Hickory Medical Direct Primary Care, LLC
Membership Contract

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 DPC"). 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 DPC.I have reviewed and agree to abide by this Hickory Medical DPC 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 DPC does not provide health insurance coverage of any sort. Hickory Medical DPC 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 DPC. If I do seek reimbursement from any insurance carrier for any services, I may be putting myself and/or Hickory Medical DPC 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 DPC and other providers. Hickory Medical DPC 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 DPC 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 DPC 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 DPC membership at any time and for any reason, by providing written notice to Hickory Medical DPC. Termination will take effect at the end of the month in which notice is received. Until written termination notice is received by Hickory Medical DPC, membership fees will continue to be my obligation. *Initials:*_____

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

Rejoining: If I terminate my Hickory Medical DPC 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 DPC physician. *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:

$39 per adult each month
$19 per child each month (when an adult is enrolled in the program)

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 DPC 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): ☐ ***Private Insurance*** ☐ ***Medicare*** ☐ ***Medicaid*** ☐ ***Not Insured***
(If I have selected Medicare, I have signed and will abide by the Medicare Private Contract.) *Initials:*_____

Addressing concerns: I agree to first bring a written account of any complaints regarding Hickory Medical DPC to the attention of Hickory Medical DPC 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 DPC 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): _____