Company Registration Form

PERSONAL MD®

GUARANTOR INFORMATION

Last Name: First Name: DOB

Billing Address City: State: TX Zip:

Phone #1: ( ) __ Work __ Cell ___ Home | Phone #2: ( ) __ Work __ Cell __ Home

MEMBERSHIP INFORMATION

Company: | Membership Start Date:

Program: ____ Personal MD Medical Care ___ Personal MD Medical Care with on-site clinic (# of employees ____________)

REGISTRATION FEE: $250. Please designate if you want monthly fees charged to a separate form of payment

Monthly Billing Date: ___ 1st ___ 15th (To cancel Monthly Billing - Simply fill out a cancellation form with 30-days written notice)

Payment Options: ___ Credit Card or ___ Checking Account (fill out information below)

Card Type: ____ Visa ____ Master Card ___ Discover	Name on Account:
Card #:	Bank Name
Expiration Date: _____/________	Account #:
Billing Zip Code:	Routing #:

Use "Personal Information Form" to add employees to your company policy

Use a separate "Personal Information" form to add individual employees if your company has less than 50 total

Employees participating in the program. A final list of all members will be sent to the Guarantor prior to being billed.

Notes:

AUTHORIZATION

- By signing below, I hereby authorize Personal MD to contact me using the information I have provided above. By signing below, I hereby authorize Personal MD to initiate charges to my credit card, debit card or bank account for my periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my care fee plus the care fees of any individuals on my account.
- This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until Personal MD has received written notification from me of its termination in such time and in such manner as to afford Personal MD and my financial institution a reasonable opportunity to act on it.
- I understand that my participation in Personal MD is continuous and that, by signing below, I authorize recurring credit/debit card charges.
- I understand and that a $25 fee will be charged to me for declined credit card, debit card, or bank account transaction(s) that are not honored.
- I understand that the medical programs provided Personal MD are not a form of insurance and no money collected is held in a trust for services to be provided in the future. I also understand that the programs provided by Personal MD do not satisfy the requirements set forth by the Affordable Care Act ("Obamacare") and will not prevent me or my company from be assessed penalties or fees set forth by the ACA.

A photocopy or scanned copy of the above information is to be considered an original. I understand that I am financially responsible for all charges accumulated to Personal MD Family Healthcare, P.A. I understand that Personal MD Family Healthcare, P.A. does not accept any insurance of any kind and will not file to your insurance carrier for medical services provided by Personal MD Family Healthcare, P.A., Or its providers. I understand that providing medical services through a Personal MD program is not considered healthcare by the United States Tax Code. Please speak to your financial advisor on how to categorize the expenses accumulated by using Personal MD and our medical programs.

Signature: | Date:

Personal Information Form for Employee

PERSONAL MD®

PATIENT INFORMATION

Last Name: First Name: MI: DOB: ___Male ___ Female

Home Address City: State: TX Zip:

Phone #1: ( ) __ Cell __ Home __ Work | Phone #2: ( ) __ Cell __ Home __ Work

Emergency Contact: Relationship: Phone: ( )

Do You take medications for pain, anxiety, sleep, or ADD? ___Yes ___ No
Please Note: If you are taking a controlled substance regularly for any of these conditions, please see our controlled substance policy on the Personal MD website. http://www.personalmd.net/forms.html

PREFERRED METHOD OF COMMUNICATION

Please tell us how to communicate with you by checking the appropriate options.
Personal MD uses a default of home phone and letter to home address unless otherwise stated below.

___Home Phone ___Cell Phone ___Work Phone
___Letter ___In Clinic Only ___ Other ____________________

___ OK to leave a message with detailed information. ___ Leave a message with call-back number only.

COMMUNICATION WITH OTHER PEOPLE

I hereby give permission to ***Personal MD Family Healthcare, P.A.*** to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s):

Name ____________________________________ Relationship ___ Spouse ___ Child ___ Legal Guardian ___ Other ________________

Name ____________________________________ Relationship ___ Spouse ___ Child ___ Legal Guardian ___ Other ________________

___ **DO NOT** communicate my information with other people.

COMMUNICATION BY E-MAIL

Please check the appropriate Yes or No answer below:

___**Yes** – please communicate with me by email. ___ **No-**please do not communicate with me by email.

If Yes, Please give us your Preferred Email: ____

Please Write Neatly

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA)

ACKNOWLEDGMENT OF THE RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES EFFECTIVE DATE OF NOTICE: JANUARY 1, 2012
The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Personal MD is furnishing you with the attached notice, which provides information about how Personal MD and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you acknowledge that you have received a copy of Personal MD's *Notice of Health Information Practices*.

PRINT NAME:

SIGNATURE: | DATE:

FOR OFFICE USE ONLY

Pt ID #:

