Healthy Living Community

-2019 Membership Agreement-

Form due date: July 1st, 2019

On July 1st 2019 we are excited to integrate a new model of care into our practice, with the goal to allow more people access to necessary health care services.

In place of our annual administration fee, we are now implementing a sliding scale annual membership paid in monthly installments. With this membership payment, you are sustaining all the wonderful services Healthy Living Family Medicine is able to offer to patients at all income levels.
Thank you for being an integral part of the Healthy Living Family Medicine family.

Please note, this form is due by July 1st 2019 to secure your membership at HLFM.
After July 1st, Dr. Kerry will be opening up her practice to new patients.

For your convenience, forms can be returned by: mail, in person at the clinic,
by emailing to pearl@healthylivingfamilymedicine.com or faxing it to 503-376-3790.

Name : _____ Age: _____
Names and ages of additional family members seen by Dr. Kerry, who will be included in your monthly membership payment:

_____

_____

Address:

_____

_____

Phone Number: ( )_____

Membership monthly payment amount:

Please check the monthly membership payment level that reflects your *current financial capabilities* and *healthcare service usage*. If you are making a payment for all family members, please check a box that corresponds to the payment level of each member and write the name(s) of members at that level next to the box. The minimum monthly payment for each member is $5. If you have **already paid your annual admin fee for the 2019 calendar year,** check the box below and skip this section. Your admin fee payment will cover your membership for the remainder of 2019. You will be required to start membership payments in January 2020.

☐ I have already paid my admin fee for 2019 year. (If so, skip to pay-by-appointment section)

Monthly Payment Selection:

☐ $5 _____ ☐ $25 _____

☐ $10 _____ ☐ $30 _____

☐ $15 _____ ☐ $35 _____

☐ $20 _____ ☐ Other $_____

If applicable, combined family total per month: $_____

If you would prefer not to make monthly payments, you have the option to pay your membership fee in one lump sum payment. How would you prefer to make your membership payments?

I would prefer to make: ☐ Monthly payments ☐ One total lump sum payment

If you chose a **lump sum annual membership payment**, please calculate your total payment below. (Multiply the monthly membership level you choose for you or your family by 12.)

My total payment for this year: $_____

Pay-By-Appointment Information:

Another component of our new clinic model involves paying for an appointment at the time of your visit on a sliding-scale, that ranges from paying our full cost for a visit to whatever amount your financial situation allows. You may submit paperwork to insurance for possible reimbursement, but HLFM will no longer bill insurance directly.

For planning purposes, we ask that you make an estimate of what you anticipate being able to pay for a visit with Dr. Kerry.

For your reference, we have calculated that our actual cost for a 60 minute appointment is $240 (factoring in Dr. Kerry's time, clinic staff time, admin costs, space rental and upkeep).

Note: This is not a commitment to pay a certain amount, this is only a prediction to help us with financial planning. Thank you for putting thought into this response!

I predict that I (or my family member), will pay this amount for an appointment when I come in to see Dr. Kerry: $_____ (Please see enclosed HLFM Services Price List for more details)

Payment Information:

In order to make monthly or annual membership payment(s), we will require bank account or credit card information on file in order to make automatic withdrawals from your account. This information will remain confidential and only be used to make authorized withdrawals.

Bank Account or Credit Card Information:

Bank Account (our preference - by not paying credit card fees we keep our costs lower):

Bank/ Credit Union:_____

Is this account: ☐ Business ☐ Personal

Name of Account Holder: _____

Phone Number of Account Holder: _____

Account Type: ☐ Checking ☐ Savings

Account Number: _____ Routing Number:_____

Credit Card

Type of Card: ☐ Visa ☐ Mastercard ☐ American Express

Name on Card:_____

Card Number: _____ Expiration date: _____

3 digit Security code: _____

Address: ☐ Same as above

_____

_____

Patient Care Fund

I would like to add the amount below onto my monthly payment, or make a one time donation, to Healthy Living Family Medicine's Patient Care Fund, and support the care of others who may be unable to afford it at this time.

We are currently working on acquiring a non-profit status. We are very excited about this possibility. Although donations to the Patient Care Fund are not tax-deductible at this time, we appreciate your generosity to help others in receiving unique, holistic, patient-centered care with Dr. Kerry.

I would like this donation to be: ☐ Added to my monthly payment ☐ One time donation

☐ $5 ☐ $10 ☐ $20 ☐ $60 ☐ $120 ☐ $240 ☐ Other: $_____

Support a fellow patient's appointment costs: 15 min = $60, 30 min = $120, 60 min = $240.

Office Policies

☐ I have reviewed the updated office policies online on the Healthy Living Family Medicine website. I understand that by becoming a member, I am agreeing to these policies.

FAQ's

☐ I have read/reviewed the FAQ sheet and am aware of what the new Healthy Living Family medicine clinic model entails. I understand that this FAQ may be updated as new questions arise.

Terms and Conditions

☐ I have read/reviewed the attached Terms and Conditions. I understand that by becoming a member, I am agreeing to these terms.

Agreement

By signing this form I understand that I am agreeing to become a member starting July 1st 2019. I acknowledge that in order to remain a patient of Dr. Kerry's I must re-submit this membership agreement annually, and that by becoming a member I am committing to a full year of membership. I agree to allow Healthy Living Family Medicine to withdraw from my bank account or charge my credit card the amount above with the indicated frequency.

Signature: _____ Date: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Healthy Living Family Medicine in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Healthy Living Family Medicine may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form.