ProHealth Medical Membership Application

PRIMARY MEMBER: Last name _____ First name _____ Middle _____ Last 4 of SS # _____ Email _____

Street Address _____ City _____ State _____ Zip _____ Telephone w/ area code _____ ☐ Male ☐ Female

DOB: ___ / ___ / _____

If you wish to apply for membership for a spouse and/or unmarried children who are under age 18, please list them below.

Provide last name if different from yours. **Number of members applying**: _____

MEMBER 2: Last name _____ First name _____ Middle _____ Last 4 of SS # _____ Email (For info on your membership) _____

Street Address _____ City _____ State _____ Zip _____ Telephone w/ area code _____ ☐ Male ☐ Female

DOB: ___ / ___ / _____

Relationship to Primary Member: ☐ Spouse ☐ Child ☐ Other: _____

MEMBER 3: Last name _____ First name _____ Middle _____ Last 4 of SS # _____ Email _____

Street Address _____ City _____ State _____ Zip _____ Telephone w/ area code _____ ☐ Male ☐ Female

DOB: ___ / ___ / _____

Relationship to Primary Member: ☐ Spouse ☐ Child ☐ Other: _____

MEMBER 4: Last name _____ First name _____ Middle _____ Last 4 of SS # _____ Email _____

Street Address _____ City _____ State _____ Zip _____ Telephone w/ area code _____ ☐ Male ☐ Female

DOB: ___ / ___ / _____

Relationship to Primary Member: ☐ Spouse ☐ Child ☐ Other: _____

If referred, please specify the person's full name here: _____

Membership Fees

$34.95/month/person **$25** (one-time) registration fee

Monthly Dues by Credit Card

Card Type: MC VISA DISC

Credit Card # _____

Credit Card Expiration: _____ CCV: _____

Monthly Dues Bank Draft Information

Monthly dues (and other fees, as applicable)

Check or Savings acct # _____

Check # _____

Routing # _____

Driver's License Number: _____

For Office Use Only:

$34.95 per month per person X ___ $_____

Payment Discount Options: - $_____

- ☐ Monthly: No discount
- ☐ Quarterly: 3%
- ☐ Semi-Annually: 5%
- ☐ Annually: First month FREE

# of months receiving payment: _____

Registration Fee ($25) $_____

Method of Payment: _____ **TOTAL: $_____**

Date: _____ Emp: _____ Office: _____

Paid in office: ☐ yes ☐ no

Notes:

Auto-Recurring Payment Authorization Form

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 $25 and then monthly recurring payments thereafter of $_____ on the _____ 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 or my annual membership on a yearly basis until cancellation. I must call to cancel my membership.

_____ _____ _____

Signature Printed Name Date

Terms and Conditions

1. The membership period is _____ months (minimum of 6 months), beginning _____. A member may resign from the ProHealth Medical Membership (PMM) if they provide a written notice to ProHealth 30 days before cancellation. A $25 cancellation fee will be applied if the cancellation is prior to six months of membership. Notices must be received before the end of business hours on the 10th of the month in order to terminate the following month. The member is responsible for the payment of all fees, dues, and charges due to ProHealth (we will not prorate for the month).
2. The medical Providers reserve the right to refer any patient to a physican, 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.

As such, patients joining the plan must agree to be referred when a medical problem is outside the scope of general medical care or for pre-existing conditions requiring care by a specialist as determined by our Providers. If you choose to waive this consensus you agree not to hold ProHealth and their Providers liable for any adverse outcomes resulting from failure to seek more definitive care. _____ *initials*

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 ammend 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.

Member's signature _____ Date _____

Print Name _____ Staff initials _____

For Office Use Only:

☐ ACT _____ ☐ ST _____

☐ QB _____ ☐ ID _____

☐ RB _____ ☐ FUM _____

Notes:

Application Updated: 4/11/2018