

WEST BEND FAMILY MEDICINE

Direct Primary Care Membership Agreement

This Direct Primary Care (DPC) Membership Agreement specifies the terms and conditions under which you (the “Member”) will participate in the benefits available under the West Bend Family Medicine (WBFM) Agreement.

1. This Direct Primary Care Membership Agreement is NOT A HEALTH INSURANCE POLICY, and does not cover services or care given at any other facility. This Agreement includes only the specific services as outlined in Section 8 below of this agreement, and does not include any major catastrophic medical care provided by emergency rooms, hospitals, urgent care centers, services rendered by specialists or specialty clinics, or offsite laboratories.
2. Member(s) understand that Health Insurance cannot be billed for any services provided by West Bend Family Medicine’s Direct Primary Care participants. Member(s) that may be covered by other health insurance plans with which participating providers are contracted, agree(s) NOT to seek reimbursement from their insurance plan for services received under this Agreement. West Bend Family Medicine will not file an insurance claim for Member(s), and Member(s) also agree not to file an insurance claim. Member(s) understands that the monthly membership fees required under this contract will not apply towards any health insurance plan deductible. Furthermore, membership under this contract DOES NOT fulfill the personal health insurance mandate under the Affordable Care Act.
3. Please see Section 8 for the list of all covered services under this agreement. All services performed at West Bend Family Medicine and not listed under covered services as outlined in Section 8 must be paid for at time of service. (See Section 9 for more details)
4. The pricing fee schedule for this Direct Primary Care at the date of this agreement is as follows:

INITIATION FEE (waived for existing patients)	\$50 per person or \$80 per family
INDIVIDUALS	\$79 per month
COUPLES	\$139 per month (\$69.50 pp)
CHILDREN under 18yrs (with enrolled parent)	\$10 per month (per child)
5. Initiation fee is due at date of registration and is a one time, non-refundable charge. If a Member decides to cancel the membership at any time and later rejoins, a new initiation fee shall be charged to reinstate the contract.
6. Member(s) understands that both West Bend Family Medicine and Direct Primary Care Member(s) have the right to terminate this agreement at any time and for any reason. Such termination by either party must be in writing 30 days in advance. Any pre-paid monthly membership fees will be refunded at the prorated amount according to the date of membership termination. Refunds will be issued to Member(s) by stated termination date. Member(s) further understands that dismissal as a patient by the provider assumes an automatic dismissal as a Direct Primary Care Member.
7. The Department of Consumer and Business Services has issued a certification to this practice. You can contact consumer advocates at The Department of Consumer and Business Services at (888) 977-4894, dcbs.in@mail@state.or.us, or www.insurance.oregon.gov

8. Covered Services are as follows:
- **Unlimited** office visits, including urgent care, annual wellness exam and family planning
 - Correspondence with your physician via **secure text messaging** will be responded to within 3 business hours (M-F, 8am-5pm) and within 12 hours otherwise. **Emails** via our patient portal will be responded to within 48 hours (therefore no urgent messages shall be sent via this method). Physicians will not assume responsibility for any urgent medical messages sent via the portal. **After hours phone services** are available 24/7 and if your physician is out of town or unavailable, a covering partner will take the call.
 - **Virtual visits** via a secure internet link from the comfort of your home are available at the physician's discretion during regular business hours in lieu of a clinic visit.
 - Access to **same day or next day appointments** will be with a covering physician if your physician is unavailable due to personal leave.
 - **Extended appointment** times of 30-60 minutes
 - **Fracture care** with casting or splinting if appropriate
 - **Wound care**, including stitching lacerations
 - Free **in-office labs**: strep tests, urinalysis, pregnancy tests, diabetes testing and influenza screen
 - 2 Free **skin biopsies** per year and free skin tag removal
 - **Cryotherapy** as indicated for skin lesions such as precancerous growths or warts
 - **Joint and trigger point injections** as indicated by your physician
 - Personalized **Pediatric** care –Vaccines offered at wholesale cost
9. Member(s) understands that there may be additional charges for equipment, laboratory services, pathology, referrals, or any other services that are ordered by our office to be performed by any facility other than West Bend Family Medicine. This Agreement does not cover additional charges for such circumstances. Only the services specifically outlined below in Section 8 are covered by the membership fees. If a provider renders services beyond the scope of this Agreement, there will be added charges. Member(s) agree to pay for these additional charges at the time of service. If these or any other additional charges are not paid at the time of service, Member(s) agree to allow West Bend Family Medicine to charge the Member(s) account(s) on file for those amounts. Those items available for an additional fee are as follows:
- **Immunizations and vaccinations** (these may be purchased at wholesale cost)
 - **Nutritional Screening**
 - **Pathology** fees associated with biopsies such as skin, cultures, pap smears
10. If a Direct Primary Care patient cannot make a scheduled appointment, every attempt must be made to notify the office of the need to cancel. If a patient is a "NO SHOW" to a scheduled appointment without notification there will be a \$25.00 fee added to the patient's account balance.
11. Monthly membership fees shall be paid by monthly charges to the Member's credit card, debit card, or automatic bank draft. Charges to the Member's card will occur every month, either on the 1st or the 15th of the month, depending on the date of the patient's first appointment. The first month fees shall include the initiation fee and the monthly fee up to 2nd month's payment. Member shall update credit card, debit card, or banking information when necessary and in a

timely manner, and will be responsible for any amounts owed to WBFM regardless of whether the account or card is expired, cancelled, or otherwise not accepted for payment. Member(s) agree to pay a \$25 added charge each time the Member(s) account declines payment of the monthly charge.

