



Direct Primary Care Membership Agreement

This Direct Primary Care Membership Agreement (the “Agreement”) specifies the terms and conditions under which you (the “Member”) and your spouse or dependents included in the Agreement will participate in the benefits available under the agreement.

1. This Agreement is between Highlands Health and Wellness (HHW) and _____ (Primary Member), and includes the following person(s) listed below (attach additional sheets if necessary):

Name:	DOB:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. The term of this Agreement is for one year, beginning on the date this contract is signed or the date in which the primary member uses our online membership form to sign up on the HINT software . The Agreement shall automatically renew for successive one year periods unless either party cancels the Agreement in writing.
3. This Agreement is **NOT A HEALTH INSURANCE POLICY**, and does not cover services or care given at any other facility than the participating clinics as shown below. This Agreement includes only the specific services as outlined in Section 17 below, and does not include any major catastrophic medical care provided by emergency rooms, hospitals, urgent care centers, services rendered by specialists or specialty clinics, or other entities not outlined specifically as a participating clinic. Member(s) acknowledges that neither HHW, nor the Providers participate in any health insurance or HMO plans or panels and has opted out of Medicare.
4. Adult Members participating in the Agreement may sign up a spouse or dependents under this Agreement. Others outside of that relationship wishing to join as Members must have their own separate Agreement. A valid picture ID is required to enroll in membership and will be required to verify identity before receiving membership services, except in the case of a minor enrolled in the membership, who must be accompanied by a parent or legal guardian that is also enrolled in the membership.

5. At the date of this Agreement, membership fees are as follows:
 - a. Individual (Age 24 or Older): \$75/month
 - b. Individual (Age 0-23): \$25/month with paid adult
 - c. Couple (2 Adults): \$125/month
 - d. Family (2 Adults, 2 Under 24): \$150/month; Extra \$25/month for each additional Child
6. Members will also be charged an enrollment fee of \$75 per individual or group (i.e. one registration fee per couple or family) signed up under the Agreement, at the time of enrollment, unless they are already established as a patient at the participating clinics. This enrollment fee is non-refundable if this Agreement is terminated. An enrollment fee of \$300 will be charged to Members re-enrolling after a previous termination. This re-enrollment fee will apply to everyone. After termination of the contract, there is a one year waiting period for re-enrollment.
7. Monthly membership fees shall be paid by monthly charges to the Member's credit card, debit card, or automatic bank draft. Initial charge will include the enrollment fee and first month's dues. Charges to the Member's card will occur every month beginning on the day of enrollment, and then on the same day of every month following (i.e. Signed up on January 15th, next charge date February 15th, then March 15th and so on). Member shall update credit card, debit card, or banking information when necessary and in a timely manner, and will be responsible for any amounts owed to HHW regardless of whether the account or card is expired, cancelled, or otherwise not accepted for payment. Member(s) agree to pay a \$25 added charge for each time the Member(s) account declines payment of the monthly charge.
8. This Agreement authorizes HHW to keep credit card, debit card, or banking information on file, and to charge the Member's applicable account for monthly fees without requiring HHW to obtain written authorization for each new charge.
9. **Member(s) understands that WITHOUT EXCEPTION, all Members included in this Agreement will not be scheduled for a patient appointment unless the membership fees have been paid up through or beyond the date of the desired appointment.**
10. Member(s) understands that HHW or Member(s) may terminate this Agreement at any time and for any reason. Such termination by either party must be in writing and fees charged within 30 days of cancellation are non-refundable. Member(s) further understands that dismissal as a patient by a participating provider or clinic includes an automatic dismissal as a HHW member.
11. Member(s) understands that HHW may add or decrease services, participating providers, and participating clinics, OR increase membership fees at any time. In the event of such changes, HHW will provide notice to Member(s) at least 30 days before the change.
12. Member(s) understands that there may be additional charges for equipment, laboratory, referral, or other services that are ordered through outside entities or providers as a result of care given by a participating clinic or provider. This Agreement does not cover additional charges for such items. Only the services specifically outlined below in Section 17 are covered by the membership fees. If a participating clinic or provider renders services beyond the scope of this Agreement, there will be added charges. **Member(s) agree to pay for these additional charges at the time of service.** If these are any other additional charges are not paid at the time of service, Member(s) agree to allow HHW to charge the Member(s) account(s) on file for those amounts.

