Member Registration Form

This form can be completed in paper form or online. It should be completed for each family member. To become a member, in addition to this form, you need to complete a Release of Records Form, the Membership Contract, and the Medicare Private Contract (if Medicare eligible).

Name: _____ Date of Birth:_____

Gender: ☐ Male ☐ Female

Email: _____

Home Phone: _____

Work Phone:_____

Cell Phone: _____

Address: _____

_____

Provider

☐ Tara Klofta, APRN-CNP

☐ Adult: $40 Joining Fee, $40 Monthly Membership Fee, $20 Visit Fee

☐ Child: (under 18 with parent): $21 Joining Fee, $21 Monthly Membership Fee, $20 Visit Fee

Payment

Recurring payments can be setup using a debit/credit card or checking account. Payment information will be collected over the phone or at your Established Care Visit.

When complete, paper form can be faxed to (937) 404-2428 or mailed to Hickory Medical Direct Primary Care, LLC, 208 West Columbus Avenue, Bellefontaine, OH 43311.

Hickory Medical Direct Primary Care, LLC

Membership Contract with Hickory Medical

Decision to join: I am voluntarily becoming a member of **Hickory Medical Direct Primary Care, LLC**– a Limited Liability Company registered in the State of Ohio (herein "Hickory Medical"). This agreement is non-transferable. This agreement is effective on completion of all appropriate paperwork and the receipt of payment of the joining fee by Hickory Medical. I have reviewed and agree to abide by this Hickory Medical Membership Contract, and I have had the opportunity to ask questions and receive answers regarding its content. _____ (initials)

DPC, <u>not</u> insurance: I am joining with the understanding that Hickory Medical does not provide health insurance coverage of any sort. Hickory Medical will not bill insurance carriers for any services. Also, I will not seek reimbursement from any insurance carrier for the services rendered by Hickory Medical. If I do seek reimbursement from any insurance carrier for any services, I may be putting myself and/or Hickory Medical in violation of legal standards and will be held responsible for any damages that occur as a result such as fines and legal fees. _____ (initials)

Charge responsibility: I am responsible for the charges incurred for health care services. This includes but is not limited to the services provided by Hickory Medical and other providers. Hickory Medical provides services common to family medicine including managing diagnostic, laboratory, and procedural aspects of basic medical care as well as offering guidance and counsel regarding health, disease processes, and medical treatment. Hickory Medical is not responsible for non-primary care services including, but not limited to emergency room visits, hospitalization, specialist care, ongoing counselling services, imaging, and lab tests performed by third parties. It is my responsibility to pay all costs and fees. _____ (initials)

Billing in arrears: After paying my registration fee, I agree to pay my membership fee(s) on or before the due date. Membership fees will be assigned after the month of service is completed. This payment will cover the prior month's membership fee. In the event that I am unable to pay my fee(s) on time, I will notify Hickory Medical and attempt to find a solution. I understand that late payment may result in a late fee of up to 200% of the outstanding bill and that my membership may be terminated. _____ (initials)

Quitting the practice: I may terminate my Hickory Medical membership at any time and for any reason, by providing written notice Hickory Medical. Termination will take effect at the end of the month in which notice is received. Until written termination notice is received by Hickory Medical, membership fees will continue to be my obligation. _____ (initials)

Termination: Hickory Medical may terminate my Hickory Medical membership by providing me written notice in accordance with the law. Hickory Medical will not terminate this Membership Contract on the basis of a status protected by law. Hickory Medical will cooperate and assist in transferring records to a new primary provider. _____ (initials)

Rejoining: If I terminate my Hickory Medical membership, I may not rejoin the practice for 18 months unless I pay a $400 early rejoining fee for each member and get written permission from a Hickory Medical provider. _____ (initials)

Health Savings, Health Reimbursement, and Flexible Spending Accounts for Direct Primary Care: At this time, I recognize that I cannot use these accounts for Direct Primary Care expenses due to current IRS rules. _____ (initials)

Fees and Change in Service: Membership fees are paid for the preceding month. The current membership fee schedule is $40 per adult each month and $21 per child each month (when an adult is enrolled in the program). These fees can be paid annually at the beginning of the year (adults: $480, children: $252) and a prorated rebate for the unused portion will be offered if I leave the practice and provide a written request for the rebate. Other common charges include a $20 scheduling fee when an appointment is scheduled and a $20 procedure fee for procedures that require additional equipment (e.g. mole removal, stitches, joint injections, etc.). I recognize that Hickory Medical may add or discontinue services or may increase my fee schedule at any time (but no more than once per year), and I will be given written notice of such changes at least sixty (60) days before such fee schedules change. _____ (initials)

Medicare and Medicaid: In order to avoid potential legal and billing problems, I confirm that my current insurance coverage is provided by (check all that apply). If I have Medicare, I have signed and will abide by the Medicare Private Contract. _____ (initials)

☐Private Insurance ☐Medicare ☐Medicaid ☐Not Insured

Addressing concerns: I agree to first bring a written account of any complaints regarding Hickory Medical to the attention of Hickory Medical staff. If the issue is not resolved, I will seek a mediated solution in which I earnestly seek a solution in the presence of an owner of Hickory Medical prior to pursuing legal action. _____ (initials)

Signature:_____ Date: _____

Printed Name: _____

If you are a parent registering on behalf of a minor, please write the minor's name on the line below. Your completion of this form will be interpreted as affirmation that you are the proper legal guardian of the minor.

Name of Minor (if applicable): _____

HICKORY MEDICAL
DIRECT PRIMARY CARE

Tara Klofta, APRN – CNP (937) 404-2488

Name: _____ Date of Birth: _____

Acknowledgment of Receipt of Notice of Privacy Practices

_____ Initials

I have received a copy of the practice's Notice of Privacy Practices for Protected Health Information (PHI). A copy of the notice is also accessible at http://www.hickorydpc.com/privacy

Prescription History Consent

_____ Initials

I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component of mycare. I authorize Hickory Medical Direct Primary Care, LLC to query and review my medication fill history including medication, dose, form, strength, prescribing provider, and pharmacy.

Sending Unencrypted Protected Health Information by Email or Text

_____ Initials

I understand that communication by email and text can lead to more efficient communication and can benefit my care. I understand that precautions are taken to protect my information but recognize that email and text messaging are not completely secure means of communication. I authorize Hickory Medical Direct Primary Care, LLC to exchange information that may include Protected Health Information by unencrypted email andtext.

Communication Preferences regarding Protected Health Information

_____ Initials

I understand that it may be helpful for my care if the providers and staff of Hickory Medical Direct Primary Care, LLC discuss my Protected Health Information (PHI) with others. I give permission to share my PHI with the following named individuals:

Spouse/Significant Other: _____

Parent: _____

Child/Grandchild: _____

Caregiver: _____

Other: _____

It is OK to leave a message: ☐ Answering Machine/Voicemail ☐ Cell Phone ☐ At work

_____ _____

Patient/Representative Signature Date

HICKORY MEDICAL
DIRECT PRIMARY CARE

Tara Klofta, APRN – CNP (937) 404-2488

Release of Records

Patient Name: _____ Date of Birth: _____

1: I hereby authorize and request: (Sender)

_____
_____
_____

To Permit: (Recipient)

Hickory Medical Direct Primary Care, LLC
208 West Columbus Avenue
Bellefontaine, Ohio 43311

to release/disclose the above-named individual's health information. I understand that the information in my record may include information pertaining to HIV/AIDS, AIDS-related conditions, sexually transmitted diseases, drug/alcohol abuse, and mental health.

I understand that by signing this authorization, I am authorizing the release of such information unless otherwise specified. The sender is authorized to deliver such information in person, via US Mail, private delivery service, facsimile or electronic transmission.

Furthermore, I hereby release the sender from any liability that may result from the recipient's use, or further dissemination of the information sent. I understand that if the person or entity that receives this information is not a health care provider, or health plan covered by Federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the Federal privacy regulations.

