Texas Family Physicians Medical Membership Program

Thank you for choosing to become a member of the Texas Family Physicians Medical Membership Program (the "Membership Program"). This packet outlines the terms and conditions relating to the Membership Program and will serve as the agreement under which we provide you our services. Please review this information in full and complete those sections that require your input. If you have any questions please do not hesitate to contact us. Once complete, please sign this agreement and return it to us at your earliest convenience.

1. Membership. By signing this agreement and returning it to Texas Family Physicians, you agree to become a member of the Membership Program subject to the attached terms and conditions. Your membership shall become effective immediately as of the date this packet is signed and submitted back to Texas Family Physicians and shall continue in effect until terminated by either of you or Texas Family Physicians as allowed by the terms and conditions.

2. Membership Services. The services available under the Membership Program (the "Membership Services") are described in the Membership Services Attachment attached hereto. Texas Family Physicians may modify, add, or discontinue Membership Services at any time, as it may choose in its sole discretion. Texas Family Physicians shall provide at least sixty (60) days written notice prior to making any changes to the Membership Services.

3. Membership Options and Fees. You may select an individual membership or a family membership. A family is defined as a head of household and their dependents. As such, a family membership may only include those individuals living in one household who are dependents on the head of the household.

Please select your membership and payment type below. You agree to pay the membership fee in accordance with the Membership Program option selected below.

Membership Fees can be paid in one single annual payment or in monthly installments, both in the amounts set forth above. If you select monthly payments, you hereby authorize Texas Family Physicians to automatically charge the credit card identified below in the amount set forth above. Such charges shall take place on the first (1st) day of each calendar month. To cancel such automatic payment, please notify Texas Family Physician at least three (3) business days in advance of the upcoming charge. However, cancelling an automatic payment does not terminate your participation in the Membership Program.

Membership Type	Annual Fee	Monthly Fee
☐ Individual	☐ $1,200/Year	☐ $100/Month
☐ Family	☐ $2,400/Year	☐ $200/Month
☐ Aging Parents		50% off Monthly Rate

You understand and acknowledge that the Membership Fee is compensation solely for membership in the Membership Program and for the Membership Services, and does not include any medical services provided to you by Texas Family Physicians that are not expressly included in the Membership Services. This means that Texas Family Physicians may bill your insurance for services that are not offered under the Membership Program. You shall be responsible to separately pay, either individually or through a health benefit plan, for all medical services rendered by Texas Family Physicians that are not included in the Membership Services.

CREDIT CARD INFORMATION

CARDHOLDER'S NAME	
CARD NUMBER	
CV NUMBER	
EXPIRATION DATE	

ACH DEBIT AGREEMENT as an alternative to credit card payment on last page of document (pg 14)

4. Payment for Non-Membership Services. As stated above, you understand that the Membership Fee is compensation solely for the Membership Services. You may elect to pay for any non-Membership Services through your health plan or, alternatively, you may elect to instead pay for any non-Membership Services yourself. However, if you are a Medicare or Medicaid beneficiary, you may not elect to self-pay for non-Membership Services. Please make your selection below. This selection may be changed at any time.

☐ I elect to pay for non-Membership Services through my health plan and authorize the release of all necessary information to such plan as necessary. I understand that I may be personally responsible for payment of certain fees for services not covered by my plan.	☐ I elect to self-pay for all non-Membership services. I represent that I have read and understood the Self-Pay Agreement provided to me by Texas Family Physicians. **I understand that I may not select this option if I am a beneficiary of the Medicare of Medicaid program.**

By signing below you attest that you have read and understood the entirety of this packet, including the attached terms and conditions, and that all information you have provided in this packet is true and accurate as of the date completed.

