Hometown Direct Primary Care

332 N. Bright Leaf Blvd, Suite C
P.O. Box 2559
Smithfield, NC 27577
Phone (919) 901-7344 Fax (319) 250-7453

Membership Agreement

This is an agreement between _____ and Hometown Direct Primary Care and was entered into on _____, 20____.

Background

Hometown Direct Primary Care is a hybrid direct primary care (DPC) practice, located at 332 N. Brightleaf Blvd, Suite C/D, Smithfield, North Carolina 27577. In exchange for designed membership fees, the practice agrees to provide services as described in this agreement on the terms and conditions contained in this agreement.

Notice: This medical retainer agreement does NOT constitute insurance, is NOT a medical plan that provides health insurance coverage for the purposes of the Federal Patient Protection and Affordable Care Act and cover only the health care services as designated in this agreement. The patient acknowledges that practice recommends the patient obtain health insurance that will cover healthcare not delivered by the practice, such as hospitalizations and catastrophic events.

_____ (Initial)

Term/Renewal

This agreement will last for one year, starting on _____ and the patient is responsible for all monthly/annual payments during this time. This agreement automatically renews each year on the anniversary date of the agreement unless patient notifies the practice in writing they wish to cancel on this date.

Services Covered by Membership Fees

- Up to 2 office visits per month
- Annual complete physical (including EKG and labs—CBC, CMP, TSH, Lipids, PSA, Urinalysis)
- Well baby/child exams with appropriate developmental/vision/hearing screenings
- CDL/DOT exams
- Phone visits for acute issues
- Same day/next day sick visits

- In-house testing (urinalysis, Rapid Strep, Flu testing, urine pregnancy, finger-stick blood sugar) if clinically indicated
- Minor office procedures (simple laceration repair, suture/staple removal, abscess drainage, ear wax removal, skin tag removal, toenail removal)
- Coordination of specialty care

Services Available at Additional Costs

- Additional visits over 2 per month ($25)
- Home visits ($50)
- In person visits for urgent issues after routine office hours if issue cannot wait ($100)
- Joint injections
- Cryotherapy for benign skin lesions
- Removal of suspicious skin lesions with pathology testing
- Additional lab testing with deeply discounted "cash prices" via LabCorp with no additional drawing fee if billed via our office (patients may also choose to have LabCorp bill their insurance if they wish and agree to pay those contract prices)
- X-ray services
- Vaccines

Payments

In exchange for services listed above, the patient agrees to pay a monthly/annual membership fee that appears on last page of this agreement. This monthly/annual membership fee is due on the first business of each month. The membership fee is pro-rated for the first month of service based on the date the agreement is signed and is paid in arrears. Both parties agree that the required payment method by automatic payment by debit/credit card or direct debit from a selected banking account if paid monthly. Annual payments may be made by one of the above methods or by check or cash but an automatic payment method is required for charges for additional services which shall be paid monthly. Charges for additional services are paid at next billing date after services are rendered.

Non-Participation in Insurance

The patient acknowledges that the practice nor the physician will participate in a private health insurance plan. The practice will not maintain needed billing and diagnosis coding for the patient to pursue reimbursement from their insurance company for services rendered by the practice. The practice makes no representation that any fees paid under this agreement are covered by your health insurance or other third party payment plan. Please initial to indicate your understanding of this clause.

_____ (initial)

Communications

The patient acknowledges that although the practice shall comply with HIPAA privacy requirements, communications with practice using email, fax, video, cell phone, texting and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential. As such, the patient expressly waives the practice's obligation to guarantee confidentiality with respect to the above means of communication. Patient also acknowledges that all such communications may become part of the medical record.

By providing an e-mail address to the practice, the patient authorizes the practice to communicate with patient by email regarding the patient's protected health information. The patient also acknowledges:

1) Although the practice will make all reasonable efforts to keep email communications confidential and secure, the practice cannot guarantee the absolute confidentiality of email communications.
2) Email communications may be made a part of the patient's permanent medical record at the discretion of the physician.
3) The patient understands that email is not an appropriate means of communication in an emergency situation.
4) The practice checks emails frequently on weekdays during normal business hours. If you do not receive a response to an email message by the next business day, the patient agrees to contact the office via phone or other means.
5) The practice is not responsible to any loss, injury, or expense arising from a delay in communication due to technical failure (examples include but not limited to: internet service failure, power outage, failure by email provider, failure of computer or computer network) or if patient fails to comply with email guideline set forth in this agreement.

_____ (initial)

Nonpayment

In the event that the Patient is unable to pay the monthly Membership Fee in full and on time, the practice may, in its sole discretion, inactivate or terminate this Membership Agreement. It is the Patient's responsibility to maintain a correct and up-to-date credit/debit card number or banking information on file. One month of nonpayment will results in the patient's membership marked as "inactive" and fees must be paid in full for patient to be returned to active status and receive any services. Two months of nonpayment will be considered terminated by the patient and the patient must pay the reinstatement fee to re-activate their membership.

Termination

A. TERMINATION BY PRACTICE. The practice may terminate this membership agreement upon providing the patient advanced written notice. Termination will be effective starting five business days after notification. Upon termination, the practice shall comply with all rules and regulations of the North Carolina Medical Board regarding the provision of emergent care for 30 days after termination and cooperate in the transfer of patient's medical records to the patient's new primary care physician, upon the patient's written request and direction.

B. TERMINATION BY PATIENT. The patient may terminate this membership agreement at any time and for any reason, upon providing advance written notice to practice. Such termination shall be effective on the last day of the then-current calendar month. Membership fees shall not be pro-rated for any terminal month. Monthly membership fees will continue to accrue until patient's written notice of termination is received by practice at its office location set forth above. If patient terminates the membership agreement after receiving a comprehensive physical benefit but has paid less than 6 months of membership fees, the patient will be charged the balance of 6 months of membership.

Reinstatement

In the event patient terminates this membership agreement for any reason after the effective date, the patient shall be ineligible for future membership unless the patient pays a reinstatement fee in the amount of two hundred dollars ($200.00). Each patient is entitled to only one reinstatement.

_____ (initial)

Membership Enrollment/Fees

Following are family members included under this agreement:

Name _____ DOB _____ Age _____

Name _____ DOB _____ Age _____

Name _____ DOB _____ Age _____

Name _____ DOB _____ Age _____

Name _____ DOB _____ Age _____

Name _____ DOB _____ Age _____

Name _____ DOB _____ Age _____

Patient prefers to be billed: ☐ **Monthly** ☐ **Annually** **Amount***

_____

*Amount may change based on charges for additional services (billed monthly/at visit) _____

(initial)

I, _____, certify that I have read, understand, and agree to the terms set forth by Hometown Direct Primary Care in this membership agreement form. I agree to pay the membership fee as described above. I further certify that I have received a copy of this agreement.

Signature:_____ Date: _____