ProHealth Medical Membership Business Application

COMPANY NAME: Contact Title

Phone Fax Email Website

Street Address City State Zip

BILLING INFORMATION:

Contact Title

Phone Fax Email Website

Street Address City State Zip

Membership Fees

$34.95/month/employee X_____ _____

$34.95/month/dependent X_____ _____

_____

Discount _____

Discount

- ☐ **Quarterly: 3%**
- ☐ **Semi-Annually: 5%**
- ☐ **Annually: First month FREE**

Registration Fee:

- ☐ **$50** (group of 3-25)
- ☐ **$150** (group of 26-49)
- ☐ **$200** (group of 50+)

TOTAL **$_____**

Method of payment (please check off desired method)

____ *Monthly Invoice*

Invoices for the upcoming month will be sent 14 days prior to the end of the month. Payment is due by the last day of the month for services rendered in the upcoming month.

____ *Monthly Dues Bank Draft Information*

Monthly dues (and other fees, as applicable)

Check or Savings acct # _____

Check # _____

Routing # _____

____ *Monthly Dues by Credit Card*

Bank Debit Credit Card Payroll Deduction

Card Type: MC VISA DISC

Credit Card # _____

Credit Card Expiration: _____

Auto-Recurring Payment Authorization Form (if paying with credit card or bank draft)

Please complete the information below:

I authorize ProHealth to charge/debit my account on the date of this application a one time only registration fee in the amount of $_____ and then monthly recurring payments thereafter for $34.95/member on the 25th day of each month for the entire duration of my membership. This is an authorization to automatically renew my 6 month membership on a month to month basis until cancellation. I must call to cancel my membership.

Terms and Conditions

1. A business may resign from the ProHealth Medical Membership (PMM) by providing a written notice to ProHealth 30 days before cancellation. Notices must be received before the end of business hours on the 10th of the month in order to terminate the following month. The business is responsible for the payment of all fees, dues, and charges due to ProHealth (we will not prorate for the month) up to the termination date.
2. The medical Providers reserve the right to refer any patient to a physician, a specialist, the emergency room, a hospital and/or other facilities if they deem the patient's illness goes beyond their scope of training and experience.

Patients joining the plan must agree to be referred when a medical problem is outside the scope of general medical care of for pre-existing conditions requiring care by a specialist as determined by our Providers. ProHealth and their Providers are not liable for any adverse outcomes resulting from failure to seek more definitive care.

3. PMM does not cover services rendered at other medical facilities outside its practice. Outside services are the financial obligation of the member.
4. ProHealth reserves the right to amend its rules, fees and regulations at any time. Members will receive at least 30 day notice via mail and / or email of any charges.
5. Members agree to pay, when due, all registration fees and monthly charges in accordance with this agreement and in accordance with the rules and regulation of ProHealth. If a member should fail to pay when due, any amounts payable to ProHealth, they will be assessed an interest charge of 1.5% per month until paid, plus any penalty that ProHealth imposes for nonpayment.
6. Should collection efforts be required, the member shall be fully responsible for payment of all costs of collection, including reasonable attorney fees.
7. ProHealth retains the right to suspend or cancel this membership and/or impose fines of $25 plus costs on any member for failure to pay dues or charges when due, or for returned checks, or declined credit card payments.
8. Membership benefits:
   a. Teladoc 24/7 Access (starts June 1, 2018)
   b. $12/visit co-pay
   c. 10% discount on lab work and in-office procedures
   d. Unlimited visits at ProHealth Medical Care
   e. Annual flu vaccine - FREE!
   f. First month free if first year total paid in full
9. Basic healthcare services provided for: (additional fees may apply)
   a. Colds, sore throat, fever, flu-like symptoms
   b. Minor emergencies
   c. High blood pressure
   d. Children's health (age 2+)
   e. School and sport physicals
   f. Diabetes management
   g. Depression / anxiety
   h. High cholesterol
   i. Women's health
   j. Arthritis, joint pain
   k. Minor laceration repair
   l. Acute and chronic care
10. Non-covered services include, but are not limited to, the following:
    a. Treatment for:
       1. Cancer treatment
       2. HIV treatment
       3. Pain management (no narcotics)
       4. Heart attack or stroke
       5. Obstetric care
       6. Children under 2 years of age
    b. X-rays, MRI, CT scans, Ultrasounds
    c. Immunizations

I have read and fully understand the contents of this document.

Print Name _____ Date _____

Signature _____

Title

For Office Use Only:

☐ MR _____ ☐ RB _____

☐ ACT _____ ☐ ID _____

☐ QB _____ ☐ FUB _____

Notes:

Application Updated: 4/2/2018