Membership Agreement (This is a legal contract so read carefully and don't just sign)

PERSONAL MD®

Personal MD Family Healthcare, P.A. (Personal MD or Clinic) is a direct primary care practice that delivers primary care services through its healthcare providers and staff (medical team). In exchange for certain fees, the Clinic agrees to provide our clients with the services on the terms and conditions contained in this agreement.

1. **Member**. In this agreement, "Member" means the person(s) for whom the medical team shall provide care and who has/have signed this agreement or are listed on the membership enrollment form.
2. **Services**. In this agreement, "services" means the primary medical care services offered to you by the medical team in this agreement.
3. **Notice**: This Member agreement does not constitute Health Insurance and is not a Medical Plan that provides health insurance coverage for purposes of the patient protection and affordable care act and covers only "primary medical care services" as defined by Texas occupations code 162.251 as designated in this agreement. By signing this agreement, you acknowledge that you are not currently facing an emergency or urgent healthcare situation. Furthermore, you acknowledge that you have voluntarily elected to enter into this agreement under which you will be personally responsible for payment for health care services.
4. **Term**. The initial term of this agreement shall be for one month starting on the date this agreement is signed by both parties
5. **Renewal**. This agreement will automatically renew each month on the first or fifteenth of the month as designated on this agreement.
6. **Termination**. Notwithstanding anything contained in this agreement, either party has the right to cancel this agreement at any time. To terminate this agreement, a thirty-day notice is required by either party. For the Member to terminate the agreement, the "Personal MD Cancellation Form" must be filled out and submitted. A link to this form is found at personalmd.net/cancel. The date of submission will act as the first day of notice. Termination of this agreement will mean the relationship between you and the Clinic is also terminated. If such an event were to occur, the Clinic will comply with all applicable laws, rules, and regulations with respect to ending the physician-patient relationship. Upon request, the Clinic will provide you with recommendations to help you secure another physician for your needs and will transfer records to the new physician upon your signed authorization.
7. **Membership Fees and Refunds**. In exchange for the services, you agree to pay Personal MD a monthly fee every month. A one-time registration fee of $100 will be applied at the time this contract is signed by both parties. Monthly membership fees will be prorated at the time of registration and monthly membership payments will begin the first or fifteenth day of each month thereafter until termination of the membership contract by either party as noted in #6 above.
8. **Change of Law**. If there is a change of any relevant law, regulation, or rule, federal, state, or local which affects the terms of this agreement, the parties agree to amend this agreement to comply with the law.
9. **Severability**. If any part of this agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable and the remainder of this agreement will in force as originally written.
10. **Legal Significance**. You acknowledge that this agreement is a legal document that gives the parties certain rights and responsibilities. Member also acknowledge having reasonable time to seek legal advice regarding this agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of this agreement.
11. **Miscellaneous**. This agreement shall be construed without regard to any rule requiring that it be construed against the party who drafted the agreement. The captions in this agreement are only for the sake of convenience and have no legal meaning.
12. **Entire agreement**. This agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.
13. **No Waiver**. Each party agrees that the party may choose to delay or not to enforce the other party's requirement or duty under this agreement (for example, notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.
14. **Governing Law and Venue**. This agreement shall be governed and construed under the laws of the State of Texas. The parties agree that the state and federal courts of Texas in Collin county shall be the exclusive courts of jurisdiction and venue for any legal action, special proceeding, or other proceeding that may be brought, or arise out of, in connection with, or by reason of this agreement. The parties specifically waive any rights of venue in any other courts that they might otherwise have.
15. **Service**. All written notices are deemed served if sent to the address of the party written below or appearing on the Member enrollment form by first class U.S. mail. The parties may have signed duplicate counterparts of this agreement on the date first written below.
16. **Confidentiality**. Member should understand that the terms and conditions of this agreement are confidential and will not be transmitted to any other healthcare provider when copies of all or part of your medical record are transmitted. This agreement is not considered part of your medical record.
17. **Certification**. You hereby certify that you have read this entire agreement and have been given the opportunity to ask questions and receive answers about all provisions of this agreement. You certify that you have received a signed and executed copy of this agreement.

Member Printed Name:	Member Signature:
Date of Signature:	Personal MD Representative Signature:

Membership Billing Form

PERSONAL MD®

GUARANTOR /PRIMARY MEMBER INFORMATION			
First Name:	Last Name:		DOB
Billing Address	City:	State:	Zip:
Phone #1: Type:		e-mail for receipts:	

MEMBERSHIP INFORMATION	
Membership Program: Personal MD Medical Care	Is this is a Corporate Contract:
	Employer (If corporate):

BILLING INFORMATION	
I prefer to be billed on the: ___ First of Each Month ____ Fithteenth of Each Month	
Payment Options: ___ Checking Account	___ Credit Card
Name on Account:	Card Type:
Bank Name	Card #:
Account #:	Expiration Date: CVV (3 digit code):
Routing #:	Billing Zip Code:

ADDITIONAL MEMBERS: 1st member: $80/month | Additional: Adults: $80/month, Kids: $40/month		
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 TO BILL YOUR ACCOUNT

- 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 individual 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 until I notify Personal MD in writing that I wish to terminate my membership. Termination forms are provided online.
- I understand that a $25 fee will be charged to me for declined credit card, debit card, or bank account transaction(s) that are not honored.

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 from visits 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 after your visit to Personal MD Family Healthcare, P.A. I also understand that being seen in our office for medical care is consent to receive treatment. I hereby authorize Personal MD medical provider(s) to treat myself or if a minor, my child, as deemed medically necessary.

SIGNATURE OF GUARANTOR/ACCOUNT HOLDER	
Date:	
Print Name:	Signature: