choosing a smart diet and a reasonable amount of exercise to gain optimum health. Not just drugs, drugs and more drugs.

Since you may be a Medicare beneficiary, I have also included a sample **Medicare Private Contract**. Dr. Bunch was one of the first in Prescott to Opt-Out of Medicare; and the number of healthcare providers doing the same are growing. Medicare does require a contract between the doctor and patient every two years agreeing that you understand and agree with this arrangement.

When you are ready to explore Dr. Bunch's concierge medicine practice and learn how she can coordinate your complete health plan, we will schedule a FREE full 45-minute Prospective Member appointment for you to fully explore your current situation and goals of teaming up with Dr. Bunch as your primary care concierge physician. These open-ended appointments are generally held in the afternoon, at 2:00pm.

That's concierge medicine. You will love her simple, straightforward, unhurried and personal approach. It's health care that fits your life.

Click to go to directly to Dr. Bunch's website: **Ellen Bunch MD**

We are looking forward to meeting you soon!

Best of Health,

Ken Bunch
PRACTICE MANAGER

Ellen F Bunch MD

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MEMBER REGISTRATION

NAME ______________________________ DATE ______________

ADDRESS ____

CITY ________________________ STATE ________ ZIP __________

HOME PHONE ________________ CELL PHONE ____________________

E-MAIL________________________ REFERRED BY? ______________

FEE SCHEDULE

(Rate Per Patient)

ANNUAL MEMBERSHIP FEE

Full Year	One-Time* Setup Fee	**Complete 1st Year Cost**
$3,960	$500	**$4,460**

ANNUAL MEMBERSHIP FEE w/SPOUSE

Full Year	One-Time* Setup Fee	**Complete 1st Year Cost**
$3,762	$500.00	**$4,262**

Residents in Assisted Living Premium – Add 15% to Full Year Fee

We accept payments by Zelle®, Cash or Check only. Thank you!

Zelle® payment to: **ken@ellenbunchmd.com**

* Renewal of membership following termination, for any reason, incurs an additional Setup Fee

Revised 05/03/2023

Medical Services Agreement

This Fixed Fee Medical Services Agreement executed this _______ day of _____________, 20____, by and between ELLEN F. BUNCH, M.D. (hereinafter "Physician") and ____ (hereinafter "Patient") shall be effective on the date of deposit ("Effective Date") of the Patient's first payment into the Physician's business checking account along with receipt of a fully executed copy of this agreement.

Recitals

Physician intends to enter into this agreement with patient and provide services in accordance with the terms and provisions of this fixed-fee medical services agreement; and

Patient understands and desires to obtain the benefits and services of Physician in accordance with the terms and provisions of this fixed-fee medical services agreement and the parties agree as follows:

FOR GOOD AND VALUABLE CONSIDERATION, the parties agree as follows:

PHYSICIAN AGREES TO PROVIDE THE FOLLOWING MEDICAL SERVICES TO PATIENT:

1. One (1) Annual Physical Examination, including in-office EKG with interpretation;
2. Telephone consultations during regular office hours;
3. Email communications during regular office hours *exclusively* through our HIPAA compliant Elation Passport communication portal;
4. Proactive health counseling, including stress management, nutrition and exercise guidelines;
5. Education and focus on preventative healthcare;
6. Coordination of inpatient, specialty and convalescent care;
7. Direct Access to the Physician via cell phone for after-hour *urgent* care matters.

The following services are Excluded:

1. All diagnostic testing except testing which can be provided in the office (i.e. ECG, pulse oximetry, etc.);
2. Treatment by other providers;
3. Medication costs; and
4. All other services not specifically addressed herein.

PATIENT AGREES TO A *MINIMUM* OF **ONE FACE-TO-FACE OFFICE** VISIT PER YEAR.

Physician's Out-of-Office Time

Physician may be unavailable for face-to-face encounters from time to time throughout the year, including but not limited to continuing medical education (CME) and other personal time off. Physician may be available by telephone during out-of-office times and will generally provide advance notification of same via Elation Passport email and/or USPS. Physician reserves to right the contract for alternative physician coverage for out-of-office time. Personal time and CME time out-of-office is up to six weeks per year.

Initials _______

Controlled Substance Contract

As per Arizona State Board of Pharmacy's Controlled Substances Prescription Drug Monitoring Program, patient agrees to sign a Controlled Substance Contract for any and all Controlled Substance medication prescriptions for the treatment of chronic medical condition(s). Further, Patient agrees to face-to-face office visits with Physician every 90 days for review of chronic medical condition(s) for continued drug therapy.

Fees & Payments

Patient agrees to pay an Annual Membership Fee *and* a One-Time Setup Fee, at the time of signing this Agreement. Patient agrees the Annual Membership Fee and One-Time Setup Fee are NON-REFUNDABLE.

Patient agrees to make all payments as per Invoice Terms. In the event the Patient fails to do so, Physician can, at Physician's discretion, terminate this agreement immediately for non-payment.

Patient understands and acknowledges that the annual fixed fee provided for herein is not represented nor warranted to be reimbursable under any insurance plan. Patients should consult their tax advisor and/or CPA to determine the tax deductibility of medical expenses and fixed fees paid pursuant to the terms of this agreement.

Termination

Patient <u>or</u> Physician, may, upon <u>thirty (30) days'</u> *written notice*, terminate this agreement at any time for any reason. The option to rejoin the practice of Ellen F Bunch MD as a Patient *may* be unavailable. If Patient elects to terminate this membership agreement (terminate medical services provided by Ellen F Bunch MD for any length of time) and later chooses to reestablish medical care with Physician, a subsequent Registration Fee will be collected at time of rejoining Physician's practice.

Physician may elect to terminate this agreement for any of the following reasons:

1. **Failure or refusal by patient to <u>fully</u> disclose <u>all</u> prescriptions and medications received by previous physicians <u>prior to the date of signing this agreement</u> and at any time thereafter.**
2. **Failure or refusal by patient to notify this office of any and all prescription medications received from any other physician or facility while under the care of Ellen F Bunch MD within 2 business days following receipt of same.**
3. **Failure or refusal to comply with any or all recommendations provided or ordered by Ellen F Bunch MD in the course of your treatment plan as outlined, without prior consent of Ellen F Bunch MD.**
4. **Physically, verbally, or in writing, any demeaning, threatening, insulting or abusive intent or actions by patient toward Physician or any member of the office staff, or any other medical professional treating Patient while under care of Ellen F Bunch MD.**
5. **Failure to Pay any and all fees per invoice payment terms. Patient will be required to pay an *additional* Registration Fee, and any historical discounted fee will be surrendered if Patient chooses to continue with Dr. Bunch beyond the <u>payment due date</u> stated on the invoice. <u>Specifically, if your Agreement lapses and you decide to reinstate your membership with Dr. Bunch, your annual retainer fee will be the rate in effect at the time of agreement signing.</u>**

Notwithstanding the execution of this Agreement by the Patient and receipt of the annual fee, the Physician may, at Physician's sole and absolute discretion, reject the agreement.

Initials _______

Agreement Term

The term of this Agreement shall commence on the effective date as herein defined and terminate one (1) year thereafter. Patient can automatically extend the term of this agreement by paying the subsequent annual fee on or before the expiration of the current agreement term. (For example, if the effective date of this agreement is January 15, 2022, the next annual fee must be paid on or before January 14, 2023.)

Entire Agreement

Patient and Physician agree to be bound by the terms of this Agreement, all of which are expressly contained herein. Physician makes no other representations or warranties except as provided herein. Notices and any communication required or permitted under the terms of this Agreement shall be in writing and shall be sent via facsimile transmission or certified mail, return receipt requested, which notice shall be effective as of the date posted. **Any change in address by Patient or Physician shall be communicated to the other party within fifteen (15) days of the change of address.**

Arbitration

Any dispute or claim arising from or related to this agreement shall be submitted to binding arbitration, with said arbitration to be held in Prescott, Yavapai County, Arizona, unless the parties hereto agree otherwise. The initial costs of the arbitration, including any initial fees to be paid to an arbitrator or arbitrators shall be paid by the party invoking the arbitration, but shall be subject to allocation between the parties by the arbitrator or arbitrators at the conclusion of the arbitration.

Governing Law

This Agreement shall be governed and construed in accordance with the laws of the State of Arizona.

PATIENT: (sign)____

(print)_________________________ DATED: ________________

ADDRESS ____

CITY ____________________ STATE _______ ZIP __________

PHYSICIAN ACKNOWLEDGEMENT: ____________________________________

Ellen F Bunch MD

EFFECTIVE DATE: ________/_______/________

Ellen F Bunch MD
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RELEASE OF MEDICAL RECORDS

CONSENT TO RELEASE or RECEIVE
CONFIDENTIAL and/or SENSITIVE INFORMATION

Name ____ Date _______________

Address ____

City ____ State ___________ ZIP ____________

Phone_______________________________________ SSN ________-________-____________

DOB: ______/_____/________ I, ____________________________________ hereby authorize:

Ellen Bunch, M.D., Direct Concierge Family Medicine
1456 W Gurley St
Prescott, AZ 86305
(928) 777-8880 phone
(928) 777-8884 fax (unlimited pages)

_____ to release to:

_____ to receive from:

PLEASE NOTE:
Digital patient records in C-CDA format are preferred (.xml or .zip containing the .xml file).
C-CDA file(s) can be emailed as an attachment to info@ellenbunchmd.com
Please call our office if you have any questions. Thank You!

____
(physician's name and/or facility)

____
(address) (city) (state) (ZIP)

____
(phone) (fax)

☐ Complete Medical Records ☐ Records from ________________ to ________________

This record request is for:

____ Transfer of Primary Care: Establishing as a new patient with Ellen F. Bunch, MD

____ Current patient: Collaboration of Primary Care

____ Current patient: Coordination of Specialist Care.

____ Other: (please provide details below)

____

I understand that the above consent is subject to revocation by me at any time except to the extent that action has been taken in reliance on this consent prior to revocation. In any event, if no expiration date is specified above this consent will automatically expire one year from the date noted below. The Federal Regulations of Confidentiality of Alcohol or Drug Abuse Patient Records (42 CFR Part 2) and State Law protecting the confidentiality of patient records that has been explained to me.

____
(Patient's Full Name – please print)

____
(Patient Signature) (Parent/Legal Guardian)

____
(Witness Signature) (Date)

Ellen F Bunch MD
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Health Information Disclosure Authorization and Emergency Contact Form

I, ____, give permission to Ellen F Bunch MD to
Print Your Full Name
disclose and release my protected health information described below to:

Name:	Relationship:	Phone:

Health Information to be disclosed (Check all that apply):

- o My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- o My complete health record, as above, with the exception of the following information: (check as appropriate):
  - o Mental health records
  - o Communicable diseases (including HIV and AIDS)
  - o Alcohol/drug abuse treatment
  - o Other (please specify____ _____________________

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- o All past, present, and future periods, OR
- o Date or event:____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

____ ________________________
Printed Name of the Individual Giving this Authorization

____ ________________________
Signature of the Individual Giving this Authorization Date

THIS SAMPLE CONTRACT WILL BE PERSONALIZED (IF YOU ARE A MEDICARE BENEFICIARY) WHEN YOU JOIN. EACH "SAMPLE PATIENT" WILL BE POPULATED WITH YOUR NAME AS IT APPEARS ON YOUR MEDICARE CARD.

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private contract with a Medicare beneficiary. Enter the provider's name and the beneficiary's name in the appropriate boxes. Signatures from the provider, a witness and the patient/beneficiary or their legal representative are required below. The supplier must submit an affidavit to Medicare expressing his/her decision to opt-out.

I, ELLEN F BUNCH MD have not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act NPI 1730289380

I, SAMPLE PATIENT or my legal representative accept full responsibility for payment of charges for all services furnished by ELLEN F BUNCH MD**.**

I, SAMPLE PATIENT or my legal representative understand that Medicare limits do not apply to what ELLEN F BUNCH MD may charge for items or services furnished.

I, SAMPLE PATIENT or my legal representative agree not to submit a claim to Medicare or to ask ELLEN F BUNCH MD to submit a claim to Medicare.

I, SAMPLE PATIENT or my legal representative understand that Medicare payment will not be made for any items or services furnished by ELLEN F BUNCH MD that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I, SAMPLE PATIENT or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The expected or known effective date and expected or known expiration date of the opt-out period is **July 21, 2016** and **July 20**, **2018**.

I, SAMPLE PATIENT or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

This contract cannot be entered into by me, SAMPLE PATIENT, or by my legal representative during a time when I, SAMPLE PATIENT, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual)

I, SAMPLE PATIENT or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

I, ELLEN F BUNCH MD will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

INFORMATION ONLY

I, ELLEN F BUNCH MD will supply CMS with a copy of this contract upon request.

