Membership Enrollment Package

***You can request a copy of the *Members Private Healthcare, PLLC – Patient Agreement* by emailing us at admin@membersprivatehealthcare.com**

Patient Understandings (initial each):

___ *Patient Agreement is for ongoing primary care and is not a medical insurance agreement.*

___ *I do NOT have an emergent medical problem at this time.*

___ *I am enrolling (myself and my family if applicable) in Practice voluntarily.*

___ *In the event of a medical emergency, I agree to call 911 first.*

___ *I understand that the practice physician(s) will make every effort to be available via phone, email, other methods such as "after hours" appointments when appropriate. However, depending on my medical condition, I may need to visit the emergency room, hospital or urgent care from time to time.*

___ *I do not expect the practice to file or fight any third-party insurance claims on my behalf.*

___ *This Agreement does not meet the individual insurance requirement of the Affordable Care Act.*

___ *This Agreement is non-transferable.*

___ *I do **NOT** expect the practice to **prescribe chronic controlled substances** on my behalf.*

(These include but not limited to commonly abused opioid medications, benzodiazepines, and stimulants.)

___ *I understand failure to pay the membership fee will result in termination from Practice.*

Patient Name _____Date _____

Patient (or Guardian) Signature _____

Howard Bortman D.O
Name of Physician

_____
Signature of Physician Date

Xiaonan Guo D.O_
Name of Physician

_____
Signature of Physician Date

31330 Northwestern Hwy, Ste D, Farmington Hills, MI 48334_____248-918-2337___
Principal Office Address Telephone Number

Membership Enrollment Form

□ **Gold Membership (18 – 29 y/o)**

□ **Gold Membership (30+ y/o)**

□ **Platinum Membership (30+ y/o)**

□ **Executive Physical**

Membership fees shall apply to the following Patient, who by signing below agree to the terms and conditions of the *Members Private Healthcare, PLLC – Patient Agreement*

_____ _____

Printed Name Date of Birth

_____

Address, stress, city, state, zip code

_____

Cell Phone Home Phone Work phone

_____

Preferred email

Payment Method: □ Visa □ Debit Card □ Checking account

Installments: □ Every 4 months □ Every 6 months □ Pay in full

I certify that I have read, understand, and agree to the terms set forth in the. In the Members Private Healthcare PLLC – Patient Agreement. I further certify that I have received a copy of this form.

Signature: _____ Date: ____/ _____/ 20___

** if pay annually, patient will receive total of 14 months of membership service with no additional charge.

Automatic Billing Authorization

To enjoy the convenience of automated billing, simply complete the payment and account Information section below and sign the form. All requested information is required. Payments are made directly through our secure link accessed through your electronic statement sent to your email. You will receive statement prior to any payments or deductions.

PAYMENT INFORMATION:

I _____(Patient's Name) authorize *MEMBERS PRIVATE HEALTHCARE, PLLC*

to start automated billing
- ☐ Every 4 months
- ☐ Bi-annually
- ☐ Annually

Start billing on: ____/____/____ End billing: 30 days after the written request was received

CREDIT CARD INFORMATION:

- ☐ Visa (Credit Card)
- ☐ MasterCard
- ☐ Debit Card

Card number: _____ Expiration Date: ___ / ____

_____ _____

Cardholder's name (as shown on Credit card) CVC (Security code)

Cardholder's signature _____ Date: ___ / ___ / 20 ___

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____(**Patient's Name**) have received a copy of **Members Private Healthcare, PLLC**'s Notice of Privacy Practices effective 11/15/2018.

Signature: _____ Date: _____

I am a parent or legal guardian of _____ (**Patient's name**).
Relationship to Patient: ☐ Parent ☐ Legal Guardian, I have received a copy of **Members Private Healthcare, PLLC's** Notice of Privacy Practices effective 11/15/2018.

Your Name: _____

Signature: _____ Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective 11/15/2018 given to individual on _____ (**date**)
☐ In Person
☐ Mailing
☐ Email
☐ Other _____

Reason individual or parent/legal guardian did not sign this form:
☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature.
*Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature.

****More than one attempt must be made.**

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

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E: admin@membersprivatehealthcare.com