**RENEW DERMATOLOGY COSMETIC MEMBERSHIP**

**APPLICATION AND AGREEMENT**

**Patient Application and Information**

**Complete for each Patient/Participating Cosmetic Member**

|  |  |  |
| --- | --- | --- |
| Legal Last Name: | Legal First Name: | MI: |
| Patient Date of Birth: | Nickname or Name Preference: |
| Mailing Address: |
| City: | State: | Zip Code: |
| Home Phone: | Cell: | Sex:❑ Male ❑ Female |
| Email: | Emergency Contact Person: |
| Emergency Contact Phone #: | Relationship to Emergency Contact: |
| ❑ Payment Method: ❑ Credit Card ❑ Cash ❑ Cash and Credit Card  |
| Membership Choice (See details on next page and **make your selection(s) below**): ❑ **“I LOVE BOTOX”**❑ ***ANNUALLY (*$1999.00)**❑ ***MONTHLY ($185.00)***❑ **“I AM RENEWED”**❑ ***ANNUALLY (*$3375.00)**❑ ***MONTHLY ($315.00)***❑ **“HELLO GORGEOUS”**❑ ***ANNUALLY (*$3999.00)**❑ ***MONTHLY ($354.00)*** \*\*\*\*Please note that ANY additional Botox beyond the plan above within the fiscal year will be billed at $10.00/unit. \*\*\*\*Additional filler beyond the plan above within the fiscal year will be at a 20% discount from retail.  |

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| ***COSMETIC MEMBERSHIP OPTIONS:**** *ALL MEMBERSHIPS INCLUDE**4 TREATMENT VISITS PER YEAR with 4 Follow-up visits (no longer than 10 minutes for follow-up visits)*

**\*\*\*Note: Annual Fees for Membership package must be PAID IN FULL within 30 DAYS to receive these discounts, NO EXCEPTIONS\*\*\*\*****I LOVE BOTOX ($10/UNIT): ($701 SAVINGS OFF RETAIL)*** *200 UNITS OF BOTOX TO USE OVER 1 YEAR*
* *ANY ADDITIONAL BOTOX NEEDED ABOVE 200 UNITS DURING THE YEAR OF MEMBERSHIP WILL ALSO BE BILLED AT $10/UNIT PRICE*

**I AM RENEWED ($1013 SAVINGS OFF RETAIL)*** *200 UNITS OF BOTOX*
* *ANY ADDITIONAL BOTOX NEEDED ABOVE 200 UNITS DURING THE YEAR OF MEMBERSHIP WILL ALSO BE BILLED AT $10/UNIT PRICE*
* *1 SYRINGE OF VOLUMA AND 1 SYRINGE VOLLURE*

**HELLO GORGEOUS ($1279 SAVINGS OFF RETAIL)*** *200 UNITS OF BOTOX*
* *ANY ADDITIONAL BOTOX NEEDED ABOVE 200 UNITS DURING THE YEAR OF MEMBERSHIP WILL ALSO BE BILLED AT $10/UNIT PRICE*
* *2 SYRINGES OF VOLUMA & 1 SYRINGE VOLLURE*
 |
| ***\*Note: If you are paying monthly for a package, you must pay in full for any treatment you receive, and your monthly installment will be adjusted appropriately***  |

