

# Application and Agreement for Peninsula Family Medical Center

This Application and agreement (“Agreement”) describes the terms under which the undersigned (“You” and “Your”) may participate in [Membership Practice] offered by Peninsula Family Medical Center (the “Practice”).

1. **[Membership Practice]:** [PFMC Membership Practice] is open only to individuals who are enrolled patients of the Practice. [PFMC Membership Practice] members will be entitled to the benefits and services described herein. Patients of the Practice who do not become [Membership Practice] members will not be so entitled and will need to establish with a different practice.
2. **Benefits and Services:** The Practice will provide to [PFMC Membership Practice] members the benefits and services described in Appendix A to this application. These additional benefits and services are over and above the services covered by insurances and so are not covered by insurances. The Practice reserves the unrestricted right to change the scope and composition of [Membership Practice] benefits and services from time to time in its sole discretion based on various factors, which may include the experience and expressed desires of the [Membership Practice] members. The Practice will notify [Membership Practice] members any of such changes.
3. **[Membership Practice] Fees and Payment Options:** Your membership in [ PFMC Membership Practice] (“Membership”) is in effect from the date your application is accepted by the Practice and will continue in effect indefinitely unless and until terminated by either Your or the Practice as provided by Paragraph 8 below. Membership fees for [Membership Practice] are as follows (“Membership Fees”):
  - a. Individuals (Age 26+) \$35 per month/\$385 yearly,  
Non-refundable
  - b. Children of Existing Patients age 25 or less \$Free
  - c. Children under 25 years of age \$20 per month/\$220 yearly,  
Non-refundable
  - d. During each annual membership year, the Membership Fees are guaranteed and will not be increased. Membership Fees may be adjusted at the beginning of any succeeding annual membership year. Memberships are non-transferable. Payments may be made by credit card, debit card or once yearly check. Membership will auto renew at the end of each annual term whether annual (or separate payment agreement), and your credit or debit card will reflect your agreement to auto renew.
4. **[Membership Practice] benefits and services are not covered or paid for by health insurance.** Fees for [PFMC Membership Practice] do not cover any medical or health care services covered by your health insurance.
5. **[Membership Practice] is not health insurance:** You (or Your insurance company) will be financially responsible for all billable medical and health care services received from the Practice or its staff. If You have health insurance, the Practice will bill Your health care insurance under most circumstances for those health care services furnished to You and covered by Your insurance. You are financially responsible to the Practice for any co-payments, coinsurance or deductible amounts due under your insurance, and for medical and healthcare services which are excluded from Your insurance coverage. Nothing in this agreement supersedes or modifies the terms or conditions of any agreements relating to Your insurance.

6. **Protection of your Health Information, E-mail Communications:** we are committed to protecting your information from unauthorized use. The Practice is also subject to federal regulations under the Health Information Portability and Accountability Act (HIPAA). There are issues with privacy and the use of e-mail and the internet which you should understand before you use these media to either communicate with us, or to access your medical or billing information. Please note that standard email communication with the Practice is inherently insecure and would not meet HIPAA privacy standards. The messaging application inside the Practice Patient Portal does meet HIPAA standards.
7. **Mutual Satisfaction and Membership Termination:** If You are not satisfied for any reason with your [PFMC Membership Practice] Membership, you may at any time withdraw your Membership and terminate this Agreement on 30 days prior written notice delivered to the office of the Practice. The Practice may also terminate this Agreement and Your status as a [PFMC Membership Practice] member by providing 30 days prior written notice to You, if: (a) You fail to pay the Membership Fees or any charges or fees payable by You for health care services rendered by Practice when due; (b) You fail to abide by the terms and conditions of Your Insurance coverage(s), if any; or (c); You fail to abide by this Agreement or the policies of the Practice.
8. **Application Acceptance:** This Agreement becomes effective as an application for Your participation in [PFMC Membership Practice] when either: (a) it is signed by You and delivered to the Practice, or (b) when You have agreed to the terms and conditions of the Agreement in an online purchase transaction at:[website]. This Agreement becomes effective as the [PFMC Membership Practice] Membership Agreement when the Practice accepts your tender of Membership Fee payment.
9. **Personal Physician:** our personal physician at this Practice is as named here [ ] or as You have designated in Your online or telephone call application process.
10. **Governing Law:** This Agreement shall be governed by and construed in accordance with the laws of the State of Washington, and if a provision is held to be invalid or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, unless the provisions held invalid or unenforceable shall substantially impair the benefits of the remaining portions of the Agreement.

By signing below, the undersigned indicates his/her desire to participate in [PFMC Membership Practice] and agrees to the terms of this Application and Agreement.

Date: \_\_\_\_\_ Applicant Signature: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Applicant Printed Name: \_\_\_\_\_

**OR**

By signing below, the undersigned indicates his/her understanding of the medical philosophy of the Practice and indicates his/her desire **NOT** to participate in [PFMC Membership Practice].

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Patient Printed Name: \_\_\_\_\_



## **PFMC Appendix A**

Services provided by Peninsula Family Medical Center Membership Program that are not covered by insurance.

- Coordination of community care services and referrals
- Travel Counseling
- Non-Emergency care when traveling outside of the U.S.
- Cost-effective prescription management
- In-house triage
- No additional charge for completing administrative paperwork (FMLA, Jury Duty, Sports physicals and Excuse Letters)
- Peninsula Family Medical Center portal access
- 24/7 Telephone access to Physicians for medical emergencies
- Quarterly Med Talks