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
☐ 2 Person Family	$1,800/Year	$150/Month

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 the next page of this document

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: ________________________

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

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.**