LifeScape
Medical Associates, PC

Consent to Annual Fee

LifeScape Medical Associates is committed to the highest level of medical care and innovative, patient-centered services. In order to meet this standard and cover the cost of a growing multitude of non-covered and excluded administrative expenses, LifeScape charges an annual fee of $20 per patient age five through twenty-three and $50 per patient age twenty-four and above. This fee is due at the time care is established and annually thereafter until LifeScape is notified in writing that care has been discontinued. Failure to provide payment when due may result in termination of care. Patients unable to pay due to financial hardship may contact LifeScape staff to discuss other options.

LifeScape's administrative fee allows it to provide services not covered by insurance without levying multiple charges. Depending on your health plan, non-covered or excluded services may include, but are not necessarily limited to:

- Completion of many standard documents including Family Medical Leave Act and Return to Work forms, immunization records and school, camp and sport medical forms, pharmacy forms including change requests and special authorizations
- Medical record duplication and mailing other than as required by law
- Appointment reminders
- Internet-based appointment and prescription refill requests, health maintenance and immunization schedules, practice forms, and account statements

For your convenience, LifeScape also offers these services at no additional charge:

- Near same-day appointments with the first available provider
- Extended hours and lunch hour care
- Direct, after-hours telephone access to a LifeScape physician

We hope that you will find our annual fee convenient and preferable to the periodic charges that otherwise would be necessary. Your feedback is extremely important to us. Please contact us if you need further information or have suggestions for improvement.

Receipt acknowledged and annual fee agreed to by:

______________________________	______________________
Signature of the Patient or the Patient's Legal Representative	Date
______________________________	______________________
Print Name	If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

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