**Patient Cosmetic Agreement**

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| --- |
| I, the undersigned (the “Patient”), confirm that I have applied to participate in the Renew Dermatology (the “Practice”) Cosmetic Membership (as defined below) and that I have read, understand, and agree to the attached Renew Dermatology Cosmetic Membership Terms and Conditions which are incorporated by reference into this Patient Cosmetic Agreement. **I understand that, once accepted by Renew Dermatology, this Patient Cosmetic Agreement constitutes my binding agreement to participate in the Renew Dermatology Cosmetic Membership Program (the “Program”) in addition to all rules, guidelines and stipulations set forth herein.**As a condition of my participation in the Program, I certify and agree that:1. I have provided full and accurate information to the Practice regarding my identity, mailing address, contact information and financial payment information and will update the information provided immediately with any changes. I understand that my eligibility for participation in the Program may be affected by the accuracy or inaccuracy of information provided.3. I authorize the Practice to collect Cosmetic **ANNUAL** Membership Fees for myself and all of the Participating Family Members (listed below) as set forth in the Agreement for services I have selected. I understand that I may terminate the Agreement only as provided in Section 10 of the Agreement and that ANY AND ALL FEES FOR SERVICES ALREADY REDEEMED AT THE TIME OF CANCELLATION WILL BE CHARGED TO MY CREDIT CARD ON FILE AT REGULAR **NON-DISCOUNTED** PRICES AND ARE NONREFUNDABLE. I understand that I am responsible for this cosmetic membership and all related fees. Participating Member:  4. I understand that my participation in the Program is subject to the written approval of the Practice, which may be granted or withheld in its sole discretion. The effective date of any such approval (as set forth below) shall be the effective date of my participation in the Program (“Effective Date”).5. I UNDERSTAND THAT PARTICIPATION IN THE COSMETIC MEMBERSHIP PROGRAM IS NOT DEEMED IN ANY WAY TO BE A FORM OF HEALTH INSURANCE AND DOES NOT MEET ANY INDIVIDUAL HEALTH BENEFIT PLAN MANDATE THAT MAY BE REQUIRED BY LAW.6. I UNDERSTAND THAT, WITH RESPECT TO MY PROGRAM PARTICIPATION, I AM NOT ENTITLED TO HEALTH INSURANCE PROTECTIONS FOR CONSUMERS AS PROVIDED BY COLORADO REVISED STATUTES TITLE 10.7. I certify that I have had an opportunity to review all information without pressure or coercion and ask any questions and have received answers from Renew Dermatology staff to my satisfaction. Printed Name of Patient: Signature of Patient or Patient’s Legal Representative: Date of Signature: Printed Name of Patient’s Legal Representative (if applicable): Status of Legal Representative (e.g., parent or legal guardian): Program Application Accepted by Practice: Date of Acceptance into Program:  Program Administrator |

**RENEW DERMATOLOGY COSMETIC MEMBERSHIP PROGRAM**

**TERMS AND CONDITIONS**

**As a condition to participating in the Renew Dermatology Cosmetic Membership Program (the “Program”) offered by Destination Dermatology, LLC doing business as Renew Dermatology (the “Practice”), the Patient agrees as follows:**

**1. The Program is Not an Insurance Policy.**

1. Patient understands that he or she is participating in the Program to receive certain limited cosmetic health services (the “Program Services” as further defined in Paragraph 6 below).
2. The Program is being offered by the Practice and only applies to Program Services provided at the Practice Location at 60 Main Street, Ste F, G & H in Frisco, CO, 80443.
3. **Unless the Agreement is terminated as provided herein, Patient is responsible for paying Annual Membership Fees IN FULL WITHIN 30 DAYS of signature or payment recurrence which covers the agreed to services based on the Membership option for a period of one (1) year**.
4. Patient understands that the Program is not an insurance plan and participation in the Program should not be considered or used as a substitute for an insurance plan.
5. For questions about the Program, the Practice Location, and/or Program Services please contact the Program Administrator: ***Kelly Ballou, 970-409-4000,*** ***info@renewdermatology.com***

