**Bradley Shumway DO**
Shumway Family Medicine PLLC
4447 E. Broadway Rd. Suite 107, Mesa, AZ 85206
Phone: 480-550-9610 Fax: 480-500-6858
shumwayfamilymedicine@shumwayfamilymedicine.com

# Direct Primary Care Membership Terms and Agreement

Member (Patient) Name: _____

Member (Patient) Date of Birth: _____

1. **General & Definitions**
   1.1. I understand that the person listed above is voluntarily entering a direct primary care membership agreement as a "Member" with Shumway Family Medicine PLLC (which includes Bradley R. Shumway DO [the "Doctor"] and any employees of the practice), and that this agreement is non-transferable.
   1.2. I understand that the "Membership" refers to all services including but not limited to health care and administrative tasks that the Member may receive from Shumway Family Medicine PLLC.
   1.3. I recognize Bradley R. Shumway DO as the owner and primary physician of Shumway Family Medicine PLLC ("the Practice"). I understand that there may be periods of time when other physicians may provide care to the Member if the Doctor is unavailable.
   1.4. I understand that I am entitled to a copy of this document.
2. **Membership Fees**
   2.1. I understand that being a Member of the Practice requires payment of an up-to-date, non-refundable, monthly Membership fee in order to receive membership services.
   2.2. I understand the monthly fee schedule to be as follows:
      2.2.1. The first payment (which is the same amount as the monthly Membership fee below in 2.2.2) is due at the time of the first visit. In subsequent months, the monthly fee as in 2.2.2 will be due on the 28th day of the month of Membership (billing in arrears).
      2.2.2. Monthly Membership fee based on age:
         2.2.2.1. 0 through 19 years of age: $20 per month if parent or guardian also enrolled, otherwise $65 per month.
         2.2.2.2. 20 through 49 years of age: $65 per month.
         2.2.2.3. 50 years of age and older: $85 per month.
   2.3. I understand that the Practice may change the Membership fee amount in 2.2.2 at any time in the future, but will notify me of any changes at least 90 days prior.
   2.4. I understand that the services and goods included in the Membership fee are at the full judgment and discretion of the Practice and that these services and goods may change without notice (also see section 4).

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2.5. I understand that missing an appointment or canceling within one full business day of the appointment may result in a $50 no-show fee. I also understand the importance of arriving on time for appointments so there will be sufficient time to address issues.

**3. Cancellation and Re-Enrollment**

3.1. I understand that the Member and the Practice both have the absolute and unconditional right to cancel this Membership agreement at any time, and for any reason EXCEPT on the sole basis of health status.

3.2. I understand that the Practice may terminate this Membership agreement at the sole discretion of Dr. Bradley R. Shumway by providing the Member with a 30-day written notice of cancellation.

3.2.1. I understand that threats, manipulation, or aggressive behavior may result in an immediate discharge from the practice and possible involvement of law enforcement.

3.3. I understand that if Membership fees are unpaid for 60 days, the membership will be considered canceled.

3.4. I understand that re-enrollment after a cancellation or termination will require a one-time re-enrollment fee equal to three times the most current, age-applicable, monthly membership fee amount in addition to the fee schedule as outlined in 2.2.

3.5. I understand that this agreement will be automatically renewed on a monthly basis unless canceled or terminated as above.

3.6. I understand that if the Member cancels the membership agreement before the end of a month, a prorated amount for the partial month that has transpired will be due at time of cancellation.

**4. Services provided, scope of practice, and availability**

4.1. I understand that the Membership includes, at no additional charge beyond those outlined in section 2, a limited set of services including: basic communications with the Doctor and the Practice, unlimited Doctor visits during regular business hours, some in-office lab and diagnostic testing, coordination of care and referrals to other providers, and some minor procedures.

4.1.1. I understand that the availability of these services may be limited by specialty training, experience, equipment, supplies, safety, and other unforeseen situations, and that the Doctor ultimately has the right to decide what services the Practice provides at a given time.

4.1.1.1. I understand that the Doctor does not manage long-term controlled medications within the membership, such as opioids, testosterone, benzodiazepines, and stimulants. I understand that the Doctor may recommend tapering off said medications prior to establishing or continuing a physician-patient relationship.