Signature: _____ Date: _____

Printed Name: _____

Member Profile

Primary Member

Last Name	First Name	Middle Initial
Insurance Company	Insurance Group Number	Insurance Member Number
Insurance Phone Number	Insurance Billing Address	Social Security Number
Home Address	City, State	Zip Code
Date of Birth	E-Mail Address	
Home Phone:	Cell Phone:	Business Phone:
Emergency Contact Name		Emergency Contact Phone Number
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Contact Preference ☐ Home ☐ Cell ☐ Business ☐ E-Mail	Sex ☐ Male ☐ Female
Preferred Pharmacy Name	Preferred Pharmacy Address	Preferred Pharmacy Phone
Billing Contact Name (If Different than above)		Billing Contant Phone Number

*skip to Terms and Conditions if this is an individual membership

Family Member 1

Last Name	First Name	Middle Initial
Insurance Company	Insurance Group Number	Insurance Member Number
Insurance Phone Number	Insurance Billing Address	Social Security Number
Home Address	City, State	Zip Code
Date of Birth	E-Mail Address	
Home Phone:	Cell Phone:	Business Phone:
Emergency Contact Name		Emergency Contact Phone Number
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Contact Preference ☐ Home ☐ Cell ☐ Business ☐ E-Mail	Sex ☐ Male ☐ Female
Preferred Pharmacy Name	City, State	Pharmacy Phone
Billing Contact Name (If Different than above)		Billing Contant Phone Number

Family Member 2

Last Name	First Name	Middle Initial
Insurance Company	Insurance Group Number	Insurance Member Number
Insurance Phone Number	Insurance Billing Address	Social Security Number
Home Address	City, State	Zip Code
Date of Birth	E-Mail Address	
Home Phone:	Cell Phone:	Business Phone:
Emergency Contact Name		Emergency Contact Phone Number
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Contact Preference ☐ Home ☐ Cell ☐ Business ☐ E-Mail	Sex ☐ Male ☐ Female
Preferred Pharmacy Name	City, State	Pharmacy Phone
Billing Contact Name (If Different than above)		Billing Contant Phone Number

Family Member 3

Last Name	First Name	Middle Initial
Insurance Company	Insurance Group Number	Insurance Member Number
Insurance Phone Number	Insurance Billing Address	Social Security Number
Home Address	City, State	Zip Code
Date of Birth	E-Mail Address	
Home Phone:	Cell Phone:	Business Phone:
Emergency Contact Name		Emergency Contact Phone Number
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Contact Preference ☐ Home ☐ Cell ☐ Business ☐ E-Mail	Sex ☐ Male ☐ Female
Preferred Pharmacy Name	City, State	Pharmacy Phone
Billing Contact Name (If Different than above)		Billing Contant Phone Number

Family Member 4

Last Name	First Name	Middle Initial
Insurance Company	Insurance Group Number	Insurance Member Number
Insurance Phone Number	Insurance Billing Address	Social Security Number
Home Address	City, State	Zip Code
Date of Birth	E-Mail Address	
Home Phone:	Cell Phone:	Business Phone:
Emergency Contact Name		Emergency Contact Phone Number
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Contact Preference ☐ Home ☐ Cell ☐ Business ☐ E-Mail	Sex ☐ Male ☐ Female
Preferred Pharmacy Name	City, State	Pharmacy Phone
Billing Contact Name (If Different than above)		Billing Contant Phone Number

***Please contact Texas Family Physicians if more Family Member Profile sheets are needed.**

Medical Membership Agreement Terms and Conditions

This Medical Membership Agreement ("**Agreement**"), by and between Martin C. Molina, MD PA d/b/a Texas Family Physicians ("**Medical Group**") and the undersigned member or members ("**Member(s)**") is effective as of the date that this packet is signed and submitted to the Medical Group ("**Effective Date**").

All references to the Member shall be considered to also be a reference to the plural "Members" and thereby include all individuals described herein. In consideration of the mutual promises and undertakings set forth below and for other valuable consideration, receipt and sufficiency of which are hereby acknowledged by the parties, and intending to be legal bound, the parties hereby agree as follows:

1. Membership. Patient hereby agrees to enroll as a member in the Medical Group's membership program ("**Membership Program**") beginning on the Effective Date set forth above. By being a member of the Membership Program, Member shall be eligible to receive certain basic medical services described in the Membership Services Attachment ("**Membership Services**"), attached hereto and made a part hereof, and shall be subject to the conditions and limitations described therein. Membership in the Membership Program includes only the Membership Services specifically described in such attachment. The Medical Group may add or discontinue Membership Services at any time, as it may choose in its sole discretion. The Medical Group shall provide at least sixty (60) days' advance written notice upon any change to the Membership Services.

