JOHN C. CHIU, M.D. 100 LOS GATOS SARATOGA ROAD, STE B, LOS GATOS, CA 95032
TELEPHONE: (408) 863-0709

Direct Primary Care Membership Agreement

This Direct Primary Care Membership Agreement (the "Agreement") specifies the terms and conditions under which you (the "Member") and your spouse or dependents included in the Agreement will participate in the benefits available under the Agreement.

1. This Agreement is between John C. Chiu, M.D. (the "Practice") and

   _____ (name of Member),

   _____ (name of Spouse, if applicable), and includes the following dependent(s) listed below (attach additional sheets if necessary):

Name	*DOB*	*Relationship:*
_____		
_____		
_____		

2. **The term of this Agreement** is for one year, starting _____. The Agreement shall automatically renew for successive one year periods unless terminated (see Section 10).
3. **This Agreement is *not a health insurance policy***, and does not cover services or care given at any facility besides the Practice. This Agreement includes only the specific services as outlined in Section 6 below, and does not include any major catastrophic medical care provided by emergency rooms, hospitals, urgent care centers, or services rendered by specialists or specialty clinics. Furthermore, membership under this contract ***does not*** by itself fulfill the personal health insurance mandate under the Affordable Care Act (commonly known as "Obamacare").
4. **Included Members.** Adult Members participating in the Agreement may sign up a spouse or dependents under this Agreement. Others outside of that relationship wishing to join as Members must have their own separate Agreement. A valid picture ID will be requested to enroll in a membership to verify identity before receiving membership services, except in the case of a minor enrolled in the membership, who must be accompanied by a parent or legal guardian that is also enrolled in the membership.
5. **MEMBERSHIP Fee Schedule:** At the date of this Agreement, membership fees are as follows:

   - Age 0-17 $30 per month
   - Age 18-29 $40 per month
   - Age 30-49 $50 per month
   - Age 50-64 $60 per month
   - Age 65+ $75 per month

   Family discounts are available. The oldest parent will be charged full price, and children and spouses will receive at 10% discount off monthly fees.

6. **Included services:**

   - Annual Comprehensive/Sports/School/Well Child Physical Examination
   - Unlimited sick office visits
   - Management of Chronic Illness
   - Minor skin surgery (e.g. Simple Laceration Repair, Cryotherapy, Skin Biopsies, Skin Tag Removal)
   - EKG
   - Audiogram
   - IV Hydration
   - Joint Injections
   - Nebulizer Treatments
   - Office based lab work (e.g. Strep, Urine, Pregnancy testing)
   - Blood Draws
   - All clinic clerical services (e.g. prescription refills, forms, copies of records)

7. **Membership fees shall be paid in advance**, either in full for the year, biannually, or quarterly. Fees paid biannually or quarterly require payment by automatic draft from Member's credit card, debit card, or bank account (as available). Fees are due in advance of the first visit. Member shall update banking information as needed, in a timely manner, and will be responsible for any amounts owed to the Practice regardless of whether the account or card is expired, cancelled, or otherwise not accepted for payment. Member(s) agree to pay a $25 added charge for each time the Member(s) account declines payment of the regular charge. Services under the Agreement may be terminated until payments due are made current.
8. **Banking Transfers.** This Agreement authorizes the Practice to keep banking information on file, and to charge the Member's applicable account for scheduled fees without requiring the Practice to obtain written or verbal authorization for each new charge.
9. **Future Routine Appointments.** Member(s) understands that all Members included in this Agreement will not be scheduled for a patient appointment unless the membership fees have been paid up through or beyond the date of the desired appointment.
10. **Termination of Agreement.** Member(s) understands that an initial 1 year service contract is required. Cancellations within the first year will be subject to an early cancellation fee equal to the number of months remaining on the 1 year contract. At the end of the initial 1 year contract, Member(s) may terminate the Agreement for any reason with 30 days' prior notice. If the Member terminates their contract and the re-enrolls at a later date, they will be required to sign a new 1 year contract. The Practice may terminate the Agreement for any reason at any time with 30 days' prior notice, during which, the Practice will continue to offer medical care for emergent needs. Such termination by either party must be in writing. In the event that the Member elects to cancel membership and had pre-paid for months in advance, they will receive a prorated refund with the contract ending date 30 days after date of receipt of the notice to cancel.
11. **Possible change of Terms of Agreement.** Member(s) understands that the Practice may add or decrease services, participating providers, and participating clinics, OR increase membership fees at any time, but membership Fee is guaranteed for one year from original beginning date of the Agreement. In the event of change of membership Fees, the Practice will provide notice to Member(s) at least 30 days before the change.
12. **Additional charges not covered.** Member(s) understands that there may be additional charges for equipment, laboratory, referral, or other services that are ordered through outside entities or providers as a result of care given by the Clinic. The Agreement does not cover additional charges for such items.
13. **Other insurance.** Member(s) covered under Medicaid or other health insurance understand and agree that their insurance WILL NOT be billed for services rendered to Member(s) under this Agreement, and Member(s) agree to not seek reimbursement from their insurance for any services rendered under this Agreement.
14. **Medicare Opt-Out.** Member(s) also enrolled in Medicare understand and agree that Medicare WILL NOT be billed for services rendered to Member(s) under this Agreement, and Member(s) agree to not seek reimbursement from Medicare for any services rendered under this Agreement (see the Acknowledgement of Medicare Opt-Out agreement).
15. **Declining to enroll.** The Clinic reserves the right to refuse membership to any person for any reason, or for no reason.

16. **Additional charges for available items/services.** Member(s) understand(s) that charges for items not covered by the membership must be paid at the time of service, and will NOT be billed through the Member(s) regular membership payments.
17. **Excluded services (include, but no limited to):**

    - Immunizations (charged at wholesale cost)
    - Material supplies (charged at wholesale cost)
    - Hospitalizations
    - Hospital visits
    - Pathology Fees
    - Specialist Care
    - Lab Work
    - Physical Therapy
    - Surgical Procedures
    - ER/Urgent care visits
    - Radiological Studies

18. **Responsibility for Insurance/fiscal planning.** Member(s) understands that the visit and membership fees required under this contract DO NOT necessarily apply towards any health insurance plan deductible. Member(s) also understand that The Clinic makes no representations regarding the tax implications of membership in this agreement. Member(s) are encouraged to seek the advice of a competent tax professional for advice regarding any related tax issues.
19. **Violation of Agreement.** Member agrees to reimburse the Clinic for any costs and reasonable attorneys' fees that result from violation of this Agreement by Member(s).

Member Signature Date

Spouse Signature Date

or

Legal Representative Signature Date

Witness Signature Date

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ENROLLMENT FORM FOR DIRECT PRIMARY CARE

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

MONTHLY FEE: _____

I, _____, am a (circle one) NEW // FORMER PATIENT who chooses John C. Chiu, M.D. as my out-of-network primary care provider and I opt to join and would like to pay:

☐ every 6 months (requires payment by automatic draft from credit card, debit card, or bank account)

☐ once a year and receive a 5% discount (requires payment by automatic draft from credit card, debit card, or bank account)

Payment Method: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ ACH

Name on Card: _____ Number: _____

Expiration: _____ CVV: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Account #: _____ Routing #: _____

Signature: _____

Date: _____