Conner Family Health Clinic • 211 West Matthews Street Suite 102 • Matthews, NC • P: (704) 708-4301

Conner Family Health Clinic Wellness Program Agreement

First and Last Name ____ | DOB _______________

Phone(s) _________________________________ | Email ____________________________________

Address ____ | State _______ | Zip Code ______________

Monthly Pricing

Enrollment Fee	**$0**
Adults	**$99/month**
Children (5-18 years old)	**$60/month**
Couples Only Pricing	**$175/month**

Household Participants

Including financially responsible people if applicable. Household participants may include dependent children not living at home and those approved by Dr. Conner. This does not include NON-participating household members. Below, please give us the information of those who will be participating. If you have more than 5 members of your household interested in participation, please add them accordingly.

	Full Name	Date of Birth	Age	Relationship	Monthly Cost
1.					
2.					
3.					
4.					
5.					

Total Monthly Participant Cost _______

By Signing below, I (financially responsible person(s) mentioned above) assume financial liability for the monthly participant fees of the above named individuals as well as any costs incurred during the course of their care outlined in the attached agreement.

Printed Name: ____ Date: ______________

Signature: ____

Doctor-Patient Letter of Agreement

Dear Patient,
I am delighted that you have chosen to participate in Conner Family Health Clinic's (CFHC) Direct Primary Care participant program. The Direct Primary Care initiative provides participants comprehensive primary care services for a simple monthly price

Not Insurance: The wellness program is not comprehensive health insurance. I supply an array of high quality primary care services. Your participation at CFHC makes those services available for a single month fee. CFHC will not bill insurance for any of the care you receive. Care received by CFHC does not go towards your insurance deductible. You will need to purchase a high deductible health insurance plan to cover catastrophic medical expenses you may incur outside of this practice and to meet the requirements of the Affordable Care Act to avoid paying a penalty. One such insurance plan is found at sedera.com which even covers routine screenings including colonoscopy.

What Is Included: As a patient at CFHC, you will receive unlimited quality primary care. Services covered are as outlined in the services section of the website at *www.connerclinic.com*. Of course, it's good practice (and medically indicated) to let your health care provider see you in person in certain circumstances so I do ask that you come to the office for visits whenever medically appropriate.
I provide the same day or next day availability to patients in the event of an acute illness of urgent medical need Monday through Friday during office hours except holidays, weekends, or after hours.
In a life threatening emergency, call 911! For urgent medical issues, including a request for same day appointment, please call the office number (704) 708-4301.

After Hours (Evenings, Weekends and Holidays): Please call the after-hours number for care. A provider should return your call within 30 minutes. If the call is not returned, please try again in case phone coverage was interrupted. After telephone discussion and agreement that your situation requires same-day attention, CFHC will help you over the phone or arrange to see you in the office, or refer you to another facility as appropriate. Wellness or preventive visits, follow-up visits, medication refills, and non-urgent matters are not guaranteed to be same day or next day visits.

What Is Not Included: Participant benefits do not include any services provided by other health care providers, institutions, or organizations. Specialists, hospital and emergency room visits, imaging,

laboratory testing, vaccinations, medications, and other care not listed here are not included in your doctor-patient agreement. You, the patient, are responsible for the charges for all the services, supplies, medication, and equipment that are not included in the cost of the wellness plan. If you have insurance, these outside services may bill your insurance, but you must arrange this with them yourself.

Billing Details: Your benefits begin on the first day of the month for which your monthly fee is paid. Subsequent months are due on the first day of that month. In addition to medical costs described above, you agree to pay CFHC's established charges related to returned checks, copies of medical records provided to the patient, and other administrative/compensatory fees. These fees are available upon request and subject to change without notice.
Fees are due on the first of each month (unless other arrangements have been made) and apply to the entirety of that month. Patients who miss payment for more than two (2) consecutive months will be terminated and will have to reinstate their plan(s) and pay a $300 re-enrollment fee ($100 for children). I may choose to change (add or discontinue) services or change my fee schedule at any time. You will receive written notice at least sixty (60) days prior to any changes taking effect.

Terminating Your Plan: Your Doctor-Patient Agreement is designed and intended to be continuous, though you may terminate your participation at any time. If you terminate your participation, you will have to wait 3 months to reinstate and pay a $300 re-enrollment fee ($100 for children). CFHC will reimburse you any fees collected in advance for the month(s) following the termination of your plan. Please request the termination in writing and with a 72 hour notice before your next payment is drawn. CFHC does not offer prorated refunds for partial months.

Final statements: This is a private letter of agreement between CFHC and you/your family. This letter (signed by each responsible party) and attached list of household members signed by the household's financially responsible person constitutes the full terms of your plan. CFHC may exclude or terminate any individual or household from participation. This agreement is not an insurance policy and contains no obligations, explicit or implied, outside of those outlined above. Either party may terminate this agreement at any time with written notice to the other.

Sincerely,

Will Conner M.D.

William Jordan Conner, M.D.
Diplomate of the American Board of Family Medicine

Credit Card Information

Please enter your credit card information below to be billed monthly for your DPC Wellness Plan.

Name On Card	Credit Card Number	Expiration Date
Card Zip-Code	Billing Address	Card Type: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Other:____________

By signing below, I confirm I have read and accepted the conditions mentioned above. I also authorize the use of the credit card information I entered above. Should I decide to use a different method of payment, I will inform the office via telephone (704-708-4301) or email (connerclinic@connerclinic.com) at least 72 hours before my payment is due on the first of the month.

Accepted by…

Full Name: ____ Date: _____________

Signature: ____