MEMBERSHIP ENROLLMENT

SELECT A PLAN ☐ Prestige HD ☐ Prestige Pediatric

ADULT ENROLLMENT *(This form may be typed in and printed)*

PATIENT 01 *(This individual is the main account holder and is responsible for patients associated with this account)*

Last Name _____ First Name _____ MI _____

Gender ☐ M ☐ F Date of Birth _____ Driver's License No. _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address _____ City _____ State _____ Zip Code _____
(if different from Home Address)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

Emergency Contact: Name _____ Phone Number _____ Relationship to Patient _____

PATIENT 02

Last Name _____ First Name _____ MI _____

Gender ☐ M ☐ F Date of Birth _____ Driver's License No. _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address _____ City _____ State _____ Zip Code _____
(if different from Home Address)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

Emergency Contact: Name _____ Phone Number _____ Relationship to Patient _____

PATIENT SERVICES AGREEMENT

I hereby certify that I have read and agree to the terms and conditions specified in the Patient Services Agreement.

Patient Signature _____ Date _____

MEMBERSHIP ENROLLMENT

CHILD ENROLLMENT

CHILD 01

Last Name _____ First Name _____ MI ____ Gender ☐ M ☐ F Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____
(if different from Adult #1)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

Emergency Contact: Name _____ Phone Number _____ Relationship to Patient _____
(for all children)

CHILD 02

Last Name _____ First Name _____ MI ____ Gender ☐ M ☐ F Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____
(if different from Adult #1)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

CHILD 03

Last Name _____ First Name _____ MI ____ Gender ☐ M ☐ F Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____
(if different from Adult #1)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

CHILD 04

Last Name _____ First Name _____ MI ____ Gender ☐ M ☐ F Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____
(if different from Adult #1)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

MEMBERSHIP ENROLLMENT

A NEW AND REFRESHING HEALTHCARE EXPERIENCE

Prestige Urgent Care does not require a long-term contract or commitment. You may cancel your membership at any time. Three easy payment options are available:

- **Month to Month Membership** - Members pay membership fees monthly via drafts against a credit card, debit card, bank account, or suitable alternative.
- **Six-Month Prepaid Membership** - Members pay for a six month membership in advance and receive a 5% discount.
- **Full Year Prepaid Membership** - Members pay for a full year membership in advance and receive a 10% discount.

Enrollment Fee – One time fee of $59 for initial enrollment.

BILLING INFORMATION

Name _____ Phone Number _____ Email _____
(as it appears on your credit card or bank account)

Billing Address _____ City _____ State _____ Zip Code _____

MONTHLY PAYMENT INFORMATION

Please indicate the method to pay monthly membership fees or prepay. Payment information also can be provided in person at our clinic or over the phone.

- My first month's payment is $ _____
  (enter amount, including enrollment fee if applicable),
- My subsequent monthly payments will be $ _____
  (enter monthly amount or zero if 6 or 12 month prepay).

CREDIT CARD INFORMATION

We accept Visa, Mastercard, Discover and American Express.
For Bank Account withdrawals, please provide a voided check.

CREDIT OR DEBIT
Card Type Card Number _____ Security Code _____ Exp. Date _____ Name on Card _____
(last four digits)

BANK ACCOUNT
Bank Name _____ Account Number _____ Routing Number _____ Name on Account _____

OTHER
Please Specify _____

I hereby authorize Prestige Urgent Care to deduct my monthly membership fee from the payment source listed above:

Patient Signature _____ Date _____

PATIENT SERVICES AGREEMENT

This Patient Services Agreement governs the relationship between Prestige Urgent Care and patients who enroll in one of our monthly membership programs.