2. Membership Services.

a. Payment for Membership Services: Member acknowledges that Membership Services currently listed in in the Membership Services Attachment attached hereto are not covered by Member's insurance contract. As such, the costs for these Membership Services are not reimbursable by Member's insurer. Instead, Member's Membership Fee shall pay for the cost of these Membership Services. Member agrees to bear the sole financial responsibility for the Membership Fee, which is an out-of-pocket expense to be paid by the Member and cannot be reimbursed to the Member by any insurance company.

b. Payment for Services not Included in Membership Services: Member acknowledges that there may be services which are not currently listed in in the Membership Services Attachment attached hereto and that are not covered by the patient's health insurance. Member agrees that these services are outside the scope of the Membership Program, not covered by the Membership Fee, and not covered by the Member's insurer. As such, Member shall bear the sole financial responsibility for these services.

Additionally, Member acknowledges that they may receive services which are covered and reimbursable by their insurer. Services which are covered and reimbursable by the Member's insurer are not part of the Membership Services. If Member approves, Medical Group will separately charge Member or Member's insurer for medical, clinical, diagnostic or therapeutic services rendered by Medical Group to Member that are not part of the Membership Services, if the insurer so allows and to the extent covered by Member's insurer. Member shall be liable for any remaining balance that their insurer does not provide reimbursement for.

If Member is not a beneficiary of the Medicare or Medicaid program, Member may choose to self-pay for those services which are not Membership Services.

c. Member understands, agrees and covenants that this Agreement is a service contract, and not a contract for health insurance.

3. Term. Unless earlier terminated as set forth below the initial term of the Agreement shall be for one (1) year, commencing on the Effective Date and terminating on the day prior to the first anniversary of the Effective Date (the "**Initial Year**"). Thereafter, the Agreement shall automatically renew for successive one (1) year periods (each, a "**Renewal Year**"), unless either party notifies the other party in writing, not less than thirty (30) days prior

to the expiration of the Initial Year or the Renewal Year, as applicable, of such party's decision not to renew the Agreement. The Initial Year and each Renewal Year shall be referred to collectively as the "**Term**."

4. Termination.

a. Member may terminate this Agreement at any time upon sixty (60) days' prior written notice to Medical Group; provided, however, Membership Fees will still be due during such sixty (60) day period (in the event Member has selected to pay the Membership Fee on a monthly basis). If the Membership Fee is paid annually, Member will not be entitled to a refund of any portion of the Membership Fee previously paid by Member.

b. Medical Group may terminate this Agreement, at any time, upon: (i) the occurrence of Member's breach or default under this Agreement and failure to cure such breach or default within ten (10) days, or (ii) without cause upon thirty (30) days' prior written notice to Member; provided, however, that Member will be entitled to a refund of a prorated portion of any Membership Fee paid by Member for the month in which termination becomes effective (if paid monthly) or for the remainder of the applicable one (1) year term.

c. Member will not be entitled to any refund of all or a portion of Membership Fees paid if this Agreement is not renewed by either party under Section 3 of this Agreement.

5. Membership Fee. Member agrees to and shall pay the applicable Membership Fee. Unless this Agreement is not renewed, as provided in Section 3, payments will automatically continue in the manner selected above. For annual payments, Member will be invoiced for the amount due thirty (30) days prior to the beginning of the Renewal Year and payment shall be due within thirty (30) days of receipt of such invoice. Member agrees to submit all payments of Membership Fees to **Texas Family Physicians at River Place.** Any checks for payment of the Membership Fees shall be made payable to, and credit card payments shall be processed by **Texas Family Physicians at River Place.**

6. Privacy. Medical Group shall abide by all applicable laws and regulations related to patient privacy, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("**HIPAA**"). See the Medical Group Notice of Privacy Practices ("**NPP**") for more information regarding Member privacy.

7. Electronic Communications.

a. If so selected by Member in the NPP and unless advised otherwise in writing as provided in the NPP, Member authorizes the Medical Group and Medical Group staff and designees to communicate with Member by e-mail, text message or other electronic means regarding Member's protected health information, or "PHI" (as such term is defined in HIPAA) at Member's e-mail address or cell phone number set forth in the NPP. Member acknowledges and agrees that:

i. E-mail, text messaging and other electronic communication methods may not be a secure medium for sending or receiving PHI, and in particular, if Member sends or receives such electronic communications through Member's employer's mail system, such employer may have the right to review it;

ii. Although Medical Group and its designees will make reasonable efforts to keep electronic communications confidential and secure, Member understands that Medical Group and Medical Group's staff and designees cannot assure or guaranty the confidentiality of electronic communications;

iii. At the discretion of Medical Group, electronic communications may be made a part of Member's permanent medical record; and

iv. Electronic communication is not an appropriate means of communication regarding emergency or other time-sensitive issues, or for communication regarding sensitive information.

