



Annual Membership Consent Form For Uninsured Patients

Patient Name: _____ Date of Birth: _____

I understand that by signing this form, I am enrolling in the Annual Membership Program at Smart Prime Care, specifically designed for uninsured patients. The membership provides access to discounted services and is valid for one year from the date of enrollment.

Membership Details:

- Annual Fee: \$75 (non-refundable, non-transferable)
- Duration: 12 months from date of enrollment
- Auto-Renewal: Membership will automatically renew every year, with the \$75 fee charged to the payment method on file.

Cancellation: Cancellation must be requested by phone at least 30 days before the renewal date to avoid automatic billing.

Cancellation & Re-Enrollment Policy:

- Once canceled, the Member will lose access to schedule any visits, labs, or other member services. To regain access, the Member must re-register at the membership rate in effect at that time. The current \$75 annual membership fee is locked in for 3 years from the original enrollment date.
- After 3 years, fees are subject to change as per clinic policy.

Services Included in Membership:

Members are entitled to access the following at discounted rates:

- Laboratory testing through affiliated labs
- Primary care visits (e.g., wellness, sick visits, chronic care)
- Women's wellness services (e.g., Pap smear, breast health assessment)
- Timely access to care, including priority scheduling
- Personalized health counseling and preventive care

All medical services are billed separately. This program offers discounted access, not full coverage.

Important Disclosures:

This membership is not insurance and does not satisfy the Affordable Care Act requirements. It does not cover emergency services, hospital stays, specialist care, or services rendered outside Smart Prime Care. Members are responsible for maintaining valid payment methods for renewal.

Consent & Acknowledgment:

By signing below, I confirm that I am currently uninsured. I understand and agree to the benefits, limitations, cancellation, auto-renewal, and re-registration policy of this membership. I authorize Smart Prime Care to charge the annual fee of \$75 every year until I cancel as per the stated policy. I understand that cancellation leads to loss of service access and re-enrollment will be subject to the then-current rate.

Patient Signature: _____ Date: _____

Address: 4103 Lafayette Blvd Ste 2B, Fredericksburg, VA 22405