4.1.1.2. I understand that the Doctor requires a chaperone for examination of the breasts or anogenital region in female patients, and

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strongly recommends having one present for examination of sensitive areas in all patients.

4.1.2. I understand that routine matters will be addressed by phone, voicemail and email during regular business hours. Text messaging is not utilized for services.

4.1.2.1. I understand that urgent matters occurring outside of business hours should be communicated via the “After-Hours Urgent Line”: 480-818-5106. I also understand that time-sensitive, urgent issues during a business day may be best communicated by the “After-Hours Urgent Line” as well.

4.1.2.2. I understand the Doctor may be unavailable at times due to vacations, illness, technical malfunctions, or other unforeseen situations. I understand that if the Doctor is unavailable, I should visit a local urgent care or emergency department for urgent issues or contact the specified covering healthcare provider if available. I understand that suspected emergencies should always be directed to calling 911 and/or visiting the nearest emergency room.

4.2. I understand that some services, including but not limited to: visits outside of business hours, house calls, some labs/procedures/medications, may require payment of an additional fee. These fees are subject to change without notice, but will always be disclosed to the Member prior to rendering the services.

4.3. I understand that charges the Member incurs outside of those outlined in 4.1, such as from a diagnostic testing facility, hospital, pharmacy, or other physician, are the responsibility of the member and will not be reimbursed by the Practice.

**5. Insurance, Health Plans & Medicare**

5.1. I acknowledge and understand the following disclaimer that is applicable to this agreement according to state law 44-1799.91: The organization facilitating the direct primary care agreement is not an insurance company and the direct primary care company guidelines and agreement are not an insurance policy. Participation in the direct primary care agreement or a subscription to any of its documents should not be considered to be a health insurance policy. Regardless of whether you receive treatment for health care issues through the direct primary care agreement, you are always personally responsible for paying any additional health care expenses you may incur. If you have health insurance, it may include, at no additional charge, some of the preventive services that are also available under this direct primary care agreement. The primary care provider may not bill your health insurance for primary care services provided under this direct primary care agreement.

5.2. I understand that the Practice does NOT participate in, or accept payment from, any health insurance plans – including but not limited to Medicare, Medicare Advantage plans, Medicaid, PPOs, HMOs or TriCare.

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5.3. I understand that the Practice cannot guarantee reimbursement for any services provided by the Practice from any third-party payers. I acknowledge that neither I nor the Practice will submit claims to Medicaid or Medicare for services provided within this membership.
5.4. I understand that any services provided outside of the Practice as outlined in section 4, including services that are ordered by the Practice, are the responsibility of the member in conjunction with any health insurance plan the Member may have.
5.5. I understand that I will notify the Practice immediately if the Member becomes enrolled in any Medicare or Medicaid plan for any reason.

**6. Privacy and Communications**

6.1. I understand that any protected health information will be safeguarded by the Practice's commitment to current medical ethics and standards, and I have reviewed and understand the Practice's Notice of Privacy Practices for Protected Health Information.
6.2. I understand that any and all methods of correspondence may be used by the Doctor and the Practice to generate information for the member's medical records.
6.3. I understand that the Practice offers, but does not require, some forms of communications (including web-based unencrypted email, phone calls, etc.) in discussion of protected health information that cannot reasonably be guaranteed to be fully secure.
6.4. I acknowledge that the Practice will only use the contact information provided upon registration (see Communication Permission Form) or in subsequent updates.
6.5. I acknowledge that the Practice advises the Member against using employer owned or operated computers or email in communications with the Practice and also recommends NOT communicating health information about sensitive health topics through unsecured means.
6.6. I understand that unless as mentioned in section 4.1.2, the Member should reasonably expect to hear a response to electronic or phone communications within 24 hours during business days. If the Member has not received a response within this time, the Member should attempt to contact the Practice by another means of communication.
6.7. I agree not to hold the Practice or the Doctor liable or accountable for any loss, injury, damages, costs, or expenses which are sustained or the result of any technical failures, power outages, failure of software or hardware, or interception of communications by a third party.

Member or Guardian/Responsible Party Name: _____

Member or Guardian/Responsible Party Signature: _____