c. Member further acknowledges and agrees that all electronic communication between Member and Medical Group shall be performed in accordance with Medical Group policies.

d. **Member acknowledges and accepts that communicating about a medical issue with the Medical Group through electronic means does not replace an in-person exam. All electronic communications from Medical Group to Member shall be considered advice only and not medical treatment. ELECTRONIC COMMUNICATION WITH MEDICAL GROUP SHOULD NOT BE USED IN THE EVENT OF AN EMERGENCY AND DOES NOT REPLACE THE USE OF 9-1-1 EMERGENCY SERVICES.** Neither Medical Group nor any of Medical Group's designees, agents, consultants or representatives will be liable to

Member for any loss, damage, cost, injury or expense caused by, or resulting from: (i) a delay in response to Member due to technical failures, including, but not limited to, technical failures attributable to internet service provider, power outages, failure of electronic messaging software, failure by Medical Group or any of Medical Group's agents, consultants or representatives to properly address electronic communications, failure of computers or computer network, or faulty telephone or cable data transmission; (ii) any interception of electronic communications by a third party; or (iii) Member's failure to comply with the guidelines regarding use of electronic communications set forth in the Medical Group policies.

8. Miscellaneous

a. Notices. Any communication required or permitted to be sent under the Agreement (other than communications referenced in Section 7 relating to Member's PHI) will be in writing and sent via facsimile, recognized overnight courier or certified mail, return receipt requested, to the addresses set forth above. Any change in address will be communicated to Member and Medical Group in accordance with this Section 8(a).

b. Independent Medical Judgment. Notwithstanding anything to the contrary contained in this Agreement, Member's physician retains full and free discretion to, and shall, exercise his/her professional medical judgment with respect to medical services rendered to Member, and nothing in this Agreement shall be deemed or construed to influence, limit or affect the physician's independent medical judgment with respect to physician's provisions of medical services to Member and Member's medical treatment.

c. Change of Law. If there is a change in any state or federal law, regulation or rule or interpretation thereof, which affects this Agreement or the activities of either party under this Agreement, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights or obligations under this Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the applicable terms of this Agreement. If the parties are unable to reach an agreement concerning the modification of this Agreement within thirty (30) day after the date of the notice seeking renegotiation, then either party may terminate this Agreement by written notice to the other party.

d. Governing Law; Arbitration. THIS AGREEMENT SHALL BE GOVERNED AND INTERPRETED IN ACCORDANCE WITH, AND THE RIGHTS OF THE PARTIES SHALL BE DETERMINED BY, THE LAWS OF THE STATE OF TEXAS, WITHOUT REGARD TO CONFLICTS OF LAWS PRINCIPLES. THE PARTIES INTENTIONALLY AND VOLUNTARILY WAIVE ANY RIGHT TO A TRIAL BY JURY IN ANY MATTER ARISING OUT OF THIS AGREEMENT. ANY DISPUTE BETWEEN MEMBER AND MEDICAL GROUP OR ITS RESPECTIVE AFFILIATES AND AGENTS ARISING UNDER OR RELATING TO THIS AGREEMENT SHALL BE RESOLVED EXCLUSIVELY BY BINDING, CONFIDENTIAL ARBITRATION IN TRAVIS COUNTY, TEXAS, BEFORE A NEUTRAL ARBITRATOR, UNDER THE AUSPICES OF THE AMERICAN ARBITRATION ASSOCIATION, IN ACCORDANCE WITH ITS THEN CURRENT EXPEDITED RULES AND PROCEDURES FOR COMMERCIAL ARBITRATION. ANY AWARD RENDERED PURSUANT TO SUCH ARBITRATION SHALL BE FINAL AND BINDING UPON THE PARTIES, AND JUDGMENT UPON THE AWARD RENDERED BY THE ARBITRATOR MAY BE ENTERED IN ANY COURT HAVING JURISDICTION OVER THE PARTIES. THE PREVAILING PARTY IN ANY DISPUTE RESOLUTION SHALL BE AWARDED ITS COSTS AND ATTORNEYS' FEES IN CONNECTION WITH SUCH PROCESS.

