DPC Membership Agreement

Please read entirely and sign below

Patient Agreement: This Patient Agreement (the "Agreement") specifies the terms and conditions under which, you, the participating patient ("you" or the "Patient") may participate in the direct primary care medical model ("DPC') offered by Four Points Wellness, PLLC (the "Practice"). This Agreement between the practice and the patient will become effective on the date the agreement is signed by the patient and payment is received, whichever is later, and a copy will be provided to you if requested.

The Monthly Fee covers only the services provided by the Practice, with Board Certified Nurse Practitioner for the Practice, with the exception of those "add-on" services noted below. In exchange for the Monthly Fee (as defined below,) the Practice agrees to provide the following Services (collectively, the "Services") at no cost to you:

Membership includes: Annual Physical Exam once per year with general health panel labs and interpretation (CBC, CMP, TSH, UA, A1c, Lipid panel), Unlimited Office visits, Unlimited Video Visits, Unlimited Telephone consults, Unlimited E-mail Consults, Weight Loss Counseling Initial Consult and follow up appointments, Unlimited Point of Care testing (flu, strep, covid tests, urine dipstick), ear lavage, Simple Dermatologic procedures (punch/shave biopsy *Lab/path fees may apply), Sutures, Skin Tag removal, Large joint (hip/knee) injections (4 per year), Priority booking in the infusion schedule, 10% DISCOUNT on all infusions, comprehensive medical care at your convenience.

____ DPC members may be charged out of pocket at a discounted contract rate for lab pathology fees or non-routine lab costs that are not included in the membership package. This will be discussed with the patient at the time of ordering.

Routine Office Hours are Monday-Friday 9am-5pm. The provider will be available to answer DPC Member calls/texts during these hours.

Urgent Care Issues will be handled by the provider for DPC members *ONLY* during the additional times: Monday- Friday 5pm-8pm, Saturday 8am-noon, Sunday 1pm-4pm for an ***on-call fee of $40.***

Membership Fees:

Single Adolescent Age 12-21_____$59 / month
Single Adult Age 22-44_____$79 / month
Single Adult Age 45-64_____$99 / month
Single Adult Age 65 +_____$119 / month
Complex Chronic Condition/Functional Medicine_____$159 / month

Family Packages:

Adolescent added to any single adult membership_____+$30 / month
Couple <44_____$149 / month
Couple 45-64_____$179 / month
Couple >65_____$219 / month

Family of 3 (2 adults + 1 Adolescent) _____$188 / month
Family of 4 (2 adults + 2 Adolescents)_____$218 / month
Family of 5 (2 adults + 3 Adolescents)_____$248 / month
** *Adolescent age 12-21 in same household*

_____ A **3 month contract** is required with monthly automatic billing for at least the initial 3 months. There is a $175 re-enrollment fee if a member cancels their membership and then later decides to re-enroll in membership again. This also applies if a membership is cancelled due to non-payment and the patient desires to re-instate and maintain their membership.

_____ A **30 day notice of cancellation is required** to terminate the billing and service contract. If DPC membership is cancelled before the initial 3 month period is completed, the first 3 month's membership fees will still be charged as contracted.

Term, Cancelation and Termination: The term of this Agreement is from the date of signing for at least 3 months and until it is canceled by the patient or the Practice as set forth below. A 30- day notice is required prior for cancellation. Failure to pay the monthly fee by the 15th calendar day will result in a $10 late fee. Three late payments may result in termination from the practice. The Practice has the right to terminate this agreement for any cause. A 30-day notice will be given to the patient prior to cancellation.

Acknowledgement and Agreement

_____ I have read the membership agreement

_____ I agree with the terms

_____ I understand the normal office hours and urgent care hours as a DPC Member

Printed Name _____ **DOB** _____

Signature _____**Date** _____