**2. Definitions. The following definitions apply to the Agreement:**

1. Participating Family Members shall mean all individual Patients who have applied for participation with a Responsible Family Member (as defined below), who are related to the Responsible Family Member as spouse, parent, or child, and who reside at the same address as the Responsible Family Member.
2. Responsible Family Member shall mean an individual Patient who has agreed to pay and be financially responsible for all Membership Fees, costs, services, and expenses and other amounts due to Practice with respect to all of his or her Participating Family Members.
3. Program Administrator shall mean: Kelly Ballou, 970-409-4000. See email address above.
4. Program shall mean the program offered by the Practice to qualified patients under which, upon payment of an established annual or monthly rate, the Patient receives certain Program Services, subject to all of the Terms and Conditions herein.
5. Practice Location shall mean the following: 60 Main Street, Suites F,G & H, Frisco, Colorado 80443.
6. Practice Providers shall mean the following Providers: **Kelly Ballou, PA-C**, and/or any other qualified licensed providers at this Practice location. This list is subject to change from time to time. For up-to-date information, please contact the Program Administrator listed above.
7. Program Services shall have the meaning described in Paragraph 6 below. Program Services only include Services as listed under Cosmetic Membership options with details of what each plan offers clearly documented.
8. Participation shall mean a Patient’s privileges to participate in the Program subject to the terms and conditions of the Agreement as set forth herein.
9. Participation Fees shall have the meaning set forth in Paragraph 4 below.
10. Patient shall mean an individual who has been accepted for participation in the Program and who continuously satisfies all conditions of Participation as set forth herein (including but not limited to payment of applicable Participation Membership Fees and all other sums due to the Practice).

**3. Participation Restrictions.**

1. Participation in the Program is subject to the Patient, or his/her Responsible Family Member, having paid all Participation Fees and other outstanding amounts due to the Practice on a timely basis as documented throughout this document.
2. Participation is non-transferable.
3. The Participation Application must be approved in writing by the Practice, in its sole discretion, prior to participation in the Program. The effective date of approval shall be the effective date of participation in the Program (the “Effective Date”).
4. Patient agrees to provide full and accurate information to the Practice and will immediately update the information provided if his or her (or a Participating Family Member’s) information changes. Patient understands that eligibility for participation in the Program may be immediately terminated at the Practice’s discretion without notice if the Practice discovers ANY inaccurate or fraudulent information was provided.

**4. Participation Fees.**

1. Participation Fees must be paid:
2. For the FULL Annual Amount on the Date of the First Service and subsequent annual invoices
3. For the FULL Annual Amount Within 30 Days of the Date on This Agreement to qualify for annual discounted prices
4. Monthly recurrent payments must be set up with a valid credit card which has sufficient funds as the signed agreement documents.

***If you are paying monthly for a package, you must pay in full for any treatment you receive, and your monthly installment will be adjusted appropriately***

Patient or his or her Responsible Family Member will be responsible for Participation Fees based on the per Patient fee schedule attached as Exhibit A. This fee schedule is subject to change by Practice at any time after the expiration of one year from the Effective Date provided that Practice shall give Patient at least thirty (30) days’ notice of any such change.

b. Patient is solely responsible for payment of all Services that are in addition to the Included Services for the Membership option chosen at the time services are rendered. Additional Services may or may not be discounted, please inquire with your provider for this information which will be documented by a Renew Dermatology staff member once the provider quotes the price for any additional services outside of those included in your Membership Plan.

d. Practice reserves the right to discontinue services at any time if Participation Fees are not paid when due.

e. **Participation Fees are not refundable except when Program participation is terminated in accordance with Section 10(a)(i), Section 10(a)(ii), or Section 10(b)(iii), (v) or (vii) in which case Participation Fees applicable to periods after the effective date of the termination will be refunded to Patient only as this document allows.**

f. Any Patient who is a Responsible Family Member shall assume all of the financial responsibilities of his or her Participating Family Members with respect to the Program and shall pay Practice all Participation Fees and other sums due with respect to each of his or her Participating Family Members in accordance with the terms and conditions of this Agreement.