PATIENT AGREEMENT & DISCLOSURE STATEMENT

TERMS

- I acknowledge and understand that I am voluntarily becoming a Personal MD Family Healthcare, P.A. ("Personal MD") patient and that this agreement is non-transferable.
- I have reviewed the *Personal MD Patient Services* guide and I have had the opportunity to ask questions and receive answers regarding its content.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance and that it provides only the health care services specifically described in the *Personal MD Patient Services Guide*.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of Personal MD including but not limited to emergency room, hospital and specialty services and that Personal MD will not bill insurance carriers for any services provided by Personal MD.
- I acknowledge and understand that Personal MD must maintain a record of my health information and must protect the privacy of my health information as per the terms of the *Notice of Privacy Practices*. I understand and acknowledge that this policy is available for my review at any time at www.PersonalMD.net or upon request.
- I acknowledge and understand that I may terminate this *Patient Agreement* at any time and for any or for no reason by providing written notice to Personal MD or my Human Resource department. Monthly fees will continue to accrue until written termination notice is received. Any pre-paid monthly care fees will be prorated to the date Personal MD has received my written termination and refunded to me within ten (10) business days.
- In addition, I acknowledge and understand that Personal MD may terminate this *Patient Agreement* by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and refunded to me within ten (10) business days. Personal MD will not terminate this *Patient Agreement* solely on the basis of health status.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the *Medicare Opt-out Agreement* for review and signature before my first appointment. *(The Opt-out Agreement does not prevent me from receiving current or future Medicare benefits from non-Personal MD providers; neither I nor my Personal MD health care provider(s) will seek reimbursement from Medicare for the medical services I receive from Personal MD.)*

RIGHTS & RESPONSIBILITIES

- I understand that I have the right to choose my personal health care clinician and to change my clinician at any time, for any reason. I understand that all reasonable efforts will be made to accommodate my request, but only if my new clinician's patient panel is open to new patients.
- I understand that I have the right to receive accurate and easily understood information about Personal MD's health care services, health care professionals and health care facilities. If I speak a language different from my clinician, have a physical or mental disability or do not understand something, I understand that Personal MD will make its best effort to provide assistance so I can make informed health care decisions. If I require interpreter services beyond what can be provided by Personal MD, professional interpreters may be provided at an additional cost to me.
- In the event of membership termination, I understand that I must complete a written Service Cancellation Form. I understand that I must give a 30-Day time frame for the cancellation of my program and program fees from being charged. Care will be continued until the last active date of the Contract. A copy of the Service Cancellation form can be found at www.personalmd.net/forms.html.
- I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation. I understand that I do not and can not expect my employer to pay for medical services rendered as a member of any Personal MD program.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Personal MD health care clinician (s). I also understand that I am responsible for communicating clearly and respectfully with my clinician. Should I become dissatisfied with my care or Personal MD services, I agree to notify Personal MD immediately so my concerns may be addressed in a timely manner.
- I understand that I have the right to know all of my treatment options and to participate in my health care decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions if proper written notice is provided.
- I understand that I have the right to speak in confidence with my Personal MD provider(s) and to have my health care information protected. At not time will my employer have access or privilege to my health information without my written notice, unless it is under legal obligation.
- I understand that Personal MD will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider(s) amend my record if I feel it is inaccurate or incomplete by contacting the Personal MD Management Department. I understand that there may be charges for printing/copying fees if I desire to have a copy of my records for personal use.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care clinician(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities.
- I agree to first bring any complaints to the attention of Personal MD staff and to participate in the Personal MD complaint and grievance process. Unresolved complaints may be brought to the attention of the Office of the Insurance Commissioner for the State of Texas by calling the Consumer Advocacy department at: (800) 578-4677 (TDD 512-322-4238).
- In order to receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to my Personal MD health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Personal MD health care clinician(s) of any health care services I receive outside of Personal MD (such as emergency room, specialist, or hospital services).
- I understand that I am responsible for not exposing myself or others to disease or danger. I understand that I can receive information from my Personal MD health care clinician(s) about protecting the health and safety of myself and others.

By my signature below, I agree to become a Personal MD patient and I agree to the terms outlined in this Patient Agreement

Print Name:	Date:
Signature:	For Office Use Only:

Add Family Members

PERSONAL MD®

ACTIVE EMPLOYEE INFORMATION		
Last Name:	First Name:	DOB
Address	City:	State: TX Zip:
Phone #1: ( ) __ Work __ Cell ___ Home	Phone #2: ( )	__ Work __ Cell __ Home

MEMBERSHIP INFORMATION	
Company:	Current Date:

ADDITIONAL MEMBERS: PRICE LIST **1 adult = $80/mo ‖ Each Child age birth - 25 = $40/mo**		
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:

AUTHORIZATION

I understand that Personal MD Family Healthcare, P.A. Is not a form of insurance and does not meet criteria required by the Affordable Care Act (Obamacare) and that membership in the 40:40 Medical Care program does not constitute being insured

I understand that a dependent is defined as a spouse and/or child under the age of 21 or under the age of 26 that is still in school.

All members must live at the same address of the primary employee member on the account.

I understand and that am responsible for the full fee of additional members.

I understand that the additional fee for family members will be automatically deducted from my paycheck on a scheduled determined by my employer.

I understand that my family members will have an individual identification number and must show their membership card when required.

I understand that I can remove a family member at anytime for any reason. Removal of family members must be done in writing and is subject to billing period used by the employer.

I understand that any charges accrued during an medical visit with a Personal MD Family Healthcare, PA medical provider must be paid at the time of service.

I understand that I am financially responsible for all charges accumulated from visits to Personal M.D. Family Healthcare, P.A. and if not paid at the time of my visit can be deducted from my paycheck per my employer.

I understand that Personal M.D. Family Healthcare, P.A. does not accept any insurance of any kind and will not file to your insurance carrier after your visit to Personal M.D. Family Healthcare, P.A.

I also understand that being seen at a Personal MD office for medical care is consent to receive treatment.

I hereby authorize the physician to treat myself or if a minor, my child, as deemed medically necessary.

SIGNATURE OF GUARANTOR/ACCOUNT HOLDER	
Date:	Total Amount to Be Billed Monthly:
Print Name:	Signature: