ACCESS TO THE HOPE FAMILY CENTER
DR. MYRA DEESE HALL
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MEMBERSHIP CONTRACT

- **$55 Monthly Membership Fee- Adult**
- **Plus a $20 appointment scheduling fee for each office visit**.

You now have a Medical Home Membership, which will allow you to be scheduled for routine doctor visits for a fee of only $20 per visit. There is no extra charge for most basic lab work for our members. Some non-routine lab work that is sent out is based on actual cost at approximately a 75% discount. **All Annual Healthcare Memberships are non-refundable once any office visits or lab work has been completed**. This represents a private contract between Access To The Hope Family Center and the patient, which is executed after membership payment has been made and initial services rendered. Insurance will not reimburse for the prepaid plans and **this is not a type of insurance**. Access To The Hope Family Center does not file insurance claims or sign insurance contracts. Medicare and Medicaid recipients are not allowed to file claims for Medicare/Medicaid covered services.

Basic lab work that can be performed at no additional charge for members include: Strep Test, CMP, Lipid Panel, TSH, PSA Screening, HgA1C, Urine Dip, CBC, and an Annual Pap Smear.

Members receive an annual EKG at no additional charge. We have arranged for significantly discounted rates at participating facilities for other diagnostic tests such as X-ray, MRI, and Ultrasound testing.

*Services such as sutures or supplies like injections are **not included** or discounted with membership.*

***There is a No-Show fee for missed appointments of $20.00 per episode**.

Please SELECT **One Option** Below:

☐ I, (print name) ______________________ agree to pay **$585 in full**, for the year starting **____/____/ 20______** for this membership and ending on **___/____/20_______.**

OR

☐ I, (print name) _________________________ agree to pay **$55 per month (with the first 3 months paid in advance for new patients)** for one year starting **____/____/20______** for this membership and ending on **___/___/20________.**

This fee will be drafted from the bank account that you provide on every 1st of the month.

Either prepaid plan entitles me to discounted fees on services at this location only. I will still be responsible for other services not discounted as specifically mentioned above. **At the end of one year, this contract will automatically renew unless you inform us in writing to cancel; however, fees and terms may change annually.**

CONTROLLING LAW: This agreement shall be construed and interpreted in accordance with the laws of the State of North Carolina. As used in this agreement, the singular shall include the plural and the plural shall include the singular and the use of any genders shall be applicable to all genders.

SEVERABILITY/INVALID CLAUSES: The provisions of this agreement are severable and should any provision, clause, sentence, section, or part thereof be found to be invalid, illegal, unconstitutional, inapplicable to any person or circumstance, or otherwise unenforceable, the remainder of the agreement shall not be affected thereby and each term, provision, sentences, clauses, sections or parts of the agreement herein shall be valid and enforceable to the fullest extent permitted by law.

I understand that if I receive services under this agreement and then either fail to make a monthly payment or full annual fee that I will responsible for all charges I have incurred at the normal non-discounted rate.

________________________________ ____________________
Signature **Date**

IMPORTANT INFORMATION

- **Bring ALL medications and vitamins to EVERY VISIT!**
- **Make sure ALL of your contact information is updated.**
- **Come in a week BEFORE follow-up appointment for blood work, if blood work is necessary.**
- **Make sure your Credit Card, Debit Card, or Bank account information is current, including the EXPIRATION DATE, for monthly billing to avoid additional service fees. A service fee of $15.00 is charged on all banking returned charges.**
- **All payments must be current to be seen, to receive prescription refills, and/or receive referrals.**
- **Please notify us at least 24 hours before an appointment if you need to cancel or reschedule to avoid a $20.00 service fee.**
- **There is a $20 NO SHOW FEE for each missed appointment.**
- **Important understanding for members paying monthly. If you do not fulfill your terms of payment, you will be held responsible for all unpaid annual charges or you will be charged NON-MEMBER rates. Non-member rates are currently $130.00 per visit plus any additional services.**
- **We require new monthly members to pay the first 3 months in advance ($165). After the first 3 months, you will begin paying $55 per month on the first of each month.**
- **Failure to make your payment on time may result in being sent to collections and reported to the credit bureau.**
- **Understand that billing may come directly from our office or you may receive bills from our authorized external billing company TWIN OAKS.**
- **All office visits have a $20 scheduling fee.**

We appreciate you taking the time to review the additional information. We find this important to review so we can do everything possible to help keep our prices reasonable for all of our members.

____________________________ ____________________________

Patient's Signature **Staff member that reviewed this with patient**