

## CORPORATE MEMBER - PROVIDER SELECTION

This form can be completed in paper form or online. Family members should have the same provider unless other arrangements have been made with Hickory Medical.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Corporate Information

Company World Class Plastics

### Preferred Provider

Ryan Kauffman, MD

Adult: \$49/month (covered by employer), \$20/visit

Child: \$21/month (covered by employer), \$20/visit

Marie Barth, APRN-CNP

Adult: \$40/month (covered by employer), \$20/visit

Child: \$21/month (covered by employer), \$20/visit

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

# HICKORY MEDICAL DIRECT PRIMARY CARE, LLC

## Membership Contract with Hickory Medical for Panel of Ryan Kauffman, MD

**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 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, not 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 to 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 \$49 per adult each month and \$21 per child each month (when an adult is enrolled in the program). Membership fees may be paid annually with a small discount (adults: \$575, children: \$235) and will revert to monthly payments at the end of the one year period (unless renewed). Prorated reimbursement for any unused portion of an annual membership are available upon written request. 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): \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Acknowledgement of receipt of Notice of Privacy Practices**

\_\_\_\_\_ 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  
Initials <http://www.hickorydpc.com/privacy>

**Prescription History Consent**

\_\_\_\_\_ I understand that performing a medication reconciliation in order to prevent  
Initials adverse drug interactions and overdose is a critical component of my care. 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**

\_\_\_\_\_ I understand that communication by email and text can lead to more efficient  
Initials 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 a 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 and text.

**Communication Preferences regarding Protected Health Information**

\_\_\_\_\_ I understand that it may be helpful for my care if the providers and staff of  
Initials 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  Cell phone  At work

\_\_\_\_\_  
Patient/Representative signature

\_\_\_\_\_  
Date