**ROCKFORD FAMILY CARE, L.L.C.**

**MONTHLY CONSULTATION MEMBERSHIP AGREEMENT**

This Monthly Consultation Membership Agreement (the **"Membership Agreement"**) is entered into and effective on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_ (the **"Effective Date"**), by and between the person(s) signing below (one or more referred to herein as the **"Member"**) and Rockford Family Care, L.L.C., an Oklahoma limited liability company, with a mailing address of 319 N Rockford Rd, Ardmore, OK 73401. (the **"Company"**).

RECITALS

The Company desires to offer the Member medical consultation services (the "**Consultation Services**") on a monthly basis for a monthly fee.

The Member desires to receive the Consultation Services from the Company and its health care providers according to the terms and conditions provided in this Membership Agreement.

Therefore, the Company and the Member agree as follows:

TERMS AND CONDITIONS

1. **Consultation Services.** Upon execution of this Agreement by both parties, the Company, through its health care providers including but not limited to Rhea Buycks, P.A., will provide the Consultation Services more specifically described in Schedule 1 — Description of the Consultation Services.
2. **Membership Fee.** The current monthly fee for the Consultation Services (the **"Membership Fee"**) is $50.00 per month for a one (1) year minimum term.
3. **Payment.** The Member may choose to pay monthly by Electronic Funds Transfer or Credit Card (as designated on Schedule 2 - Enrollment Form). The Membership Fee is due on the first day of each month. The Consultation Services will not be rendered for Members with past due accounts. In the event that a Membership Fee is declined due to insufficient funds or an expired credit card, the Company may charge an additional fee of $25.00 to your account. Failure to comply with payment terms may result in the termination of this Agreement and a denial of Consultation Services.
4. **Termination.** The Member may terminate this Agreement at any time for any reason after one (1) year by providing the Company with at least 30 days written notice (mail or email) prior to the next scheduled payment date (which is the first of each month). The Company may terminate this Membership Agreement and the Member will no longer receive the Consultation Services upon 10 days' prior written notice to the Member if any of the following occur: (i) the Member fails to pay the Membership Fee when due; (ii) the Member fails to abide by the Company's policies or this Membership Agreement; or (iii) the health care provider refuses to provide the Consultation Services to the Member "for cause."
5. **Modification of Consultation Services or Discontinuation of Consultation Services.** The Company may modify the Consultation Services at any time without prior notice to or consent from the Member. The Member may terminate this Membership Agreement in accordance with Section 4 above in the event that any change is not agreeable. The Company may discontinue the Consultation Services entirely and terminate this Membership Agreement at any time with 60 days advance notice.
6. **Insurance Regulations.** The Member acknowledges. that:
7. the Company and the Consultation Services provided under this Membership Agreement are not an insurance plan, nor is this Membership Agreement a contract for insurance;
8. the Member further acknowledges that the Company and its health care providers and staff must abide by all patient privacy rules and regulation mandated by the Health Insurance Portability and Accountability Act **("HIPAA")**;
9. due to regulatory restrictions, individuals enrolled in or eligible for Medicare, Medicaid, and other government health programs are disqualified from becoming a Member under this Membership Agreement.

*Please initial your acknowledgement of Section 6*  \_\_\_\_\_\_\_\_\_\_\_\_\_  
 (Initial)

1. **Electronic Communications.** The Member may request to receive communications from the Company or its health care providers or staff by e-mail. By executing this Membership Agreement and providing your email information below, the Member acknowledges that email is not a secure method for sending and receiving potentially sensitive personal health information. Although communications between the Member and his/her health care providers are subject to confidentiality requirements under the Company's policies and that of applicable law, the Company cannot assure the protection of confidential information with respect to email communications. The Member further acknowledges that email communications are not a good medium for urgent or time-sensitive information and telephone or in-person communication are more appropriate for urgent or time-sensitive information. The Member acknowledges that, at the discretion of his/her health care provider, email communications may become part of his/her permanent medical records.

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(The Member may revoke this consent to electronic communication at any time by written notice to the Company).

1. **No Assignment.** This Membership Agreement may not be assigned or transferred by the Member
2. **Severability.** If for any reason any provision of this Membership Agreement is deemed by a court of competent jurisdiction to be legally invalid or unenforceable, the validity of the remainder of this Membership Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law.
3. **Amendment.** Any amendment to this Agreement shall be in writing and signed by both parties. Notwithstanding the foregoing, the Company may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation **("Applicable Law")** upon 30 days' prior written notice to the Member. Any changes required by Applicable Law may be incorporated herein by reference without the need for signature by the parties. The Company may also amend Schedule 1 — Description of the Consultation Services from time to time in its sole discretion.
4. **Notices.** All written notices required by this Membership Agreement are deemed served upon mailing by first-class U.S. mail to the address of the Member shown on the signature page or to the Company address specified on page 1 of this Membership Agreement.
5. **Governing Law.** This Membership Agreement shall be construed in accordance with and governed by the laws of the State of Oklahoma, without regard to its principles of conflict of laws. The parties agree that any action arising out of this Membership Agreement shall be litigated under the laws of the State of Oklahoma in a court of competent jurisdiction in Oklahoma County, Oklahoma. If any action or proceeding involving such questions arises under the Constitution, laws, or treaties of the United States of America, or if there is a diversity of citizenship between the parties thereto, so that it is to be brought in a United States District Court, it shall be brought in the United States District Court for the Western District of Oklahoma. In any event, the prevailing party shall be entitled to all reasonable attorney's fees and costs incurred in the enforcement of this Membership Agreement.

*(Signature page immediately follows).*

The Member(s) and the Company have executed this Membership Agreement on the Effective Date.

MEMBER(S):   
 Patient Signature

Print Name

Address

City/State/Zip

Patient Signature

Print Name

Address

City/State/Zip

COMPANY: ROCKFORD FAMILY CARE, L.L.C., an

Oklahoma limited liability company

BY:

NAME:

TITLE:

SCHEDULE 1

DESCRIPTION OF THE CONSULTATION SERVICES

The Member will be allowed to consult with the health care provider at the Company’s office with unlimited visits each year for the Membership Fee. During each consultation, a health care provider will take the health history of the Member and conduct a physical exam. If indicated, the Company will also provide the following tests as part of the Membership Fee:

1. Urinalysis

2. A1c

3. Strep/flu/mono/RSV swabs

4. Pap smear

If the health care provider is able to render a medical diagnosis upon completing the health history, physical exam and indicated tests as set forth above, the health care provider will provide the diagnosis to the Member, together with a prescription for medication or other therapy, if necessary.

If, after taking the Member's health history, completing a physical exam, and any testing included in the Membership Fee, the health care provider cannot render a diagnosis because additional diagnostic tests or procedures are required, the health care provider will notify the Member. If the health care provider is able to conduct the required diagnostic test or procedure, the health care provider and the Member may agree to the price of such diagnostic test or procedure and the Member will pay the health care provider directly for that diagnostic test or procedure. While not exhaustive, the health care provider will provide the following services for an additional charge:

1. Sebaceous cyst removal - $50.00

2. Ingrown toenail removal - $50.00

3. Mole removal/biopsy - $50.00

4. Simple laceration repair - $50.00

5. X-ray - $15.00

6. Splinting - $35.00

7. Casting - $45.00

If the health care provider does not provide the diagnostic test or procedure or the Member chooses to obtain the services elsewhere, the health care provider will use his/her best efforts to refer the Member to at least one medical facility that does provide the diagnostic test or procedure. If the Member desires to have the diagnostic test or procedure conducted, the Member will be required to pay the medical facility directly for the cost of that diagnostic test or procedure. Upon receiving the results of any diagnostic test or procedure, the health care provider will make a diagnosis and provide the Member with a prescription for medication or other therapy, if necessary.

In no event will the Company or the health care provider be required to provide or pay for any medical service, test, procedure, medication, or other therapy which is not otherwise expressly provided for in this Membership Agreement.

Additional Member benefits include the following:

1. Top priority for scheduling office visits

2. Extended visits with health care provider if requested

3. Discount at DLO for labs ordered by the health care provider if paid in cash

4. Discounts offered by certain physicians to whom Member is referred if paid in cash.

ENROLLMENT FORM

MEMBER INFORMATION:

o Individual Adult (Ages 18 and above): $50.00/month

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ DL#:\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Tel. \_\_\_\_\_\_\_\_\_\_\_\_

o Additional Adult (Ages 18 and above): $50.00/month

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ DL#:\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Tel. \_\_\_\_\_\_\_\_\_\_\_\_.

o Children (Ages birth - 17): $50.00/month/child

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| MEMBERSHIP: (for office use only)  Membership Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assigned Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Total Monthly Membership Fee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

PAYMENT:

OPTION A: Electronic Funds Transfer

Name of Account Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Routing Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Type: Checking/Savings (circle one)

OPTION B: Credit Card

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Type: Visa/Mastercard/Discover

(circle one)

Credit Card No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. \_\_\_\_\_\_\_\_\_\_\_\_ CSC: \_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rockford Family Care, L.L.C. (“Rockford”) provides the services described in the Monthly Consultation Membership Agreement. By signing below, you acknowledge that you have read and agree to the terms, conditions, limitations, and fee schedule and that you authorize Rockford to receive recurrent payments as set forth above. Services not included in the monthly membership fee, including any tests, treatments, or procedures administered by a specialist physician or hospital will be billed separately by those providers/institutions. Rockford is not responsible for any fees of specialist physicians or hospitals.

Participation in Rockford’s program is continuous. Rockford is authorized to withdraw membership fees as set forth above until notice of termination is received as set forth in the Monthly Consultation Membership Agreement.

Signature of Payor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_