2: In particular, without intending to limit the above authorization in any way, I am requesting the following information to be released: **Complete Medical Records**

3: The purpose of the authorized use or disclosure of the information is as follows:

☐ For Referral Only ■ Permanently Transferring to another Health Provider
☐ Pending Legal Action ☐ Other: _____

This consent will expire sixty (60) days after the date below unless otherwise specified. I understand I may revoke this authorization in writing at any time, except to the extent already taken by the sender in reliance on this authorization, by sending a written revocation to: Hickory Medical Practice Manager, 208 West Columbus Ave, Bellefontaine, OH 43311. I understand this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand I am not required to sign this authorization and Hickory Medical will not condition the pro- vision of treatment, or other benefits to me, on the signing of this authorization.

_____ _____
Signature of Patient Signature of Parent/ Legal Guardian

_____
Date

HICKORY MEDICAL
DIRECT PRIMARY CARE

Name: _____ Date of Birth: _____

Drug Allergies & Intolerances: e.g., Antibiotics (Penicillin, Amoxicillin, etc.), NSAIDs (Aspirin, Ibuprofen, etc.)			
Rx:	Reaction:	Rx:	Reaction:
Rx:	Reaction:	Rx:	Reaction:
Rx:	Reaction:	Rx:	Reaction:

Health History: Have you ever had or do you currently have any of the following:						
Diabetes	Yes ☐	No ☐		Asthma	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐		COPD	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐		Cancer	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐		Stroke	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐		Migraines	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐		Heartburn/Reflux	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐		Bleeding/Clotting Disorder	Yes ☐	No ☐
Autoimmune Disease	Yes ☐	No ☐		Stomach Issues	Yes ☐	No ☐
Thyroid Disease	Yes ☐	No ☐		Depression/Anxiety	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐		Anemia	Yes ☐	No ☐
Gout	Yes ☐	No ☐		Sleep Apnea	Yes ☐	No ☐
HIV/Hepatitis	Yes ☐	No ☐		Peripheral Vascular Disease	Yes ☐	No ☐
Do you have any other health conditions? Please list date and type of surgeries here.						

Social History:			
Do you smoke Cigarettes?	Never ☐ Quit ☐	Yes ☐ Date Quit: _____	_____ Packs/Day Years Smoked _____
Do you vape (e-cigarettes)?	No ☐ Yes ☐		
Do you drink alcohol?	No ☐ Yes ☐ _____ # Drinks/Week		
Do you use recreational drugs?	Never ☐ Rarely ☐ Opioids ☐ Times Per Month: _____ Marijuana ☐ Cocaine ☐ Other: _____		
Do you exercise?	No ☐ Yes ☐ Type: _____ How Often: _____ # Days Per Week Minutes Per Activity: _____		
Are you sexually active?	No ☐ Yes ☐ # of Sexual Partners: _____ Men ☐ Women ☐ Both ☐ Contraception: No ☐ Yes ☐ If yes, method: _____		

HICKORY MEDICAL
DIRECT PRIMARY CARE

Family History:		
Relation	**Health Condition(s)**	**Family History of Cancer?**
Mother		If yes, list relative and type of cancer:
Father		
Grandparents		
Siblings		
Children		

Preventive Care:			
Recent shots from a healthcare provider/pharmacist	☐ Flu	Date:	Place:
	☐ Covid	Date:	Place:
	☐ Shingles	Date:	Place:
	☐ Pneumonia	Date:	Place:
	☐ Tetanus	Date:	Place:
Other:		Date:	Place:
Recent tests or procedures	☐ Colonoscopy	Date:	Place:
	☐ Cologaurd/Stool Card	Date:	Place:
	☐ Mammogram	Date:	Place:
	☐ PAP	Date:	Place:
Other:		Date:	Place:

Previous Providers/Specialists:		
Provider's First and Last Name	Specialty	Town/City

Medications & Vitamins (Prescribed & Over the Counter)	
Name/Dose/Times Per Day	Name/Dose/Times Per Day

Pharmacies:		
	Name	Location
Local:		
Mail order:		
Other:		