e. No Liability. Except as required by applicable law, neither Medical Group nor any of its agents, consultants or representatives shall be liable for any damages or liability arising out of or related to the Agreement. In any event, Medical Group's liability under the Agreement shall be limited to an amount that is equal to the aggregate Membership Fees paid by the Member during the twelve-month period preceding the date on which the claim arises. In no event will any party be liable for any indirect, consequential, special, or punitive damages of any kind, whether arising in contract, tort, strict liability or otherwise, to the full extent permitted by the applicable law.

f. Waiver. The failure of any party to insist upon strict adherence to, or performance of, any term of this Agreement on any occasion will not be considered a waiver of the right to require adherence on any other occasion or regarding any other matter.

g. Severability. If any provision of the Agreement is declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of the Agreement will remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein.

h. Assignment. Member may not assign the Agreement. Medical Group shall have the right to assign this Agreement to any successor entity that assumes responsibility for Medical Group.

i. Entire Agreement; Amendment. The Agreement contains the entire agreement of the Parties and supersedes all prior agreements and understandings between the Parties regarding the subject matter hereof. The Agreement may not be changed and may only be amended by a written agreement signed by the Parties.

Membership Services Attachment

Program Services: Enhancements and Amenities

1) **Communications.** Member will be provided with the on-call provider cellular phone number, office number and e-mail address and will provide the member with detailed instructions on how to contact the providers through those means (collectively, the "Communications Enhancements"). Member will be provided the ability to contact the provider regardless of any medical necessity.

2) **Access.** Arrangements will be made for provider or, in provider's absence, provider's designee, generally to be available to personally communicate with the member (or member's authorized designee), even when not medically necessary, twenty-four (24) hours per day, seven (7) days a week through one (1) or more of the Communications Enhancements, regarding medically relevant concerns of the member.

3) **Enhanced Appointments and Alternative Appointments.** Appointments will be scheduled for up to one (1) hour if necessary. Member may request additional time when scheduling the appointment. Alternative appointments may also be requested and will be granted if medically appropriate.

4) **Practice Manager.** A representative of Texas Family Physicians at River Place at River Place will be available to the member to assist in addressing and coordinating the administrative aspect of the Medical Membership and program services.

5) **Comprehensive Health Assessment.** Arrangements will be made for provider to do an annual health assessment to set Member's annual health goals and evaluate the member's progress in achieving those goals. Member's health assessment and planning will include progressive and advanced screenings, labs, nutrition and dietary counseling. This planning also includes the coordination of care with specialists regarding specific health objectives of the member.

6) **Patient Portal.** Member will have access to a patient portal with all electronic reports and records, and ability to interact and upload information to their record.

7) **Wait Time.** Provider will use his or her best efforts to be promptly available to see the member at the time of member's schedule appointment, with no waiting time, unless provider is attending to a medical emergency.

8) **Primary Contact.** Please note Martin C. Molina, MD will continue to serve as the primary contact and team doctor for

i. Leander Independent School District; Vandegrift High School, surrounding Four points area schools, Lake Travis High School, Hill Country/Central Texas Pop Warner and Concordia University.)
ii. At times Dr. Molina may be unavailable due to a need with this type of patient and/or a school sport event or community event. An alternative appointment and/or provider will be offered.

AUTOMATED CLEARING HOUSE (ACH)
CUSTOMER ORIGINATION AGREEMENT
SCHEDULE H

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

I (we) hereby authorize _____, hereinafter called COMPANY, to debit entries to my (our) account indicated below and the Bank named below, hereinafter called BANK, to debit the same to such account. I (we) acknowledge the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

_____
(Bank Name) (Branch)

_____
(Address) (City, State) (Zip)

_____Type of Acct: ____Checking ____Savings
(Routing/Transit Number) (Account Number)

_____ _____
(Amount) (Frequency of Occurrence: Monthly, Quarterly, etc.)

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and BANK a reasonable opportunity to act on it.

_____	_____
(Print Individual Name)	(Print Individual Name)
_____	_____
(Print Individual ID Number)	(Print Individual ID Number)
_____	_____
(Signature)	(Signature)
_____	_____
(Date)	(Date)

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM