

Mountain Sage Family Clinic

Direct Primary Care Enrollment Agreement

Patient Information

Name, Last:	First:	MI:	DOB: / /	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Home Address:	City:	State:	Zip:	
Billing Address:	City:	State:	Zip:	
Primary Phone: () -	Secondary Phone: () -			
Email:	Do you authorize email contact regarding medical care? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Employer:				
Employer Address:	City:	State:	Zip:	
Emergency Contact:	Phone: () -	Relationship:		

Membership

Start Date:	
Do you have insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Billing

Payment Schedule: Annual <input type="checkbox"/> Monthly <input type="checkbox"/>			
Payment Method: Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> ACH <input type="checkbox"/>			
Name on Card:	Number:	Expiration: /	CVV:
Billing Address:	City:	State:	Zip:
Account Number:	Routing Number:		

Billing Authorization

By signing below, patient/guarantor authorizes and acknowledges as follows:

- MSFC may contact patient/guarantor using the information provided above;
- MSFC may charge my credit/debit card on the 1st of each month or annually, for patient's periodic membership fee, and any incidental charges incurred as a result of patient's registration with MSFC, together with the periodic membership fee, and any incidental charges of any individual members associated with patient/guarantor's account.
- MSFC's authorization shall remain in force until MSFC has been provided with written notification of its termination in such time and manner as to allow MSFC time and opportunity to act upon it;
- Participation as a member of MSFC is continuous and recurring credit/debit card charges are authorized in accordance with the payment schedule; and Patient/guarantor shall be charged and will pay a \$25 fee for declined transactions authorized here that are not honored by the credit/debit card company.

Card/Account Holder Signature:	Date:
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Enrollment:

Patient is voluntarily becoming an MSFC Direct Primary Care patient and agrees as follows:

- Patient/Parent/Guardian has reviewed Patient's MSFC Patient Services and has been given the opportunity to inquire and received answers about its contents.
- This Enrollment Agreement establishes a professional relationship for specified personal health care services and **is not** a contract of insurance or a contract for comprehensive health insurance coverage.
- Patient/Guarantor is responsible for the periodic membership fee, and any incidental charges for services provided by MSFC, and MSFC will not bill insurance carriers or other third-party payers for any services provided by MSFC.
- Patient/Guarantor will pay the periodic membership fee on or before its due date. Upon failure to make a timely payment, services under this Enrollment Agreement may be terminated until payments due are made current.
- Patient/Guarantor is responsible for any charges incurred for health care services performed outside of MSFC including but not limited to; emergency room visits, hospital and specialty services, advanced imaging, or laboratory tests performed in outside, third-party laboratories.
- MSFC will maintain a record of Patient's health information and will protect Patient's privacy consistent with the Notice of Privacy Practices (a copy of which is available upon request) and the Health Insurance Portability and Accountability Act (HIPAA) and other applicable law.
- Patient may terminate this Enrollment Agreement at any time and for any or no reason by providing written notice to MSFC. Periodic membership fees will continue to accrue until written termination notice is received by MSFC. Membership will terminate on the last day of the month in which written termination notice is received. If patient has pre-paid membership fees beyond the date of termination, those fees will be reimbursed within 30 days of receipt of notice of termination.
- MSFC may terminate this Enrollment Agreement based upon non-payment of fees or for disruptive, threatening, unlawful or other inappropriate behavior by Patient by providing written notice to Patient. Membership will terminate on the last day of the month in which written termination notice is provided. If patient has pre-paid membership fees beyond the date of termination, those fees will be reimbursed within 30 days of delivery of notice of termination. MSFC will not terminate this Enrollment Agreement based solely on the Patient's health status.
- MSFC may, at any time, modify or amend services by adding to or deleting from the services provided or increasing Membership. Patient/Guarantor will be provided at least 60 days' notice of any changes.
- Patient is not enrolled in Medicare or Medicaid. In the event Patient becomes a Medicare/Medicaid beneficiary, Patient will immediately notify MSFC and this agreement will terminate.
- In the event Patient has complaints or concerns about any element of Patient's relationship with MSFC, its practitioners or personnel, Patient shall bring the issue to the attention of MSFC's staff.

Rights and Responsibilities

Patient shall have the following rights:

- The right too accurate, easy-to-understand information about MSFC’s services, practitioners, and facilities.
- The right to all available information necessary to make informed decisions about Patient’s healthcare.
- The right to be informed of all treatment options and to participate in all health care decisions. Parents, guardians, family members and other individuals may represent Patient if Patient cannot participate in those decisions.
- The right to refuse treatment.
- The right to be treated with respect, good manners, civility and professionalism free from discrimination based upon gender, age, race, national origin, religion, sexual orientation or disability.
- The right to privacy and confidentiality with respect to your treatment and health care information. MSFC will not disclose Patient’s healthcare information without authorization from Patient, legal requirement, or as necessary for Patient’s care and authorized by law.
- Patient will be provided access to Patient’s personal health care records upon request.
- The right to report and seek a prompt resolution to any concerns or problems Patient may have with Patient’s health care including billing or business issues, denial of treatment, waiting times, adequacy of services and facilities, or conduct of MSFC’s practitioners and personnel.

Patient shall have the following responsibilities:

- The responsibility to be actively involved in Patient’s own health care decisions.
- The responsibility to disclose all relevant information to MSFC’s practitioners necessary to enable them to provide proper treatment and assist Patient in accomplishing health goals and objectives and to inform MSFC of any care or treatment received from health care providers outside of MSFC.
- The responsibility to take care to avoid exposing others to the spread of disease or danger.
- The responsibility to comply with the requirements of this Enrollment Agreement.

Signature

Signature: _____

Date: _____

Printed Name: _____

Patient Parent Legal Guardian