Arlington Physicians

P.O. Box 120069, Arlington, TX 76012-0069
(817) 274-1999

Please Print All Information

Enhanced Direct Primary Care Membership Application

Physician: Dr. Leffingwell **Effective Date:** _____

Patient Information

Patient Name _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Date of Birth _____ Gender Male Female
Email Address _____

Billing

The first payment is due when you submit your membership application. You may pay your annual fee, in **quarterly installments of $237.50**, by check or credit card.

Check: Please make check payable to Arlington Physicians and include with your application.

Credit Card: Please fill out the information below or call our office at the number above to pay over the phone. You may also bring it to the office if that is convenient for you.

Visa MasterCard Discover American Express

Card Number _____ Exp Date ____ / ____ Security Code_____

If different from information provided above:

Cardholder Name _____
Billing Address _____
City _____ State _____ Zip _____

This agreement will be automatically renewed and the credit card you used to join this program will be charged per the billing cycle selected above.

Patient Signature _____ Date _____

Membership Agreement

This patient membership agreement (the "Agreement") specifies the terms and conditions under which you, the undersigned patient ("Patient"), may participate in the program ("Program") offered by Arlington Physicians, P.A. This Agreement will become effective either on the date your physician commences the Program or the date of your signature on this Agreement, whichever is later (the "Effective Date").

PROGRAM

The Program's annual fee encompasses the following services ("Services"):

- Annual Wellness Program, including advanced wellness screenings, diagnostics and wellness counseling
- Personal Health Record

ANNUAL PATIENT FEE

You will pay an annual fee of $950 to Arlington Physicians, P.A. ("Annual Fee") for each year that you elect to participate in the Program.

RENEWALS AND TERMINATION

The Annual Fee covers a period of one (1) year (the "Term)". Failure to pay the renewal Annual Fee prior to the anniversary of the Effective Date shall result in termination of your participation in the Program. (For example, if the Effective Date is March 2, 2014, then you must renew on or before March 1, 2014.) You or your Physician may terminate this Agreement at any time upon 30-days written notice. If you or your Physician terminates this Agreement for any reason prior to receiving your services, you will be entitled to a prorated refund of the annual Fee. If you have received your Services, you will not be eligible for a refund, and you will be responsible for the balance of the Annual Fee. Upon Arlington Physicians, P.A. receipt of this Agreement and the Annual Fee, your Physician shall have the option, in its sole and absolute discretion, not to accept the Agreement and to return your payment to you (e.g., due to limitation on the number of patients). Unless otherwise terminated, this Agreement shall automatically renew for an additional one-year period upon the expiration of each Term.

MEDICAL CARE SERVICES EXCLUDED FROM ANNUAL FEE

The Annual Fee specified herein covers only the defined "Services" described in the Program section above. Except for your Services, you and/or your insurer, as the case may be, will be financially responsible for paying for all healthcare and medical care services received by you from your Physician and his or her staff. Arlington Physicians, P.A. will bill you and/or your insurer, as the case may be, for those healthcare or medical services provided to you. The limited practice size also enables your Physician to provide conveniences, such as same-day or next-day appointments that start on time, thorough visits, and 24/7 availability via personal pager or cell phone.

CO-PAYMENTS

The annual Fee does not affect the co-payments, co-insurance or deductibles that you are required to pay pursuant to the terms of your insurance coverage. You will continue to be financially responsible for any co-payments, co-insurance or deductible amounts by your insurer.

ENTIRE AGREEMENT

The undersigned agrees to the terms of this Agreement, all of which are expressed herein. There are no promises or representations except as set forth herein.

NOTICES

Any communication required or permitted to be sent under this Agreement shall be in writing and sent via U.S. mail to the addresses set forth in this Agreement. Any change in address shall be communicated in accordance with the provisions of this section.

BILLING

Initial payments are processed at the time of enrollment. Subsequent payments are charged quarterly, semi-annually or annually as elected by the Patient.