**Patients may incur and are responsible for the payment of the following additional charges:**

o While we understand there may be times when you miss an appointment due to emergencies, Renew Dermatology requires a 24-hour notice on all cancelled appointments to be valid without any penalty and missed appointments without any notification are considered “No-shows.” A verbal warning will be given after the first and second time either of these violations happen, then you will be required to confirm a valid credit card is on file with our office before any further appointments are made and that credit card WILL be charged a ***$100.00 non-refundable fee per violation*** that will be applied towards all further No-show or less than 24-hour cancellation notice before appointments after the second offense. Documentation of emergencies may be requested to avoid this fee. **Refusal to pay this fee may result in cancellation of all future visits or services in our office at Renew Dermatology’s discretion**.

o Any invoice unpaid 30 days from the date of service can incur an additional 18% per year or 1.5% per month “Late Fee”.

o Invoices over 30 days old may be turned over to collections and you will be subject to any and all additional fees related to this penalty as charged by the collections agency and Renew Dermatology. Thank you for your prompt attention to this matter.

**5. Payment Terms.**

 ***\*\* If patient chooses to pay monthly, the credit card provided will be debited on the 20th of each month until paid in full. Payments must be paid in full for the entire year if the annual payment option is selected.***

a. Patient understands that his or her Participation Fees must be paid IN FULL either on the date this Agreement is signed OR within 30 days of the date in which this Agreement is signed if the annual payment plan is selected. If monthly option is selected, patient understands when payment is due as documented throughout this agreement.

b. Patient understands and agrees that any counterfeit cash, debit or credit transactions or other forms of payment which are not honored by Patient’s or Program’s bank or other financial institutions due to insufficient funds or for any other reason, will result in an **additional fee of $50 per transaction.** and this amount will automatically be charged for each agreed to payment that is missed (i.e., monthly, annually).

d. If the Patient does not pay any Participation Fees by the Due Dates listed above for any reason, the “Late Fees” will accrue accordingly until all payments are brought current and the Practice reserves the right to terminate Patient and/or all Family Members Services in this Agreement due to nonpayment. The Late Fees are in addition to the Participation Fees due from the Patient. The amount of the Late Fees is subject to change by the Practice at any time.

e. Patient agrees to pay all costs and fees, including attorneys’ fees and collection fees, in the event that the Practice is required to bring legal action to obtain payment of Participation Fees.

g. Patient understands and agrees that failure to comply with payment terms may result in termination of participation in the Program.

h. **Patient understands and agrees that services will not be rendered for patients with any past due accounts.**

i. PATIENT AND THE PRACTICE ACKNOWLEDGE AND AGREE THAT (I) SOME OF THE PROGRAM SERVICES MAY BE A COVERED BENEFIT OR PROGRAM SERVICES UNDER PATIENT’S HEALTH BENEFIT PLAN (AS DEFINED IN COLORADO REVISED STATUTES, TITLE 10) AT NO COST TO THE PATIENT; AND (II) THE PRACTICE SHALL NOT SUBMIT A FEE-FOR-SERVICE CLAIM FOR PAYMENT FOR THE PROGRAM SERVICES TO ANY HEALTH PLAN, HEALTH INSURANCE PROVIDER, OR HEALTH INSURANCE ISSUER.

**6. Program Services Included in Participation.**

1. A summary of Program Services is provided in Exhibit B. Patients should check the Practice’s website at www.renewdermatology.com for an up-to-date list of Program Services including the scope of office visits included in Program Services. Changes or reductions in the Program Services available at the Practice may be made in the sole discretion of the Practice.
2. The availability of Program Services is subject to clinical guidelines, federal and state regulations, as well as scheduling and staffing limitations. Appointments for Program Services may or may not be available on a same day basis, depending on scheduling availability.
3. Program Services available under the Program include only a defined set of healthcare services provided by the Practice in the normal course of business. Program Services do not include any of other items or services other than those listed under the Cosmetic Membership Plan chosen
4. For additional information about Covered Services, please contact the Program Administrator.

