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 ________ D Male D 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 membership info*)

Street Address ________ City ________ State ____ Zip ____ Telephone w/ area code ________ D Male D Female DOB: ___/___/____

Relationship to Primary Member: D Spouse D Child D Other: ________

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

Street Address ________ City ________ State ____ Zip ____ Telephone w/ area code ________ D Male D Female DOB: ___/___/____

Relationship to Primary Member: D Spouse D Child D Other: ________

MEMBER 4: Last name ________ First name ________ Middle ____ Last 4 of SS # ________ Email ________

Street Address ________ City ________ State ____ Zip ____ Telephone w/ area code ________ D Male D Female DOB: ___/___/____

Relationship to Primary Member: D Spouse D Child D Other: ________

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

Membership Fees

$45.00/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:

$45.00 per month per person X __ $________

Payment Discount Options: - $________

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

# of months receiving payment: ______

Registration Fee ($25) $________

Method of Payment: ________ **TOTAL: $**________

Date: ________ Emp: ________ Office: ________

Paid in office: D yes D 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 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 call ProHealth 30 days before cancellation. **A $25 cancellation fee will be applied if the cancellation is prior to six month of membership.** __________ ***initials*** 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
   - b. $0/visit co-pay
   - c. 25% 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 ____________

This agreement is not health insurance and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by the agreement. This agreement is not worker's compensation insurance and does not replace an employer's obligations under Chapter 440.

The PMM creates a practice model that has the potential to eliminate third party payers from the physician-patient relationship. The PMM does not indemnify for services provided by a third party.

Primary services may include, but not be limited to: office visits, annual physicals, ECGs, or other necessary primary care procedures. It might also include patient education and chronic disease management. The monthly fee includes access to the primary care provider for the services set forth in the agreement.

For Office Use Only:

- ACT _______
- QB _______
- RB _______
- FD _______
- ID _______
- TD _______

Notes:

Application Updated: 9/20/2022