12. This Agreement authorizes West Bend Family Medicine to keep credit card, debit card, or banking information on file, and to charge the Member's applicable account for monthly fees without requiring West Bend Family Medicine to obtain written authorization for each new charge.
13. Member(s) understands that WITHOUT EXCEPTION, all Members included in this Agreement will not be scheduled for a patient appointment unless the membership fees have been paid up through or beyond the date of the desired appointment.
14. West Bend Family Medicine reserves the right to refuse membership to any person for any reason.
15. This Agreement is not complete and binding unless the Member(s) also signs the Automatic Payment or Credit Card Authorization, an Electronic Transmissions Disclosure and Agreement. Those documents are hereby incorporated into this contract by this reference.

This Agreement is between **West Bend Family Medicine LLC** and **Direct Primary Care Member** Name of Member _____

Date of Birth of Member _____

Requested Provider _____

The term of this Agreement is for one year commencing on _____

Member Signature

Date

Parent or Legal Guardian Signature

Date

*The Department of Consumer and Business Services issued a certification to this practice. You can contact consumer advocates at the Department of Consumer Affairs at (888)977-4894 dcbs.insemail@state.or.us, or www.insurance.oregon.gov

WEST BEND FAMILY MEDICINE
Authorization for Automatic Payment
(Credit Card, Debit Card, or Bank Account Authorization)

Enrolling Member Name: _____
Name as it appears on credit/debit card or bank account: _____
Account Type (credit card or bank account): _____ Routing number: _____
Account Number (credit card or bank account): _____
Card Expiration Date: _____ Security Code (on reverse): _____
Billing Address for Credit/Debit card: _____
Initiation fee to be charged: _____
Monthly membership amount to be charged or withdrawn each month: _____
Date of recurring monthly membership charge (1st or 15th of the month) _____

I hereby authorize WEST BEND FAMILY MEDICINE to charge the above referenced credit card or bank account automatically every month, and apply those charges to the membership fees required for participation in the direct primary care membership offered through West Bend Family Medicine, and to any other charges I incur from services received that are not covered by the membership. I understand that I will remain responsible for recurring charges, additional late fees and any other applicable charges if the withdrawal to the bank account I have listed above is denied for insufficient funds or the account otherwise becomes unavailable.

In the event I have selected to have automatic payments made from a bank account, I hereby authorize West Bend Family Medicine to initiate automatic withdrawals via electronic fund transfer as of the date of this agreement and as amended from time to time. I agree to indemnify the originating depository institution and any third party service providers involved in processing entries made hereunder against all claims, demands, losses, liability, or expense including attorney's fees and costs that result directly or indirectly from 1) a failure to follow the rules, 2) violation of law.

I understand it is my responsibility to notify West Bend Family Medicine of changes to my address, phone number, email address and other billing or contact information. An inability to collect membership fees due to incorrect or outdated billing information will result in the termination of my West Bend Family Medicine membership, including family members signed up under the membership.

Authorized Signature: _____ Date: _____

West Bend Family Medicine

Electronic Transmission Disclosure and Acceptance

1. Member(s) understand(s) that the various forms of electronic transmission of information carry with them the unlikely yet possible risk of exposure and potential loss of that information for a variety of reasons.
2. By signing below, Member(s) is/are indicating a desire to do business with West Bend Family Medicine providers via any or all of these electronic methods of communication, as indicated below (please initial next to those methods desired, you are not required to choose any of these modalities if you do not want access to these features):

_____ Cell phone **texting** via **Twistle** app (including attached pictures when applicable).

_____ Patient portal **emails** via **eClinical Works** electronic medical records.

_____ Video conferencing also known as **Telemedicine** via **eClinical Works**.

Please use Email Address _____

Please use Cellphone Number _____

3. By signing this document, Member(s) agree(s) to accept the risks inherent in the use of any of the above indicated communication methods for the purpose of diagnosis, treatment, or any other healthcare or business related reason. Member(s) further agree(s) to indemnify and hold harmless West Bend Family Medicine and its affiliated clinics or providers in the possible but unlikely event of a breach of confidential or protected information.

Member Signature

Date

Parent or Legal Guardian Signature

Date