

**William J. Tsai, M.D., Inc. (“WJT”)**

**POLICY – Legal Contract**

**Patient Acknowledgment and Conditions of Participation in the Comprehensive Administrative Plan (“CAP”) Membership**

WJT has established a membership program, CAP, to enable patients to obtain full access, valued based, administrative/patient convenience items as listed in The Comprehensive Administrative Plan (CAP) Benefits and Services for a reasonable \$500.00 per patient annual fee (paid over two installments).

**PATIENT ACKNOWLEDGEMENTS AND CONDITIONS OF PARTICIPATION**

Patient acknowledges and understands that Benefits and Services are unique and provided with certain specific limitations and conditions, as follows:

1. **Benefits and Services** are not covered and otherwise not reimbursable under any private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, PPOs, in which Patient is enrolled. Accordingly, Patient understands and acknowledges that **Benefits and Services** convey value and benefits that Patient does not already receive under any private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, PPOs, in which Patient is enrolled. To the extent any one or more **Benefits and Services** are considered covered and reimbursable benefits, the annual fee is consideration for the remaining items of **Benefits and Services**.
2. The list of **Benefits and Services** shall be automatically modified to the extent necessary to reflect and change in interpretation or terms of coverage and benefits of any private health insurance policy, private health plan or government program, including, but not limited to Medicare, PPOs, in which Patient is enrolled.
3. For **Benefits and Services** provided herein, Patient and/or WJT cannot, and will not, bill or seek reimbursement from any private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, PPOs, in which Patient is enrolled.
4. WJT may also provide service(s) to Patient that are covered or reimbursable from a private health insurance policy, private health plan, or government program, including, but not limited to, Medicare, PPOs, in which Patient is enrolled. In such case, WJT may bill (whether on behalf of Patient or WJT) and seek reimbursement from Patient’s private health insurance policy, private health plan, and/or Medicare, PPOs under the terms and conditions of Patient’s

enrollment agreement with such payer(s). WJT may also seek reimbursement from Patient as permitted under Patient's enrollment agreement with such payer(s) (ie copayment, deductible, coinsurance). Patient understands and acknowledges that any covered and reimbursable services are separate and distinct from and independent of the **Benefits and Services** provided hereunder.

5. Patient understands and acknowledges that existing office policy/protocol of charging and collecting medical form fees (ie RX prior auths, DMV parking, jury duty, medical letters, EDD disability/unemployment) are separate and distinct from and independent of the **Benefits and Services** provided hereunder.
6. Patient agrees that WJT's liability to any Patient for noncompliance with any aspect of this Policy or the CAP shall be limited to the amount of the most recent annual fee actually paid by Patient.
7. WJT reserves the right to modify this Policy or the Program at any time as may be required by law and also with respect to subsequent annual periods to which this Policy may apply, provided that Patient shall be informed of any such modification in connection with Patient's payment of the fee applicable to the annual period at issue.
8. WJT may terminate this Policy or the CAP as necessary in its sole discretion at any time, in which event WJT will return a prorated portion of the annual fee to Patient.
9. Priority access for appointments does not obviate that patient-related medical emergencies will always be prioritized by WJT as medically appropriate and might temporarily impair immediate availability.
10. This Policy, along with other WJT Office Policies, as they may be modified from time to time, contains the entire understanding between the Patient and WJT regarding the subject matter hereof, and supersedes any and all prior oral and written agreements, practices and understandings between the parties in this regard. No oral modifications, expressed or implied, may alter the terms of this Policy. Any representations contrary to this Policy are disclaimed.

**ATTESTATION:**

I, the undersigned, have been fully apprised of all circumstances surrounding WJT CAP Membership program and hereby agree to participate. I am aware and accept that the annual fee of \$500.00 is not billable to my insurance company(ies) and I agree to not seek re-imbusement from my insurance(s) for this expense.

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Patient Signature:

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Date:

## **The Comprehensive Administrative Plan (CAP)**

### **Membership Benefits and Services**

1. Participants will receive priority scheduling with Dr. Tsai or, if he is out of town, with one of his associates. Medical necessity based -- same week or next week appointments.
2. 24/7 all access to Dr. Tsai. Office hours thru live Front Desk personnel. After hours, via automated paging service.
3. Per participant's request, Dr. Tsai will discuss test and lab results by telephone. Alternate methods of correspondence may include regular USPS mail, facsimile and/or E-mail.
4. Referrals to highly recommended Specialists from Dr. Tsai's personal rolodex.
5. Dr. Tsai is Active Staff at HOAG Hospital (with full privileges and access to your medical records).
6. Participants may have their medical records copied at no additional charge.

**CAP Membership Program**

**Pay Option 1: Do it Yourself!**



Join today! Pay with our convenient QR code.  
Square subscription: Credit card auto renews \$250.00 every six(6) months.  
You may cancel at any time.

**Pay Option 2: We set-up for you!**

Please complete all fields. You may cancel this authorization at any time by contacting  
Office Manager MeiLin Wang. This authorization will remain in effect until canceled.

<b>Credit Card Authorization Form:</b>			
Card Type:	<input type="checkbox"/> Visa	<input type="checkbox"/> MC	<input type="checkbox"/> Discover <input type="checkbox"/> AMEX
(Sorry we do NOT accept any checks!)			
Cardholder Name (as shown on card): _____			
Card Number: _____			
Exp Date (mm/yy): _____		CVV: _____	Zip Code: _____

Patient's Date of Birth:

I, \_\_\_\_\_, **authorize William J. Tsai, M.D. Inc.**  
to charge my credit card denoted above for agreed upon purchases. I understand that my  
information will be saved to file for future transactions on my account.

[Information stored securely in accordance with PCI-DSS and data privacy requirements]

\_\_\_\_\_  
Patient Signature:

\_\_\_\_\_  
Date: