

PATIENT MEMBERSHIP AGREEMENT

This Agreement is between New West Medical Care, PLLC, (“New West”), whose principal place of business is 14508 NE 20th Avenue, Suite 102, Vancouver, WA 98686, and patient _____ (“Patient”), who resides at _____.

In exchange for the Membership Services described in the New West Patient Handbook, the Patient agrees to make payments to New West pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

Initial:

_____ I have received and reviewed the Patient Handbook, which outlines the covered and non-covered services of this membership as well as the general policies and customs of New West. Further, I have had the opportunity to ask questions and receive answers regarding its content.

_____ I acknowledge and understand that my membership does not entitle me to any and all medical services or treatments available unless medically indicated or necessary. This Agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described in the Patient Handbook.

_____ I will be enrolling as a member at a rate of \$_____ per month. My membership fees will be paid on an annual / quarterly / monthly basis. (circle)

_____ I acknowledge and understand that quarterly and monthly schedules require an automatic payment authorization and have completed the necessary paperwork.

_____ I acknowledge and understand that my membership fees will be held in an escrow account and will not be disbursed to New West until the 1st day of the month following the month enrolled.

_____ I acknowledge and understand that I am free to terminate my relationship with New West at any time with written notice of no less than 30 (thirty) days.

_____ I acknowledge and understand that New West may terminate its relationship with me on 30 days written notice within the policies and limitations expressed in the Patient Handbook.

_____ I acknowledge and understand that any and all membership fee refunds due will be processed within the policies and limitations expressed in the Patient Handbook.

_____ I acknowledge and understand that this membership is non-transferable.

_____ *For Medicare Eligible Patients:* I acknowledge and understand that I have received a copy of the Medicare Beneficiary Addendum Agreement for review and signature before signing this Agreement.

_____ *For Non-Primary Members:* I acknowledge and understand that my membership is under the primary membership of _____ at a reduced rate. I acknowledge and understand that should the primary membership be terminated by either the Patient or New West and I choose to remain a member, my enrollment rate and fees may increase within the policies and limitations expressed in the Patient Handbook.

Patient – Print Name

New West Staff– Print Name

Patient – Signature

Date

New West Staff– Signature

Date