TERMS & CONDITIONS

1. I understand and agree that I am voluntarily becoming a Prestige patient and that this agreement is non-transferable.
2. I have reviewed the List of Covered Services (available at www.prestigeuc.com) and had the opportunity to ask questions and receive answers regarding its content.
3. I understand and agree that Prestige Membership does not provide comprehensive health insurance coverage nor is it a contract of insurance. I understand that Membership provides only the urgent and primary health care services offered at Prestige Urgent Care Clinic and as defined by the List of Covered Services. Prestige recommends that patients have healthcare insurance to cover major medical events such as hospitalization, surgery, or serious illness.
4. I understand and agree that Prestige will not bill insurance carriers for any services provided by Prestige Urgent Care Clinic and I assume sole financial responsible for any and all Covered Services furnished by Prestige and its physicians and allied health personnel under this Agreement.
5. I understand and agree that Prestige healthcare providers have sole discretion to determine which services are medically appropriate to meet patient needs. I understand that if a Prestige provider determines that I require treatment beyond what is offered at the Prestige Clinic, such as treatment by a specialist or emergency room care, then such treatment will not be provided by Prestige.
6. I understand and agree I am responsible for charges incurred for health care services performed outside of Prestige, including but not limited to emergency room, hospitalization, specialty services, or any medical transportation.
7. I understand and agree that I can cancel my Prestige Membership at any time by submitting a written Cancellation Notice to Prestige at least five days before the due date of my next monthly payment. Monthly fees will continue to accrue until a written termination notice is received and processed.
8. I understand and agree that once my membership is cancelled that Prestige will no longer coordinate my healthcare, including prescription refills, referrals, and completion of healthcare related paperwork.
9. I understand and agree to pay my monthly membership fee on or before its due date. If I am unable to pay my fee(s) on time, I understand that I will be charged a $25 late fee and that my service agreement may be terminated. Covered Services may be withheld until outstanding monthly and late fees have been paid.
10. I understand and agree that although my access to the Prestige Clinic is unlimited for illness or injury, Prestige providers will direct my follow-up visits for treatment at such frequencies and durations as Prestige deems are reasonable and appropriate under the circumstances.
11. I understand and agree that Prestige may terminate this Patient Agreement at any time without cause by providing me written notice. Any pre-paid monthly membership fees will be prorated to the date of termination and refunded to me within ten (10) business days. Prestige will not terminate this Patient Agreement solely on the basis of health status.
12. I understand and agree that Prestige may add or discontinue services or increase my fee schedule at any time (but not more than once per year), and I will be given at least thirty (30) days written notice before such changes are implemented.
13. I understand that upon thirty (30) days prior written notice, Prestige may amend this Agreement in order to comply with any local, state, or federal law or regulation adopted or implemented by any federal, state or local government or agency, court or other third party which impacts the performance of this Agreement.
14. I understand and agree that if I am enrolled in Medicare I will receive a copy of the Medicare Opt-out Agreement to review and sign before my first patient visit. The Opt-out Agreement does not prevent me

Initial _____

PATIENT SERVICES AGREEMENT

from receiving current or future Medicare benefits from non-Prestige providers. I further understand and agree that neither my Prestige healthcare provider(s) nor I will seek reimbursement from Medicare for the medical services I receive from Prestige.

15. I understand that if Prestige is unable to perform its duties under this Agreement due to strikes, lock-outs, labor disputes, governmental restrictions, fire of other casualty, emergency, electricity or server outages, or any cause beyond the reasonable control of Prestige, Prestige's performance will be excused for the duration of such event.
16. I understand that if any one or more of the provisions of this Agreement is for any reason held to be invalid, illegal or unenforceable by a state or federal regulatory agency or court of competent jurisdiction, the remaining provisions shall not be affected thereby, but shall remain in full force and effect.
17. I understand that Prestige must maintain a record of my health information and protect privacy of my health information.
18. I understand and agree that Prestige providers will determine on a case-by-case basis whether or not to fulfill requests for long-term disability or to administer long-term pain management.

PATIENT RIGHTS & RESPONSIBILITIES

1. I understand that I have the right to receive accurate and easily understood information about Prestige's healthcare services, healthcare professionals, and healthcare facilities. I understand that Prestige will make its best effort to provide assistance so I can make informed health care decisions.
2. I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Prestige health care provider(s). I also understand that I am responsible for communicating clearly and respectfully with my provider. If I become dissatisfied with my care or Prestige services, I agree to notify Prestige immediately so my concerns may be addressed in a timely manner.
3. I understand I am responsible for my conduct and the conduct of any family members while visiting the Prestige facility and agree to conduct myself in a quiet and well-mannered fashion when visiting the Prestige Clinic to ensure my behavior does not disturb other patients or interfere with their treatment. I also understand the use of loud, profane, or slanderous language directed at Prestige providers, staff, or other patients is not appropriate and will not be tolerated.
4. I understand that I have the right to a fair, fast and objective review of any complaint I have against my Prestige healthcare provider(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of healthcare services and facilities. I agree to first bring any complaints to the attention of Prestige staff and to participate in the Prestige complaint and grievance process.
5. I understand I have the right to know all of my treatment options and to participate in my healthcare decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions.
6. I understand and agree to be actively involved in my healthcare decisions and to disclose all relevant information to my Prestige healthcare provider(s) so that they can help me achieve my health goals. I also agree to inform my Prestige healthcare provider(s) of any healthcare services I receive outside of Prestige (such as emergency room, specialist, or hospital services).

Each patient and family member included in their Membership hereby agrees to the terms and conditions of this Patient Services Agreement and understands their rights and responsibilities as a Prestige patient.

Patient Signature _____ Date _____