Your Private MD, LLC Membership Application

This is a contract with Your Private MD, LLC (Gina Love-Walker, MD) to provide me with primary care services. The services will begin on the date (Membership Start Date) noted below, and shall renew annually and continue until either party provides written notice to terminate. As used in this Agreement, the term "Service Year" shall refer to the 1-year period beginning on the Start Date, as well as every 1-year period thereafter.

Membership Options:

Silver Membership:

- Reduced retainer fee, with A la carte services
- Pay for office visits and physical at time of service (see bottom of page 1 for fees)
- Receive a superbill upon each visit to submit to your private insurer for reimbursement, if you so choose[1]. Depending on your insurance plan, much of the fee may be reimbursed to you.

Gold Membership:

- Retainer covers the cost of a complete physical, flu shot (starting 2014), and office visits
- In most cases, no need to pay additional out-of-pocket fees for your visits
- A bundled fee that allows you to see the doctor more frequently, without the need to pay for each visit

Membership Features:	Silver	Gold
Unhurried Visits	✓	✓
Same or next-day appointments	✓	✓
More time w/doctor, less time waiting	✓	✓
24/7 Phone & email access to physician	✓	✓
Annual Physical (included)		✓
Nearly unlimited office visits[2]		✓

OFFICE VISIT FEES:

Plan[3]	Annual Physical	Complex/ Extended Visit	Acute/ Routine Visit	Injections/ Immunizations
SILVER	$100	$50	$25	Varies
GOLD	$0	$0	$0	Varies

[1] Medicare patients will be prohibited from submitting any bills from Your Private MD, LLC to Medicare for reimbursement.
[2] For the Gold Membership, after the 8th office visit (excluding annual physical) patients will pay a fee of $25 for each visit.
[3] For Silver Members, office visit fees will be paid at the time of your visit.

Available Membership Payment Plans:

GOLD Payment Options	Under 30	30-64	65+
Annual Fee	$1,300	$1,400	$1,600
Semi Annual Fee:			
1st Payment	$650	$700	$800
2nd Payment	$675	$725	$825
Quarterly Fee:			
Quarter 1	$325	$350	$400
Quarter 2, 3 & 4	$350	$375	$425
Monthly Fee	$115	$125	$140

SILVER Payment Options	Under 30	30-64	65+
Annual Fee	$800	$1,000	$1,100
Semi Annual Fee:			
1st Payment	$400	$500	$550
2nd Payment	$425	$525	$575
Quarterly Fee:			
Quarter 1	$200	$250	$275
Quarter 2, 3 & 4	$225	$275	$300
Monthly Fee	$69	$89	$99

All Silver Members will pay an office visit fee at the time of their visit. Fees are detailed on page 1.

***Please note that all monthly (Gold and Silver) payments must be billed automatically using a credit or debit card.**

Possible Discounts:

Corporate Membership Discounts:
Please contact our office for special corporate rates

Select Your Membership Type: o Silver o Gold

Select Payment Plan:

o Annual Payment: Pay in full

o Semi-annual Payment: 1/2 now and the balance 6 months later on the 15th of the month in which payment is due

o Quarterly Payment: 1/4 now and 3 equal payments at 3-month intervals on the 15th of the month in which payment is due

o Monthly Payment: Initial payment due at enrollment, each additional payment must be billed automatically, through a debit or credit account

Check each box that applies:

o I am required to pay a one-time $50 application fee as a new or inactive patient of Dr. Love-Walker

o I authorize Your Private MD, LLC to automatically charge my credit/debit card on the 15th of the month in which payment is due

Initials: _____

Select Method of Payment:

o Check[4]: _____ Check Number

o CreditCard

o Debit Card

o FSA/HSA

o Cash

o Other (please specify, must be approved) _____

o MasterCard o Visa

_____ _____ _____

Credit/Debit Card Number Exp Date Cardholder Signature

Amount Paid $_____

Note: Each patient membership account will be charged a $25 late fee once account is 30 days past due

Membership Continuation:

My membership with Your Private MD, LLC shall renew and continue at the end of each service year, under my current membership plan. If I choose to change my membership plan at the end of the service year, I will notify Your Private MD, LLC no more than 5 business days after the anniversary of my Membership Start Date.

_____

Initials

[4] Return check fee: Patient will incur a $25 fee for each returned check.

PATIENT(S): Please print name and date, and sign form below:

I acknowledge that Your Private MD, LLC or I can terminate this Agreement upon 30 days written notice. The term of this Agreement shall commence on the Effective Date and shall continue until either party terminates the Agreement. Either party may terminate this Agreement, with or without cause, at any time upon providing the other party with written notice 30 days prior to the end of the term of the agreement. In the event that Your Private MD, LLC terminates this agreement, Your Private MD, LLC will continue to provide urgent medical treatment to Patient for any additional period required by law. An appropriate prorated refund will be returned to the patient based on the services they have received.

If I choose the automatic payment option, I authorize Your Private MD, LLC charge my account on the 15th (or next business day) of each period, based on my chosen plan. This authorization is extended by me to Your Private MD, LLC and/or its authorized agents or firms that may contract with Your Private MD, LLC to process check and charge card debits. I understand that this authorization agreement shall remain in force until I give Your Private MD, LLC 30 days written notice of my intent to end my membership. I also understand that the total fee paid throughout the year may vary, based on promotional credits to my account, late fees, or additional services received that were not foreseen at the time of this agreement.

For a Silver Membership, a refund of the prorated portion of the paid Annual Fee, based on the number of days that have elapsed in the Service Year. For the Gold Membership, refund will be prorated, and adjustments may be made based upon patient services received thus far. Any refund for the Gold Membership services will be based on the full schedule and not on a discounted rate. Refunds will be paid within 30 days after termination.

I may renew this Agreement for subsequent Service Years by paying the Annual Fee for the applicable service year as determined by Your Private MD, LLC. The terms of this Agreement will apply to all such subsequent Service Years, unless Your Private MD, LLC and I agree otherwise, in writing.

Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date

Mailing Address:
Dr. Gina Love-Walker
Your Private MD, LLC
170 Taylor Station Rd
Suite 210
Columbus, Oh 43213

Phone: 614-626-4832

******For Office Use Only******

Membership Start Date _____ **Membership End Date** _____

Amount Paid at Signing _____ **Payment Date** _____

Staff signature _____ **Current Date** _____