

The Diamond Headache Clinic, Ltd. ("Clinic") provides patients a unique approach to the care and treatment of headache sufferers that is not typical within a traditional physician's practice.

What makes our practice unique is that we offer continuity of care to our headache patients. Our physicians accept accountability for continuous quality improvement and we advocate for our patients to support the attainment of optimal outcomes. To this end, we have invested in a n electronic health system with an electronic medical record to facilitate the management of our patients and are using this system to help improve our care to patients.

We have developed the Advanced Personalized Program ("Program") as our comprehensive approach to the treatment of headaches. The Program includes a very high degree of patient care coordination, communication and enhanced access to your multidisciplinary team at the Diamond Headache Clinic. We have found this approach to be beneficial to our patients.

Depending on your needs, the following elements of care/approach may be included and provided during your care:

- Enhanced access, ongoing support, oversight, coordination and guidance by a physician-led healthcare team;
 - Integrated coherent planning for ongoing medical care, including communication and coordination with other healthcare professionals furnishing care;
 - Organized and trained staff to facilitate the coordination of care across patients healthcare needs;
 - Telephonic discussion/review of approaches to treatment
- Training and interaction with our nursing staff on medication management and education;
- With your approval, participation of family members and friends throughout your treatment;
- Multidisciplinary provider conferences regarding your care;
- Urgent headache intervention - discussion and medication changes with the physician or nurse triage.

Although all of the above elements may be available for your care and treatment, your physician, with input from you, may determine that some of the elements will not be used.

The fee for the Advanced Personalized Program is \$250 per year for outpatients services. Thereafter, the Clinic may upon thirty (30) days notice to you revise the annual fee. After the initial 12-month period, upon thirty (30) days notice to you,

the Clinic may provide additional or eliminate some of the Program elements.

The Program will commence upon your acknowledgement below and upon receipt of payment. The Clinic may terminate the Program or your participation for any reason upon thirty (30) days notice to you.

You have the option of sending the Clinic communications and receiving responses from the Clinic and/or its employee's agents and representatives. These communications will be noted in and become a part of your medical record. You should be aware that e-mail communication is not appropriate for time-sensitive or urgent contact of the Clinic. Such time-sensitive or urgent communications should be conducted by telephone or in person with the Clinic. You also should be aware that e-mail is not a secure medium for receiving or sending personal health information and, although the Clinic will take reasonable steps to preserve the confidentiality of such information, the confidentiality of such communications cannot be ensured or guaranteed.

The Program fee covers only the Program elements described above. The Program fee does not replace any insurance benefits you may have and any deductibles, co-pays and coinsurance that you are financially responsible for paying. The Clinic will bill you and/or your insurer for all non-Program services provided by the Clinic.

Any notices regarding the Program shall be in writing and shall be sent via facsimile or certified mail, return receipt requested, to the addresses of the parties.

I have read this document in its entirety, and understand the contents of this document. I have had the opportunity ask questions regarding the Clinic's Advanced Personalized Program and my questions have been satisfactorily answered. By signing the acknowledgement below, and payment of the Program fee, I request that I be allowed to participate in the Program.

Dated:

Print Name of Patient:

Signature of Patient: