R Family Medical Group
Here To Serve Your Family

Direct Primary Care (DPC) Membership Agreement

PATIENT INFORMATION (Please Print) **TODAY'S DATE: _____**

First Name: _____ Last Name: _____ MI: _____

Preferred Name (If Applicable): _____ Date of Birth: _____ SSN: _____

Address 1: _____ Address 2: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Description of Services

Your monthly Direct Primary Care (DPC) Membership Fee entitles you to unlimited covered office visits. Comprehensive Primary Care Services provided in your membership include the following:

- Annual physical exam-including well-woman exam (Thin prep pap smear is not included and subject to lab pricing)
- Office visits for acute illness or chronic disease management
- Routine tests and labs performed in office
- Electrocardiogram (EKG)
- Colon Cancer Screening (IFOBT) with annual exam
- All office visits provided by a physician, physician assistant or nurse practitioner
- **The following procedures are NOT covered under DPC and are therefore subject to additional charges:**
  - **Botox**
  - **BioTe**
  - **IV Nutrition Therapy**
  - **In-House Surgical Procedures**
  - **Weight Loss injections**
  - **Testosterone Programs**
  - **Vitamin Injection Therapy**
  - **Flu Vaccine**

The DPC model is directly paid by the patient for both access and primary medical care. **R Family Medical Group does not accept or bill third party payers**.

You cannot pay the DPC monthly fee with your Health Savings Account (HSA), Flexible Spending Account (FSA), and/or Health Reimbursement Account (HRA). Following your visit, a receipt will be given to you with a date of service, a diagnosis, and with the standard office charge posted. You may submit this receipt to your HSA for reimbursement.

Due to regulatory restrictions, the DPC model is not available to patients who are eligible for or enrolled in Medicare, Medicaid, or other government healthcare programs.

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Fee Agreement

(Please initial below)

1. _____ I acknowledge and understand that monthly fees are due on the 1st of every month.

2. _____ I acknowledge and understand that I am required to provide a credit card (to be kept on file) to participate in the DPC Membership or pay for the annual membership in full.

3. _____ I acknowledge and understand that my DPC Membership Fee will not be pro-rated.

4. _____ I acknowledge and understand that the DPC Membership Fee is automatically charged, and it is my responsibility to notify R Family Medical Group of any changes with my credit card information.

5. _____ I acknowledge and understand that fees incurred outside of my DPC Membership Fee are due at the time of service.

6. _____ I acknowledge and agree to pay the monthly fee on the 1st of every month. I acknowledge that my membership may be terminated for non-payment.

7. _____ I acknowledge and understand that **a MINIMUM of 3 months of fees is due upon registration,** equal to $240, with the Direct Primary Care Membership Agreement and this payment is non-refundable.

8. _____ I acknowledge and understand that R Family Medical Group may add or discontinue included services without notice.

9. _____ I acknowledge and understand that R Family Medical Group may change my monthly fee at any time (but no more than once per calendar year), and that I will be given at least sixty-day notice of such fee schedule changes.

10. _____ **I acknowledge and understand that I am responsible for any charges incurred for health care services outside of R Family Medical Group including but not limited to emergency room, urgent care, hospital and specialty services, imaging, labs, and pharmaceuticals.**

11. _____ I acknowledge and understand that R Family Medical Group will **NOT** be required to reimburse me for any charges that I may incur for any care outside of the R Family Medical Group clinic.

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Insurance Disclosure
(Please initial below)

- _____ I acknowledge and understand that this Agreement **DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE NOR IS IT A CONTRACT OF INSURANCE** and that it provides only the health care services specifically described within this Agreement.

- **_____ I acknowledge and understand that this Agreement does not substitute for health insurance**. I understand that R Family Medical Group will not bill insurance carriers, Medicaid, Medicare, or Medicare advantage health plans for any service provided by R Family Medical Group.

- _____ I acknowledge and understand that R Family Medical Group does not guarantee reimbursement for any R Family Medical Group service or fees from any third-party health plans, including insurance plans and savings accounts (health savings or flexible spending).

- _____ I confirm that I the patient/member am **NOT** a Medicare beneficiary, and I am **NOT** currently enrolled in a Medicare, Medicaid, or any other government plan.

Cancellation Policy
(Please initial below)

- _____ I acknowledge and understand that either R Family Medical Group may cancel this Agreement at any time and for any reason, without condition.

- _____ I understand that R Family Medical Group will **NOT** terminate this Agreement solely based on my health status.

- _____ I acknowledge and understand that I must provide written 30-day notice of cancellation and that fees will continue to be auto-charged until R Family Medical Group receives such notification.

- _____ I acknowledge and understand that R Family Medical Group may terminate this Patient Agreement for cause due to non-payment of fees.

- _____ I acknowledge and understand that a re-enrollment fee of $240.00 will be assessed to join as a Patient after cancellation of this Agreement, either by Patient's choice or due to non-payment. Re-enrollment is dependent upon availability within the program.

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HIPAA, Privacy and Communications

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its subsequent regulations and Texas privacy laws.

- _____ I have certain rights to privacy regarding my protected health information ("PHI").
- _____ I have reviewed R Family Medical Group's Notice of Privacy Practices and understand my rights contained in the notice and acknowledge that it is available by request.
- _____ I acknowledge and understand that R Family Medical Group must maintain a record of my health information and must protect the privacy of my health information as per the terms of the Notice of Privacy Practices.
- _____ I provide R Family Medical Group with my authorization and consent to use and disclose my PHI for the purposes described in the Notice of Privacy Practices.
- _____ I understand that any and all methods of correspondence may be added by R Family Medical Group to the Patient's documented medical record.
- _____ I understand that R Family Medical Group requires and encourages the use of the patient portal or encrypted email as a secure method of communication. **R Family Medical Group will not and does not communicate via unencrypted email, facsimile, text message, picture messaging, social media, and online video conferencing because these are not secure methods of communication**. R Family Medical Group makes every effort to comply with applicable federal and state privacy rules and regulations.
- _____ I understand and agree that electronic communication is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. In the event of an emergency, or a situation in which the Patient could reasonably expect to develop into an emergency, the Patient shall call 911 and follow the directions of emergency personnel.

Created 4/4/2018/mcg
Revised: 4/13/2018 mcg, 7/13/18/mcg, 9/25/2018/mcg, 7/13/2019/mcg, 11/05/2019/mcg, 12/22/2021 mcg

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Direct Primary Care Membership Approval and Billing Agreement

Memberships Requested (Indicate the number of each level needed)

Memberships	Category	Annual Cost	Monthly Cost
_____	Adult Patient	$960	$80
_____	Child (Age 5 - 17) (Individual)	$360	$30

By signing below, I hereby authorize R Family Medical Group to initiate charges to my credit or debit card for my **initial fee of $240, or three months of membership**, and authorize periodic payments of my DPC fee and any additional fees that I incur since my last billing date. I understand that my participation in DPC is continuous, and charges will continue until my membership contract concludes, or I formally terminate my membership.

Following the initial $240 fee, I hereby elect the following payment terms (Please initial choice):

1. ____ I elect to pay my DPC Membership Fee **IN FULL** in the amount of **$960**.
2. ____ I elect to pay my DPC Membership Fee in **MONTHLY** installments in the amount of **$80**.
3. ____ I elect to pay my DPC Membership Fee in **QUARTERLY** installments in the amount of **$240**.

Patient Card Information and Agreement

Please circle: MasterCard VISA Discover American Express Care Credit

Name on Card: _____

Credit Card #: _____ **Expiration:** _____/_____ **CVV:** _____

_____ **Date:** _____/_____/_____
Patient (Contract) Signature

_____
Patient (Contract) Printed Name

_____ **Date:** _____/_____/_____
Credit Card Holder Signature

_____
Credit Card Holder Printed Name

_____ **Date:** _____/_____/_____
Employee Signature