**7. Excluded Services.** This list is summary in nature, may not be all-inclusive, and is subject to modification by Practice at any time. Excluded Services also include the following:

1. Services that the Practice does not customarily provide at the time Patient seeks care.
2. Services provided by any health care provider who is not a Practice Provider as defined above.
3. Emergency medical care and services required for the diagnosis or treatment of life threatening events; services or treatment at any facility that is not a Practice facility; diagnostic studies such as outside labs, pathology, and imaging; outpatient pharmacy; any care that a Practice Provider believes is not medically, cosmetically, or surgically necessary or appropriate; any medical care that a Practice Provider believes should, in the best interest of the Patient, be provided by another facility or provider; or any services for which the patient has coverage under Medicare, Medicaid, or any government health care program;
4. Excluded Services are any services or items not specifically listed as being part of the individual Cosmetic Membership options chosen by the Patient and that the Patient has agreed to pay for in this Agreement. See more details of services included in each Cosmetic Membership option at the beginning of this Agreement.
5. For additional information or questions about Excluded Services, please contact the Program Administrator.

**8. Payment for Excluded Services.** Any Excluded Services or services that are requested in addition to what is listed in the specific Cosmetic Membership option chosen by Patient will be charged and due **ON THE DAY SERVICE IS RECEIVED** at Practice’s applicable fee schedule rates and shall be subject to all of Practice’s financial responsibility and payment policies. Patient shall be solely responsible for paying practice for all services and charges shown on the superbill. Furthermore, Practice does not guarantee that any Excluded Services which are provided or documented on a superbill will be reimbursable by Patient’s health insurance policy.

**9. Utilization of Services.**

a. In certain situations, Patients may require medical attention including but not limited to pharmaceutical prescriptions, routine or emergency treatment by a specialist or any health care provider who is not a Practice Provider as defined above, treatment by a hospital, or treatment that is not a Covered Service. These services are Excluded Services (as further defined above) and are NOT covered by the Program. The costs of any Excluded Services are the sole responsibility of the Patient/responsible family member.

1. The Practice reserves the right, in its sole discretion, to cancel the Patient’s participation in the Program for ANY and ALL reasons with or without cause, including but not limited to the following: inappropriate use of services, unprofessional or disrespectful behavior towards provider or staff, inability to be on time for services or keep appointments made or requests for services that are not Program Services.
2. The Practice provider(s) will determine the appropriateness of Patient’s visit or request for services and their decision is FINAL. The Practice provider(s) reserve the right to dismiss patient from the practice for **any reason.**

**10. Termination of Participation.**

a. Patient’s participation in the Program may be terminated by Patient as follows:

1. Patient may cancel participation in the Program within thirty days of the Effective Date (as defined in Paragraph 3.c). **Written notice of cancellation must be provided by certified mail addressed to the Administrator at address documented below in Section 20 and such notice must be received within thirty (30) days of the Effective Date.**  All fees that have been prepaid by Patient for months after the cancellation will be refunded to the Patient and all services already provided to Patient will be charged at current NON-DISCOUNTED rates.
2. Patient may cancel participation in the Program after Patient has participated in the Program for a minimum of one (1) year provided that Patient gives prior written notice of termination to Practice at least thirty days before the recurring fee is due. The effective date of the termination shall be the first day of the calendar month following the expiration of the thirty (30) day notice given by Patient.
3. Patient may cancel participation in the Program at any other time after 30 days from the Effective Date by payment of the following cancellation fee: **sixty-five percent (65%) of remaining balance**.
4. The Practice reserves the right to not offer Membership discounted prices of ANY KIND at any time in the future if you are in violation of any membership in our office.

b. Patient’s Participation in the Program may be terminated by Practice and subject to being turned over to a collection agency upon the occurrence of any of the following:

