Medical Service Agreement

PERSONAL MD®

Personal M.D. Family Healthcare, P.A. (Personal MD or Clinic) is a Direct Primary Care practice as defined by Texas Occupation Code 162 Subchapter F. The captions in this agreement are only for convenience and have no legal meaning.

1. **Legal Significance**. I acknowledge that this agreement is a legal document that gives the parties certain rights and responsibilities. I have been given reasonable time to seek legal advice regarding this agreement and I am satisfied with the terms and conditions of this agreement.
2. **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, particular proceeding, or other proceeding that may be brought, or arise out of, in connection with, or because of this agreement. The parties expressly waive any rights of venue in any other courts that they might otherwise have.
3. **Entire agreement.** This agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements, whether written or oral.
4. **Change of Law.** If any relevant law, regulation, or rule changes at a federal, state, or local level that affects the terms of this agreement, the parties agree to amend this agreement to comply with the law.
5. **Severability.** If a court of competent jurisdiction considers any part of this agreement legally invalid or unenforceable, that part of this agreeement will be amended to the extent necessary to be enforceable, and the remainder of this agreement will be in force as originally written.
6. **Notice:** This Member Servcie 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.
7. **Services**. In this agreement, "Primary Medical Care" and "Services" is defined by Texas occupations code 162.251 (5). By signing this agreement, you acknowledge that you are seeking Primary Medical Care and you are not in need of urgent or emergency healthcare services.
8. **Member**. In this agreement, "Member" means the person(s) for whom are liisted on the Membership Billing Form or the Add/Remove a Member form desinged by Personal MD. Furthermore, the guarantor of the agreeemnt acknowledges that they have voluntarily entered into this agreement under which they will be responsible for paying the Direct Fee and any miscilaneous charges for supplies or services not covered by Personal MD including, but not limted to medications, supplements, Platelet Rich Plasma, and laboratory services.
9. **Term**. This agreement's initial term will be on the date this Medical Service Agreement is signed and Personal MD accepts an initial deposit.
10. **Renewal.** This agreement will automatically renew on the first or fifteenth of the month as designated on the Membership Billing Form.
11. **Termination**. Notwithstanding anything in this agreement, either party has the right to cancel this agreement at any time. To terminate this agreement, either party must provide thirty-day notice. For the Member to terminate the agreement, the "Personal MD Cancellation Form" found at personalmd.net/cancel, must be filled out and submitted. The date of submission will act as the first day of notice. Terminating this agreement will also terminate the relationship between you and the Clinic. If such an event were to occur, the Clinic would comply with all applicable laws, rules, and regulations concerning ending the physician-patient relationship. Upon request, the Clinic will transfer medical records to the new physician upon your signed authorization.
12. **Direct Fee**. In exchange for Services, you agree to pay Personal MD a Registration Fee and a Direct Fee outlined in the Membership Billing Form. The Direct Fee will be prorated at the time of registration, and Direct Fee payments will occur each month thereafter until either party terminates the membership contract, as noted in #11 above. I understand the Direct Fee may be periodically adjusted. The Guarantor designated on the Membership Billing Form will be notified in writing at least sixty-days before any changes can be made to the Direct Fee giving Member(s) time to Terminate this Agreement if desired.
13. **Construction**. In the event that an ambiguity or a question of intent or interpretation arises, this Medical Service Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the party who drafted the contract.
14. **Served**. All written notices are deemed served if sent to the address of the party written on the original "Membership Billing Form" or the "Billing Update/Change" form by U.S. mail.
15. **Confidentiality.** Member understands this agreement is not considered part of a medical record and terms and conditions of this agreement will not be transmitted to any other party if copies of all or part of your medical record are transmitted.
16. **Original Copy**. A photocopy or scanned copy of this Medical Service Agreement is to be considered an original.
17. **Certification**. With your signature below, you certify that you have read this entire agreement and have been allowed to ask questions and receive answers about all provisions of this agreement. A digital copy of this agreement will be kept by Personal MD and a printed copy of this agreement is available upon request at no charge.

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

Membership Billing Form

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

MEMBERSHIP INFORMATION	
Membership Program: Personal MD Medical Care	Is this is a Corporate Contract ___ Yes ___ No
Primary Member: ____ I am the Guarantor and Primary Member	____ I am ony the Guarantor and Member's are listed below

MEMBER(S): Registration Fee: $100. Primary Member: $125/month | Additional Member(s): Adults: $125/month, Child: $50/month		
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:

BILLING INFORMATION	
Monthly Billing Date: ___ 1st ___ 15th (To cancel monthly billing - fill out the canelation form at personalmd.net/cancel)	
Payment Options: ___ Credit Card ___ Checking Account (fill out appropriate information below)	
Card Type: ____ Visa ____ Master Card ___ Discover	Name on Account:
Card #:	Bank Name
Expiration Date: _____/_____ CVV (3 digit code):	Account #:
Billing Zip Code:	Routing #:

AUTHORIZATION

• Your monthly Personal MD Medical Care Direct Fee covers the services described in the Personal MD Membership Agreement. By providing the above billing information you authorize Personal MD to automatically charge your card or draw on your bank account for the Direct Fee and any incidental items incured at the time of service. In all cases, charges above the Direct Fee will be disclosed in advance.

• By signing below, I hereby authorize Personal M.D. Family Healthcare, P.A. (Personal MD) and its agents 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 Direct Fee.

• 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 formal cancelation notification (found at personalmd.net/cancel) from the guarantor of this agreement. Personal MD will be given thirty-days to cancel this contract. All outstanding charges are required to be paid before this contract can be terminated.

• I understand that a $25 fee will be charged to me for credit card, debit card, or bank account transaction(s) that are not honored.

• I understand my Direct Fee may change. I will be notified in writing at least sixty days before any changes can be made and I can amend or cancel my membership at personalmd.net/cancel if I do not agree to pay the adjusted Directe Fee rate.

• 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 accrued at Personal MD. I understand that Personal MD does not accept any insurance of any kind and will not file to any insurance carrier after a visit to Personal MD. I also understand that being seen by a Personal MD provider or Personal MD employee for medical care is consent to receive treatment.

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