I, ELLEN F BUNCH MD understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

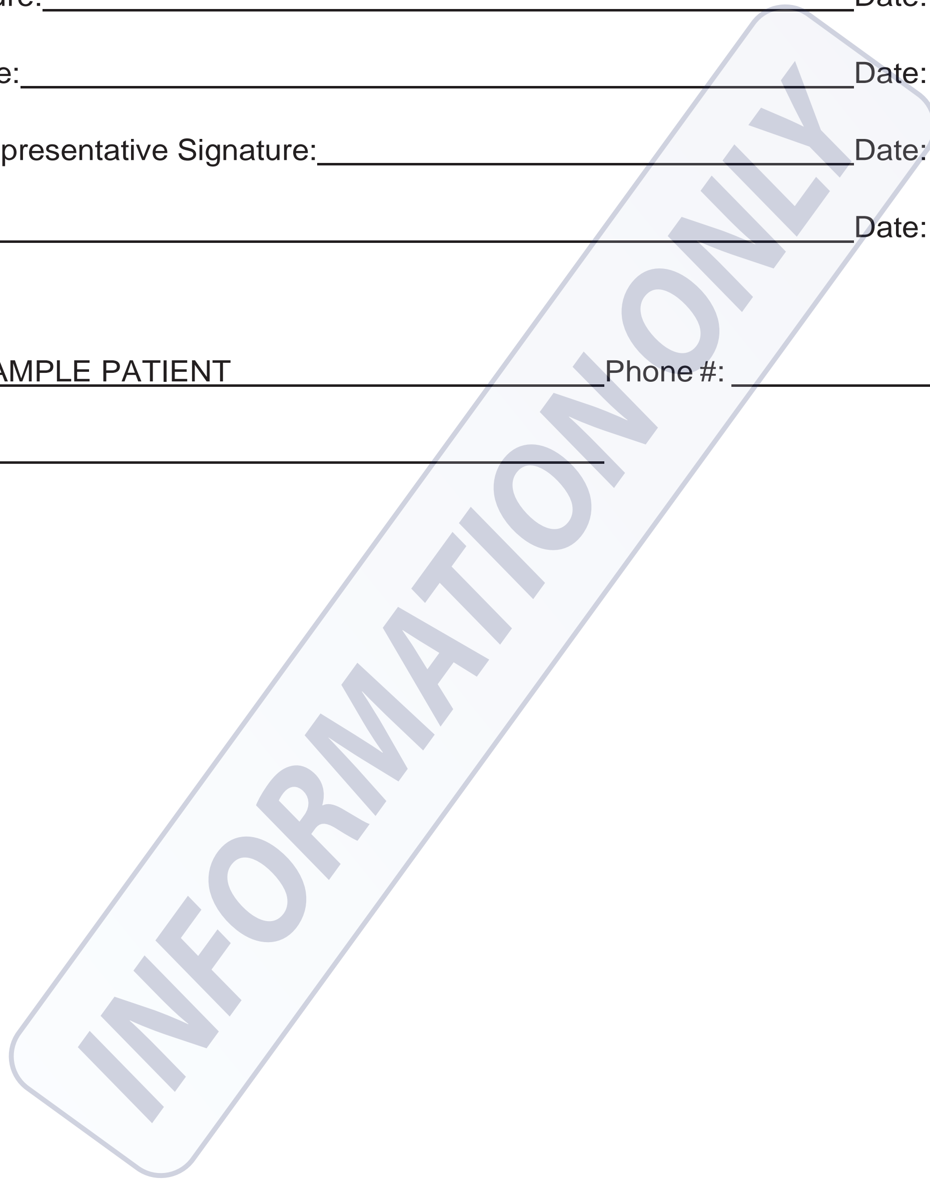
Provider's NPI: 1730289380

Provider's Signature:____________________________ Date: ____________

Patient's Signature:____________________________ Date: ____________

Patient's Legal Representative Signature:__________________ Date: ____________

Witness:____________________________ Date: ____________



Contact Name: SAMPLE PATIENT ________________ Phone #: ________________

Contact Email: ____________________________

THIS SAMPLE CONTRACT WILL BE PERSONALIZED (IF YOU ARE A MEDICARE BENEFICIARY) WHEN YOU JOIN. EACH "SAMPLE PATIENT" WILL BE POPULATED WITH YOUR NAME AS IT APPEARS ON YOUR MEDICARE CARD.

ELLEN F BUNCH MD - 1456 W GURLEY ST - PRESCOTT AZ 86305

ELLEN F BUNCH MD
1456 W GURLEY ST
PRESCOTT AZ 86305

*** NEW OFFICE LOCATION ***
(APRIL 2023)

5 minutes west of the COURTHOUSE SQUARE

1456 W GURLEY ST PRESCOTT AZ 86305

PH: 928-777-8880

www.ellenbunchmd.com