1. Patient fails to make payment of any Participation Fees by the applicable Due Date, fails to pay for additional services at time services are rendered, or otherwise fails to comply with his or her financial obligations as set forth in this Agreement.
2. Practice decides to cancel Patient’s Participation in the Program for any reason including, but not limited to, inappropriate behavior towards any other patients or staff members, repetitive late cancellations, or not showing up for appointments, etc. provided that Practice gives at least thirty days prior written notice of termination to Patient. The effective date of the termination shall be the first day of the calendar month following the expiration of the thirty (30) day notice given by Practice.
3. Practice discontinues the Program or dismisses the patient from the practice in its sole discretion.
4. Patient provides any false personal, financial, or other material information to Practice.
5. Practice determines, in its sole discretion, that there has been a change in applicable law or the interpretation or enforcement of applicable law that may substantially affect the operation of the Program.

c. If Practice terminates Patient’s participation in the Program in accordance with the terms of this Section 10, Practice shall cooperate with the Patient for the transition of care to any other facility the patient chooses.

1. Upon termination of Patient’s participation in the Program, Patient will be assessed and shall pay Practice’s full non-discounted fee schedule charges for any services provided to Patient after the effective date of termination. Additionally, if Practice terminates Patient’s participation for a reason set forth in Section 10.b.(i) above, Patient will be assessed and shall pay Practice’s full fee schedule charges for any services provided to Patient in the one (1) month prior to termination in addition to being subject to an additional fee of **sixty-five percent (65%) of remaining balance** AND any and all fees associated with collection costs if this is needed for Practice to collect amount owed.

**11. Changes in Personal Information.** Patient must inform the Practice immediately of all changes to personal, contact, financial, billing, and other account information.

**12. Entire Agreement.** The Patient Application and Information, Patient Certification, and Terms and Conditions together constitute the entire agreement (the “Agreement”) between the parties relating to the specific subject matter hereof. There are no terms, obligations, covenants, representatives, statements, or conditions other than those contained herein. No variation or modifications of the Agreement will be deemed valid unless in writing and signed by both parties.

**13. No Waiver.** A written waiver, signed by an authorized representative of the Practice, shall be required to waive any provision, requirement or obligation established by the Agreement between the Parties. The delay or failure of the Practice to require the strict performance of any of the terms or conditions of the Agreement between the Parties shall not be deemed a waiver of any breach or default in the terms or provisions herein. Additionally, a valid written waiver of any breach of the Agreement shall not establish a waiver of any subsequent or different breach of the Agreement.

**14 Assignment.** This Agreement may not be assigned or transferred by the Patient.

**15. Force Majeure.** The Practice is not liable for any delay or failure of performance caused by strikes, insurrection, war, fire, acts of God, natural disasters, electrical failure, black-outs, disruption of transmission lines, government acts or regulations, acts of third parties, pandemics, local or global illnesses, or any cause not within the control of the Practice.

**16. Governing Law/Construction.** The validity, construction, and interpretation of the Agreement and the rights and duties of the parties hereto will be governed by the laws of Colorado without regard to choice of law principles. The captions, headings, and paragraph titles in the Agreement are provided for convenience only and shall not be used to interpret, limit, or define the provisions hereof.

**17. Venue.** The exclusive venue for any legal dispute arising out of, or related to this Agreement, will be Summit County, Colorado.

**18. Unenforceable Terms.** If any provision of the Agreement is held invalid, illegal, or unenforceable by a court of competent jurisdiction, the Agreement will be interpreted as if such provision, to the extent the same has been held invalid, illegal, or unenforceable, had never been contained herein.

**19. Successors.** The Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, successors, or executors.

**20. Notices.** Any notice required or allowed to be given by the Agreement shall be addressed to the other party at the address set forth immediately below or to such other address as either party may instruct the other party in writing in accordance with this Section.

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| **Renew Dermatology:*****c/o Kelly Ballou, Program Administrator******265 Dillon Ridge Rd, Suite C402-163******Dillon, CO 80435*** | **Patient:***See address provided in Patient Application Information. Patient is responsible for updating information if any changes occur.*  |

**22.** **Arbitration**. Any dispute arising out of, or in connection with, this Agreement or Patient’s participation in the Program shall be resolved by arbitration before one arbitrator selected by the mutual agreement of Patient and the Practice. If Patient and the Practice cannot agree to an arbitrator, the matter shall be submitted to the Summit County District Court in accordance with the Colorado Uniform Arbitration Act. The court shall then select an arbitrator and the arbitration shall be conducted generally in accordance with the then-prevailing appropriate rules of the American Arbitration Association. The award rendered by the arbitrator shall be final and binding. It may be filed with the court of any competent jurisdiction in accordance with applicable law; the court may enter a judgment on this award and that judgment will be enforced as the judgment of the court. Patient acknowledges and agrees they are responsible for all of the practice’s fees, court fees, mediation fees, and any additional fees relating to the resolution of the dispute.

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Patient name (please print) Patient Signature Date\_\_\_\_\_\_\_\_

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Kelly Ballou, Renew Dermatology Managing Member­­­­­­­­­­­­­­­­ Date

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**EXHIBIT A**

**RENEW DERMATOLOGY**

 **COSMETIC MEMBERSHIP PROGRAM**

**PAYMENT OPTIONS**

**Personal Investments Must Be Made By One Of The Following Options**:

1. Annual Investment must be PAID IN FULL on the date this Agreement is signed to qualify for substantial discounts in the Cosmetic Membership Programs. \_\_\_\_\_ INITIAL

OR

1. Annual Investment must be PAID IN FULL WITHIN 30 DAYS from the date on this Agreement, otherwise Patient will be Required to pay full, non-discounted rates for the services they have already received and will be billed monthly for late fees as documented in Agreement above. All stipulations and manners of recourse outlined in Section 10 of this Agreement will apply.

\_\_\_\_\_ INITIAL

OR

1. Monthly recurring fee for **1 year** with all additional late fees as documented in this Agreement to apply if credit card information given is declined for payment. \_\_\_\_\_ INITIAL

Patient Signature Kelly Ballou, Renew Dermatology Managing Member

Patient Name (Please Print) Date

**Exhibit B: RENEW DERMATOLOGY Cosmetic Membership Program Services**

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| ***COSMETIC MEMBERSHIP OPTIONS:**** *ALL MEMBERSHIPS INCLUDE**4 TREATMENT VISITS PER YEAR with 4 Follow-up visits (no longer than 10 minutes for follow-up visits)*

**\*\*\*Note: Annual Fees for Membership package must be PAID IN FULL within 30 DAYS to receive these discounts, NO EXCEPTIONS\*\*\*\*****I LOVE BOTOX ($10/UNIT): ($701 SAVINGS OFF RETAIL)*** *200 UNITS OF BOTOX TO USE OVER 1 YEAR*
* *ANY ADDITIONAL BOTOX NEEDED ABOVE 200 UNITS DURING THE YEAR OF MEMBERSHIP WILL ALSO BE BILLED AT $10/UNIT PRICE*

**I AM RENEWED ($1013 SAVINGS OFF RETAIL)*** *200 UNITS OF BOTOX*
* *ANY ADDITIONAL BOTOX NEEDED ABOVE 200 UNITS DURING THE YEAR OF MEMBERSHIP WILL ALSO BE BILLED AT $10/UNIT PRICE*
* *1 SYRINGE OF VOLUMA AND 1 SYRINGE VOLLURE*

**HELLO GORGEOUS ($1279 SAVINGS OFF RETAIL)*** *200 UNITS OF BOTOX*
* *ANY ADDITIONAL BOTOX NEEDED ABOVE 200 UNITS DURING THE YEAR OF MEMBERSHIP WILL ALSO BE BILLED AT $10/UNIT PRICE*
* *2 SYRINGES OF VOLUMA & 1 SYRINGE VOLLURE*
 |
| ***\*Note: If you are paying monthly for a package, you must pay in full for any treatment you receive, and your monthly installment will be adjusted appropriately***  |

