Idaho Health Neighborhood Center
Urgent Care | Primary Care | Behavioral Health

IHNC PRIMARY CARE

MEMBERSHIP AGREEMENT

Note: Signing this Membership Agreement may alter your legal rights under Idaho Law. Please read entire document carefully before signing.

I, the undersigned, wish to receive primary care medical services from Idaho Health Neighborhood Center ("IHNC") and its practitioner. I understand these medical services are offered subject to the following terms and conditions:

1. Effective/Renewal Date. This Patient Agreement (the "Agreement") shall begin on _____ (the "Effective Date") and continue as long as I continue paying the Membership Fee described below and subject to termination as described below. This Agreement supersedes any prior Patient Agreement(s) I have signed with IHNC.

2. Enrollment Fee. I understand that I must pay a one-time $50 (fifty dollars) enrollment fee upon joining IHNC. I also understand that if I cancel my membership and wish to re-enroll, I will have to pay another re-enrollment fee of $50.00.

3. Services. I understand that **IHNC is not an insurance plan and DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE**, nor is this a contract of insurance. I understand that IHNC will make available: (a) certain medical services as requested by me or as deemed necessary by the Practitioner in accordance with the established standard of care for primary care practitioner; and (b) certain related services (such medical services and related services are referred to in this Agreement collectively as "Services" and described in further detail in Attachment A).

4. Membership Fee. I understand that I must pay a monthly membership fee (the "Membership Fee") in order to receive Services from IHNC. Certain Services are included in the Membership Fee but all other Services I receive from IHNC will be charged separately at the time of service according to IHNC's current Member Fee Schedule. Attachment A lists all Services included in the Membership Fee,

all other Services available from IHNC, and IHNC's current Member Fee Schedule. Attachment A also lists the current Membership Fee and describes how payment must be made.

Submission of Insurance Claims. I understand that IHNC will NOT submit any claims for Services to my insurance plan on my behalf, and that I am solely responsible for submitting such claims if I choose to seek reimbursement from my insurance plan for such Services. I also understand that any reimbursement by my insurance plan will be sent directly to me. If IHNC is mistakenly reimbursed by my insurance plan, then IHNC will return the check to my insurance plan. I understand that my insurance plan may not pay at all for some Services provided by IHNC and may only make a partial payment for other Services provided by IHNC. I further understand that IHNC makes no representations or promises regarding the amount of payment to be received for any claim(s) I may submit to my insurance plan. Medicare and HMOs do NOT permit me to submit claims for Services provided by IHNC, and I agree not to submit a claim for any such services to Medicare or any HMO.

Termination of this Agreement.

A. Termination by Patient:

1. I understand that I may cancel this Agreement at any time by sending IHNC written notice: (a) stating that I wish to cease using IHNC for my medical services, and (b) requesting that a copy of my medical records be sent to either another physician or directly to me. Please note a minimum of three (3) business days processing time is necessary to affect the cancellation.

2. I understand that after cancellation, IHNC will no longer be able to prescribe or continue any prescriptions which I may have been receiving on a long-term basis and it is further understood that PRIOR to cancelling my contract, I will establish treatment with and transfer care to my new Primary Care provider.

3. Budget billing is our monthly plan. I understand that if I terminate this Agreement within the first six (6) months of membership after utilizing the Services in any way, I will pay IHNC a total of six (6) months of membership fees in addition to any other Services costs. This is because I understand that IHNC does not place limits on the amount of care that I may receive from it per month. Accordingly, I may, based on the status of my health when joining IHNC, receive a multitude of services in a very short period of time. As a result, I understand and agree that it is only fair for IHNC to receive a total of six (6) months of membership fees despite my terminating the contract earlier than six (6) months into my

membership. Alternatively, I may opt to pay for any services received in the first six (6) months based on the current non-member (urgent care) rate.

B. Termination by Practice:

I understand that IHNC may also terminate this Agreement, as well as the physician-patient relationship with me, upon thirty (30) days' prior written notice if any Membership Fee payment is more than fifteen (15) days late. In such case, IHNC will provide me with information to assist me in finding another primary care physician to take over my care.

5. Membership Fee(s) and Fee Schedule. I understand the current amount of the fee for my monthly Membership will be calculated according to the following age brackets:

Primary Care Member Fee Schedule

Adults >= 50	$80.00
Adults < 50	$70.00
Pediatrics < 18	$60.00

Behavioral Health Member Fee Schedule

Adults >= 50	$80.00
Adults < 50	$70.00
Pediatrics < 18	$60.00

Bundle Member Fee Schedule

Adults >= 50	$120.00
Adults < 50	$110.00
Pediatrics < 18	$100.00

I also understand IHNC may change its Member Fee Schedule and the Membership Fee at any time upon ninety (90) days' prior written notice to me.

