

**P Agreement between Primary Care Physician and Patients for
Monthly Payment Plans**

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Patient Association Membership Application

Applicant's Name Last	First	MI	Age	Birthdate (MM/DD/YY)
Residence Address	City	State	Zip	
Mailing or Billing Address (if Different than Residence)				
Social Security Number	Gender: ____ Male ____ Female	Home Phone	Work Phone	
E-mail address:			County	

Select One Type of Membership: Individual Two-Party Family

Select Membership Benefits:	Annually	Mo.BD
____ PRIMARY CARE PROVIDER MONTHLY PAY PLAN (paid directly to PCP at Co-op Clinic)	_____	_____
____ Diagnostic Radiology Monthly Pay Plan (paid directly to diagnostic facility)	_____	_____
<i>Basic Membership including the initial joining fee and membership dues</i>	<i>\$ 120</i>	<i>\$ 10</i>
<i>Included ASSOCIATION PRESCRIPTION DRUG DISCOUNT PLAN</i>		
<i>Included PATIENT ADVOCACY AND HELP IN GETTING MEDICAL SERVICES</i>		
Total	_____	_____

if you are applying for Two Party or Family Coverage, list all dependents you would like to be members:

Name (Last, first, middle initial)	Gender	Birthdate	Relationship	SSN
Spouse/Domestic Partner*:				
Child:				
Child:				
Child:				
Child:				

I would like to pay my dues the following way (check one): Monthly automatic payment directly from my bank Annually billed directly

Agreement for automatic bank draft (Attach a voided check to this application)

I (we) authorize the financial institution named below to honor and pay these monthly charges. This authority is to remain in effect until revoked by me (us) in writing, and until you actually receive such notice, I (we) agree that you shall be fully protected in honoring any such check/draft. I (we) understand that in order to cancel these automatic deductions, I (we) must provide written notice to the Patient Association no less than 15 days before the next scheduled automatic deduction.

Name of the Account Holder: _____ Signature of Account Holder: **X** _____

Date: _____ Signature of the Applicant: **X** _____

Name of Association Representative: _____

Name of Primary Care Provider: _____

Name of Diagnostic Facility: _____

AGREEMENT FOR PRIMARY MEDICAL CARE SERVICES PAYMENT PLAN

This Agreement for Medical Care Provider Services Payment Plan (hereinafter referred to as the "Agreement") is made and entered into on the date the application was signed, by and between the named applicant and the named primary care provider.

PURPOSES OF THE PLAN

Whereas Patient wishes to be billed a preferred rate for the Medical Care Provider's services by either the Physician or Nurse-Practitioner at the Co-op Medical Clinic; Whereas Medical Care Provider wishes to have a predictable source of monthly income; Whereas Medical Care Provider currently pays overhead for the submission of claims for payment and for efforts to collect payments not received at the time of service; Whereas Medical Care Providers have traditionally accepted fees for parties who pay under preferred terms such as insurance and managed care companies; Therefore, premises considered, the parties agree as follows:

MEDICAL CARE PROVIDER SERVICES PAYMENT PLAN (THE "PLAN")

Patient will pay a yearly fee on an annual or monthly basis to be a member of the Plan. As a member, Patient is entitled to be billed according to the Plan's fee schedule which is attached hereto, and to receive benefits listed upon the fee schedule without further charge.

AMENDMENTS & OPTING OUT

The fee schedule may need to be amended in the future. Patient agrees that after notice of such amendment, Patient will be bound by such amendment under the following terms. Medical Care Provider agrees to notify Patient of any amendments to the fee schedule by mail at Patient's last known address. Patient understands and accepts that it is their responsibility to inquire as to the most current fee schedule before services are rendered. The acceptance of services by Patient constitutes notice and acceptance of the current fee schedule. Upon notice of any amendments to the fee schedule, Patient may send notice in writing to Medical Care Provider that Patient is opting out of the new fee schedule. When a Patient opts out of the new fee schedule, they will continue to be a member only until the end of the current term of the Agreement, and will be charged for services in accordance with the fee schedule in effect prior to the amendment. This Agreement is **NOT INSURANCE**. This Agreement **DOES NOT PAY FOR HOSPITALIZATION** nor any other service performed by anyone other than Medical Care Provider or Medical Care Provider's staff, nor for any service performed any place other than at Medical Care Provider's office or personally by Medical Care Provider at another facility. This Agreement only affects the price at which this Medical Care Provider's services are offered to this Patient while this patient is a member of this Plan.

WARRANTIES AND LIMITATIONS

Medical Care Provider will provide professional medical services for the patient in a timely manner which services include diagnosis, treatment, drugs which are on the Medical Care Provider's formulary, well-person examination and tests at the Medical Care Provider's facilities that are within the scope of the Medical Care Provider's training and experience and which are usually performed in the Medical Care Provider's private practice. In this agreement "Medical Care Provider" means a licensed health care provider who is an MD, DO, or Nurse Practitioner and specifically the person named in the application.

Patient will maintain sufficient funds in account and notify Medical Care Provider's agent of any change in banking information and will indemnify Medical Care Provider for any and all banking charges for dishonored drafts, debits or any other charges resulting from insufficient funds being available in the designated account.

If for any reason this Agreement violates any statute or law, or in the event the law changes in such a way as to make this Agreement illegal or subject to additional regulation, either party may terminate this Agreement upon written notice.