**EXHIBIT C**

**RENEW DERMATOLOGY**

**COSMETIC MEMBERSHIP PROGRAM**

**EXCLUDED SERVICES**

“Excluded Services” are, in general, all services NOT listed in the above Exhibit B titled “RENEW DERMATOLOGY COSMETIC MEMBERSHIP PROGRAM SERVICES.” Such “Excluded Services” include but are not limited to the following:

* Any services either requested by the patient or recommended by any Renew Dermatology providers that require either routine or emergency care outside of our office
* ANY removal of filler using hyaluronidase, whether the filler was placed at Renew Dermatology or another office
* Any Cosmetic visits over 4 treatment visits per year. These will be charged according to time needed on the Membership Fee Schedule.

*\*\*\*\*\*PLEASE SEE THE ATTACHED FEE SCHEDULE FOR EXCLUDED SERVICES FOR MEMBERSHIP PATIENTS (BASED ON TIME AND ROUNDED UP TO CLOSEST TIME ALLOTMENT)*

4845-3198-1130, v. 1

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| --- | --- | --- |
| **CASH PAY** |  | **MEMBERSHIP** |
|   | **SIMPLE** | **MINOR** | **ADVANCED** |  |   | **SIMPLE** | **MINOR** | **ADVANCED** |
| **TIME** | **SERVICES** | **PROCEDURES** | **PROCEDURES** |  | **TIME** | **SERVICES** | **PROCEDURES** | **PROCEDURES** |
| 10 min | $80.00 | $110.00 | $150.00 |  | 10 min | $68.00 | $93.50 | $127.50 |
| 15 min | $100.00 | $135.00 | $175.00 |  | 15 min | $85.00 | $114.75 | $148.75 |
| 20 min | $130.00 | $155.00 | $210.00 |  | 20 min | $110.50 | $131.75 | $178.50 |
| 25 min | $165.00 | $195.00 | $240.00 |  | 25 min | $140.25 | $165.75 | $204.00 |
| 30 min | $195.00 | $225.00 | $275.00 |  | 30 min | $156.00 | $180.00 | $220.00 |
| 35 min | $230.00 | $255.00 | $310.00 |  | 35 min | $184.00 | $204.00 | $248.00 |
| 40 min | $255.00 | $290.00 | $335.00 |  | 40 min | $204.00 | $232.00 | $268.00 |
| 45 min | $290.00 | $330.00 | $385.00 |  | 45 min | $232.00 | $264.00 | $308.00 |
| 50 min | $335.00 | $365.00 | $420.00 |  | 50 min | $268.00 | $292.00 | $336.00 |
| 55 min | $370.00 | $400.00 | $455.00 |  | 55 min | $296.00 | $320.00 | $364.00 |
| 60 min | $410.00 | $445.00 | $505.00 |  | 60 min | $328.00 | $356.00 | $404.00 |
| 65 min | $445.00 | $485.00 | $545.00 |  | 65 min | $356.00 | $388.00 | $436.00 |
| 70 min | $490.00 | $525.00 | $595.00 |  | 70 min | $392.00 | $420.00 | $476.00 |
| 75 min | $540.00 | $575.00 | $645.00 |  | 75 min | $432.00 | $460.00 | $516.00 |
| 80 min | $590.00 | $615.00 | $685.00 |  | 80 min | $472.00 | $492.00 | $548.00 |
|  |  |  |  |  |  |  |  |  |
| **SET FEES** |  |  |  | **SET FEES** |  |  |
| Moh's Surgery | $2,000.00  |  |  |  | Moh's Surgery | $1,750.00  |  |  |
| 2 Layers or less |  |  |  | 2 Layers or less |  |  |
|  |  |  |  |  |  |  |  |  |
| Moh's Surgery | $2,750.00  |  |  |  | Moh's Surgery | $2,250.00  |  |  |
| 3 Layers or More |  |  |  | 3 Layers or More |  |  |