6. Payment. I understand that payment of my Membership will be automatically deducted from my bank account on the 1st day of each month of my membership using the information on file or may be automatically charged to my credit card on

file. I agree to sign a credit card authorization (see Attachment B) as part of my enrollment into the IHNC Membership Program, which I understand is required prior to any Services being provided to me. If I decide not to authorize IHNC to debit my bank account or charge my credit card for monthly payments, I agree that I will provide payment for at least six (6) months of Services in advance and prior to any Services being rendered to me. I also agree to continue, throughout my Membership, to pay for Services on the same date each month.

a. Services automatically renew for your convenience unless termination has been requested.

7. Patient Rights and Responsibilities.

A. I understand that pre-existing medical conditions do not disqualify me from enrolling into IHNC and that I have a right to know my treatment options and actively participate in my healthcare decisions.

B. I understand that I have the right to a fair, expedient, and objective review of any complaint I may have against IHNC and a Practitioner and that I will submit my concerns, suggestions and patient feedback to **ihnc@c-who.org.**

C. I understand that in the event of a life-threatening medical condition, I should always call 911 or proceed to the nearest emergency department. I also understand that the costs of urgent care services not rendered by IHNC are not included in IHNC's monthly membership fees or otherwise.

D. I understand that Practitioner are available for telephone consultations in the event of an urgent medical matter, but I will call 911 or proceed to the nearest emergency department if immediate medical attention and/or treatment is required.

IHNC Member Name: _____
(Please Print)

Patient Name: _____
(Please Print)

Patient Signature: _____ Date: _____

IHNC Direct Primary Care:

Signature: _____ Date: _____
Scott Malm, PA

If the Patient is a minor, the Patient's parent or legal guardian must sign below indicating the parent or guardian's acceptance of the above terms and agreement to pay the Membership Fee on behalf of the Patient:

Name of Parent/Guardian: _____
(Please Print)

Signature of Parent/Guardian: _____ Date: _____

ATTACHMENT A

Services COVERED Under Membership

ELECTROCARDIOGRAM
FECAL OCCULT BLOOD, STOOL
GLUCOSE, FINGERSTICK, BLOOD
HBA1C (HEMOGLOBIN A1C), FINGERSTICK,
HEMOGLOBIN (HB), FINGERSTICK, BLOOD
MONONUCLEOSIS, HETEROPHILE AB, BLOOD
PREGNANCY TEST, URINE
RAPID FLU (A+B)
RAPID STREP GROUP A, THROAT
RESPIRATORY SYNCYTIAL VIRUS AG, QL, IF, NASOPHARYNX
URINALYSIS, DIPSTICK
VISUAL ACUITY*

Services NOT COVERED Under Membership

Note: IHNC makes every effort to provide any additional services at a highly discounted rate compared with other doctor's offices, which we hope will minimize your out-of-pocket spending.

- X-Rays
- Labs sent out of the office: clinic staff will notify estimated cost of external lab partners
- Any specialty care visit

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ATTACHMENT B

AUTHORIZATION AGREEMENT FOR CREDIT CARD PAYMENTS

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided for the recurring monthly payment.

Please complete the information below:

I _____authorize IHNC Direct Primary Care to charge my credit card indicated below on a monthly basis, for payment of my membership.

Billing Address_____Phone#_____

City, State, Zip _____ Email _____

Account Type:	☐ Visa	☐ Master Card	☐ Amex	☐ Discover
Cardholder Name				
Account Number				
Expiration Date	Click or tap to enter a date.			
CVV (3 digit number on back of Visa/MC,			4 digits on front of AMEX		

SIGNATURE _____DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

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AUTHORIZATION AGREEMENT FOR AUTOMATIC DEBIT PAYMENTS (ACH DEBIT)

I, the undersigned, hereby authorizes IHNC Direct Primary Care, to initiate debit entries to its bank account at the depository institution named below, ("Depository"), every month for each monthly service payment due under the IHNC Direct Primary Care Agreement, ("Agreement"), in the amount reflected on each month's invoice (based upon current enrollment and enrollment fees, if applicable).

Once the bank account information has been entered into IHNC's system, I understand I will receive an email with a link to create a profile in Hint to access invoices and related details of charges.

Failure for any reason of final credit or a reversal of any credit to the monthly service amount will constitute a breach/default under the terms of the Agreement that may result in the immediate termination of the IHNC Direct Primary Care Medical Services being provided under this Agreement.

The Agreement is supplemented by this ACH Agreement and all terms of the Agreement are in full force and effect.

Depository Name (Name on check/Checking Account):		Account Type ☐ Personal ☐ Business
Bank City:	Bank State:	Bank Zip Code:
Bank Transit/ABA number/Routing Number:	Bank Account Number:	

This authorization will remain in full force until IHNC receives written notification from me of its termination.

By: _____ _____

(Print Name) Date