Should this Agreement be terminated for any reason, Patient understands that any damages for any liability Medical Care Provider may have to Patient, or Patient's estate, under this Agreement will be limited to the amount of membership fees paid during the current term of the Agreement. For any damages owed to Patient under this Agreement, Medical Care Provider will be entitled to offset any such damages with the difference between fees for services charged at the preferred rate and the Medical Care Provider's customary rate for such services.

TERM AND RENEWAL

The term of this Agreement is one (1) year, and it will automatically renew each year unless either party gives written notice by U.S. certified mail return receipt requested, before the end of the current term. Either party may terminate this Agreement at will with proper written notice at any time. If this Agreement is terminated by Medical Care Provider, the outstanding balance of the yearly fee for the current term will be waived unless the Medical Care Provider is terminating for failure of Patient to pay fees or charges owing under this agreement. If this Agreement is terminated by Patient, the outstanding balance of the yearly fee for the current term will continue to be owed.

No WAIVER

No provision of this Agreement will be deemed waived by either party unless expressly waived in writing signed by the waiving party. No waiver shall be implied by delay or any other act or omission of either party. Medical Care Provider's consent respecting any action by Patient shall not constitute a waiver of the requirement for obtaining Medical Care Provider's consent respecting any subsequent action.

ATTORNEY'S FEES, COUNTERCLAIMS AND VENUE

If Medical Care Provider or any of its officers, directors, trustees, beneficiaries, partners, agents, affiliates or employees, shall be made a party to any litigation commenced by or against Patient and are not found to be at fault, Patient shall pay all costs, expenses and reasonable attorney's fees incurred by Medical Care Provider or any such party in connection with such litigation. Patient shall also pay all costs, expenses and reasonable attorney's fees that may be incurred by Medical Care Provider in successfully enforcing this Agreement or in attempting to collect payment due under this Agreement. Any action or proceeding brought by either party against the other for any matter arising out of or in any way relating to this Agreement shall be heard, at Medical Care Provider's option, in the County where the Agreement was Executed by the Medical Care Provider.

NOTICES

Any notice which either party may, or is required to give, shall be given by mailing the same, postage prepaid, to Patient at his residence listed on this document, or Medical Care Provider at Medical Care Provider's office address, or at such other places as may be designated by the parties from time to time.

SURVIVAL OF OBLIGATIONS

All obligations (including indemnity obligations) or rights of either party arising during or attributable to the period prior to expiration or earlier termination of this Agreement shall survive such expiration or earlier termination.

HEIRS, ASSIGNS, SUCCESSORS

This Agreement is binding upon and inures to the benefit of the heirs, assigns and successors in interest to the parties.

LEGAL CONSTRUCTION

This Agreement shall be construed in accordance with the laws of the State and County in which the Agreement was executed by Medical Care Provider.

ENTIRE AGREEMENT

This Agreement contains all the terms and provisions between Medical Care Provider and Patient relating to the matters set forth herein and no prior or contemporaneous Agreement or understanding pertaining to the same shall be of any force or effect. The signatures below attest to the fact that all provisions have been read and fully understood by the parties prior to the signing of this Agreement.

CAPTIONS AND SEVERABILITY

The captions of the Articles and Paragraphs of this Agreement are for convenience of reference only and shall not be considered or referred to in resolving questions of interpretation. If any term or provision of this Agreement or portion thereof shall be found invalid, void, illegal, or unenforceable generally or with respect to any particular party, by a court of competent jurisdiction, it shall not affect, impair or invalidate any other terms or provisions or the remaining portion thereof, or its enforceability with respect to any other party.

MODIFICATION

Neither this Agreement, nor any term, provision, paragraph or article referenced above may be modified, except in writing signed by both parties.

PAYMENT TERMS

Patient agrees to pay a yearly membership fee on a monthly basis as shown on the attached fee schedule until this Agreement terminates and fails to be renewed. Each yearly fee becomes fully owing at the beginning of the term. Patient agrees to make monthly membership fee payments by payroll deduction or by direct deposit as follows:

Patient authorizes Medical Care Provider or its designated attorney-in-fact, Patient Association, to electronically draft my account for my fees. The name of my bank, its transit number and my account number are printed below and I have attached a copy of a voided check as proof of my account and its proper numbers. I instruct the bank that I have named below to honor checks drawn in the name of Medical Care Provider or its designated agent acting as attorney in fact for Medical Care Provider. And as a convenience to me to charge my account and to pay their account the amount stated in the checks. This authorization is to remain in effect until revoked by me in writing and until you, the bank, actually receive notice, I agree that you shall be fully protected in honoring any such check or electronic debit. I agree that the bank's treatment of each such check or debit shall be the same as if it were personally signed by me. I further agree that if any such check or debit is dishonored, whether with or without cause, the bank shall be under no liability. Medical Care Provider or its designated agent is instructed to forward this authorization to you, the bank named on the voided check provided by patient:

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EVENTS UPON SIGNING OF AGREEMENT

Upon the signing of this Agreement, Patient must pay Medical Care Provider the initial monthly fee specified above and must supply all information required on this document.

SIGNED this _____ day of _____, 20__.

By _____
Patient
Patient Full Name(Print)

By _____
Primary Medical Care Provider
Full Name (Print)

_____ St Address _____

_____ St Address _____

City _____ St _____ ZIP _____

City _____ St _____ ZIP _____

Fee Schedule

Ages	Monthly Payment
0 to 18 yr	\$ 7
19+	\$20

* Laboratory and diagnostic tests done by outside reference labs and facilities are not covered by this agreement and the cost of those tests are to be paid directly to the lab or facility by the patient.