13. In the event of a change in employment, Member(s) that are enrolled under a corporate membership Agreement may transition to an individual or family Agreement, at the membership rates shown above in Section 5.
14. Member(s) also covered under Medicaid or other health insurance plans with which participating providers are contracted, agree(s) NOT to seek reimbursement from their insurance plan for services received under this Agreement. HHW will not file an insurance claim for Member(s), and Member(s) also agree not to file an insurance claim.
15. Member(s) also enrolled in Medicare understand and agree that Medicare WILL NOT be billed for services rendered to Member(s) under this Agreement, and Member(s) agree to not seek reimbursement from Medicare for any services rendered under this Agreement.
16. HHW reserves the right to refuse membership to any person for any reason.
17. Services Included in Membership:
 - a. Acute Care: Coughs, colds, flu, sprains, sinus and ear infections, sore throat, fever, rashes, diarrhea, back pain, strep tests, asthma, bronchitis, pneumonia, kidney and bladder infections, non-life threatening medical issues
 - b. Annual Physicals: School, Athletic, Adult, Well Child, Well Women, Well Male, Pap Smear procedure
 - c. Basic Annual Labs: Basic Cholesterol Panel, Basic Metabolic Panel, Complete Blood Count. One time per year.
 - d. Preventive Medicine: Electrocardiograms, vision screening, body composition analysis, nutrition counseling, Flu shot, Tdap, routine well child vaccinations
 - e. Minor Surgeries: Wound care, minor laceration repair, wart destruction, simple lypoma removal
 - f. Procedures, Test and Treatments: In-house rapid strep and flu tests, TB Test, EKG, nebulizer breathing treat, abscess draining, foreign body removal, trigger point injections, urinalysis, simple biopsy, cryotherapy (warts), simple sutures, joint injection, antibiotic injection
 - g. Men's and Women's Health: Well man and women screens, cancer prevention, preconception health, perimenopausal and postmenopausal health
 - h. Pediatrics: Well child evaluations, acute care as listed above, development evaluations
 - i. Chronic Therapy: Diabetes, arthritis, acid reflux, high blood pressure, high cholesterol, cardiovascular disease, chronic fatigue, fibromyalgia, asthma, COPD, non-narcotic pain management, low back pain
 - j. Technology Enhancements: Virtual visit capability and patient portal access
 - k. Administration Tasks: Referrals, Pre-Operative Forms, Medication Refills
18. Member(s) understand(s) that charges for items not covered by the membership must be paid at the time of service, and will NOT be billed through the Member(s) monthly membership dues agreement. Those items available for an additional fee are as follows:
Any lab test not included above, lab tests done by LabCorp, Quest, Boston Heart, Genova, DiagnosTechs or any other laboratory facility, Immunizations not included above, Ultrasounds, or any other ancillary service provided by another entity, regardless of whether their service is provided elsewhere or at the participating clinic.

19. Excluded Services:

Chronic pain management (unless a specific pain management contract is already in place with the provider), ongoing treatment with controlled medications, substance abuse withdrawal, major surgeries, procedures involving general or regional anesthesia, CT scans, MRI scans, echocardiograms, cardiac stress tests, prenatal and obstetrical care, electroencephalograms, medications, any care given by a provider not listed as participating in this membership, any care in the sole determination of the provider that is best handled in the emergency room of a hospital, any procedure in the sole determination of the provider that falls outside of his or her area of training or expertise, or care rendered by specialists or specialty clinics.

20. Discounted medications will be available to Member(s). The medication types and dosages available in stock will be at HHW's discretion. It is not guaranteed that the specific medication the Member(s) is on will be available in the office at wholesale price.

21. Member(s) acknowledge that communications with the physician and other providers using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. As such, You expressly waive the physician's obligation to guarantee confidentiality with respect to correspondence using such means of communication. You acknowledge that all such communications may become a part of your medical records. By providing Member(s) e-mail address to HHW, Member(s) authorizes the HHW, and its providers and staff to communicate with Member(s) by e-mail regarding Member(s) "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations) Patient acknowledges that: (a) E-mail is not necessarily a secure medium for sending or receiving PHI and, there is always a possibility that a third party may gain access; (b) Although and the Physician will make all reasonable efforts to keep e-mail communications confidential and secure, neither HHW, nor the physician can assure or guarantee the absolute confidentiality of e-mail communications; (c) In the discretion of the physician, e-mail communications may be made a part of the Member(s) permanent medical record; and, (d) Member(s) understands and agrees that e-mail is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. **In the event of an emergency, or a situation in which the member could reasonably expect to develop into an emergency, Member shall call 911 or the nearest Emergency room, and follow the directions of emergency personnel.** Neither HHW, nor the Physician will be liable to Member(s) for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Member(s) as a result of technical failures, including, but not limited to, (i) technical failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages, (iii) failure of the practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third party; or (v) your failure to comply with the guidelines regarding use of e-mail communications set forth in this paragraph.

22. Member(s) understands that the visit and monthly membership fees required under this contract DO NOT apply towards any health insurance plan deductible. Furthermore, membership under this contract DOES NOT by itself fulfill the personal health insurance mandate under the Affordable Care Act. Member(s) also understand the HHW makes no representations regarding the tax implications of membership in this agreement. Member(s) are encouraged to seek the advice of a competent tax professional for advice regarding any related tax issues.

23. This Agreement is not complete and binding unless the Member(s) also signs the Automatic Payment or Credit Card Authorization, an Electronic Transmissions Disclosure and Agreement, and any other patient related forms required by the entities providing care under this agreement. Those documents are hereby incorporated into this contract by this reference.

24. This Agreement contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement.

Member Signature

Printed Name

Date

Spouse Signature

Printed Name

Date



**Authorization for Automatic Payment
(Credit Card, Debit Card, or Bank Account Authorization)**

Enrolling Member Name(s): _____

Name as it appears on Credit/Debit Card or Bank Account: _____

Account or Card Number: _____ Account Type: _____

Routing Number for Bank Account: _____

Card Expiration Date: _____ Security Code (on reverse): _____

Billing Address for Credit/Debit Card: _____

Monthly Amount: _____ (see pricing in section 5 of Membership Agreement)

I hereby authorize Highlands Health and Wellness (HHW) to charge the above referenced credit/debit card or bank account automatically every month, and apply those charges to the membership fees required for participation in the direct primary care membership offered through HHW, and to any other charges I incur from services received through the participating clinics or providers that are not covered by the membership. I understand that I will remain responsible for recurring charges, additional late fees and any other applicable charges if the withdrawal to the bank account I have listed above is denied for insufficient funds or the account otherwise becomes unavailable.

In the event I have selected to have automatic payments made from a bank account, I hereby authorize HHW to initiate automatic withdrawals via electronic fund transfer entries by HINT software in existence as of the date of this agreement and as amended from time to time. I acknowledge that no entries may be made that violate the laws of the State of Colorado, or party service providers involved in processing entries made hereunder against all claims, demands, losses, liability, or expense including attorney's fees and costs that result directly or indirectly from 1) a failure to follow the rules, 2) violation of law.

I understand it is my responsibility to notify HHW of changes to my address, phone number, email address and other billing or contact information. An inability to collect membership fees due to incorrect or outdated billing information will result in the termination of my HHW membership, including family members signed up under the membership, and a re-enrollment fee of \$50 per member.

Member Signature

Printed Name

Date

Spouse Signature

Printed Name

Date



Electronic Transmission Disclosure and Acceptance

1. Member(s) understand(s) that the various forms of electronic transmission of information carry with them the unlikely yet possible risk of exposure and potential loss of that information for a variety of reasons.
2. By signing below, Member(s) is/are indicating a desire to do business with HHW or its affiliated clinics or providers via any or all of these electronic methods of communication, as indicated below (initial those methods desired):

_____ Cell Phone Texting (including attached pictures when applicable)

_____ Emails (including attached pictures or documents when applicable)

_____ Video Conferencing with HHW or their participating clinics or providers

3. By signing this document, Member(s) agree(s) to accept the risks inherent in the use of any of the above indicated communication methods for the purpose of diagnosis, treatment, or any other healthcare or business related reason. Member(s) further agree(s) to indemnify and hold harmless HHW and its affiliated clinics or providers in the possible but unlikely event of a breach of confidential or protected information.
4. If Member(s) do not consent to any electronic transmission options (cell phone texting, emails, video conferencing), they will be waiving their right to participate in the virtual visits provided as a convenience from our providers as part of the membership.

Member Signature

Printed Name

Date

Spouse Signature

Printed Name

Date



Medicare Opt Out Agreement

This agreement ("Agreement") is entered into by and between Highlands Health & Wellness, whose principal medical office is located at 3729 W 32nd Ave, Denver, Colorado, owned and operated by Dr. Shelley Meyer ("Physician") and _____, a beneficiary enrolled in Medicare Part B ("Beneficiary"), who resides at _____, _____, Colorado.

Introduction

The Balanced Budget Act of 1997 allows physicians to "opt out" of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, physicians are required to file an affidavit with each Medicare carrier that has jurisdiction over claims that they have filed (or that would have jurisdiction over claims had the physicians not opted out of Medicare). In essence, the physician must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years.

This Agreement between Beneficiary and Physician is intended to be the contract physicians are required to have with Medicare beneficiaries when physicians opt-out of Medicare. This Agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

Physician Responsibilities

- (1) Physician agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.
- (2) Physician agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.
- (3) Physician agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.
- (4) Physician agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Physician also agrees to retain a copy of this document for the duration of the opt-out period.
- (5) Physician agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS) upon the request of CMS.

Beneficiary Responsibilities

- (1) Beneficiary agrees to pay for all items or services furnished by Physician and understands that no reimbursement will be provided under the Medicare program for such items or services.
- (2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Physician for such items or services.
- (3) Beneficiary agrees not to submit a claim to Medicare and not to ask Physician to submit a claim to Medicare.
- (4) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Physician that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

(5) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other physicians or practitioners who have not opted out of Medicare.

(6) Beneficiary understands that Medigap plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare.

(7) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

Medicare Exclusion Status of Physician

Beneficiary understands that Physician has not been excluded from participation under the Medicare program under section 1128, 1156, 1892, or any other sections of the Social Security Act.

Duration of the Contract

This contract becomes effective on January 1, 2017, and will continue in effect for two years. Either party may terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

Successors and Assigns

The parties agree that this agreement will be fully binding on their heirs, successors, and Assigns. Physician and Beneficiary intend to be legally bound by signing this agreement on the date set forth below.

Dr. Shelley Meyer
Highlands Health & Wellness

Date Signed

Name of Beneficiary (printed)

Signature of Beneficiary

Date Signed