MEMBER PLUS FAMILY HEALTH
Personalized Health Care for Bainbridge Island

Gregory E. Keyes, M.D.
American Board of Family Practice

Blain Crandell, M.D.
American Board of Family Practice

123 Bjune Drive SE, Suite 101
Bainbridge Island, Washington 98110
www.member**plus**familyhealth.com
Tel: 206.842.3222
Fax: 206.842.1877

Application for Practice Membership and Agreement

This Application and Agreement ("Agreement") describes the terms under which you may participate in the medical practice of Member Plus Family Health (Gregory E. Keyes, M.D., P.S. and Blain A. Crandell, M.D.) (the "Practice").

1. The Practice. The Practice will be limited to about 1/3 the size of a normal practice. Only members will be eligible to receive medical and healthcare services from the practice.

2. Enhanced Services. The Practice will provide enhanced physician services, member health care support services, and other benefits ("enhanced services") as an adjunct to those standard medical services generally reimbursed by insurance companies. The Practice reserves the unrestricted right to change the scope and composition of such service offerings from time to time based on various factors, which may include experience and the expressed desires of the majority of members.

3. Practice Membership, Fees and Payment Options. Your membership is for one year from the date your application is accepted and signed by the Practice. Membership fees are as follows:

Individual Student Ages 15-24	**$15.00**	**$180.00**	
One Adult - Age 25-39	**$35.00**	**$420.00**	
Couple - Ages 25-39	*$65.00*	*$780.00*	
One Adult - Age 40-49	**$45.00**	**$540.00**	
Couple - Ages 40-49	*$85.00*	*$1,020.00*	
Add a child to above	**$10.00**	**$120.00**	
One Adult - 50 & above	**$65.00**	**$780.00**	***$702.00**
Plus One Child	*$75.00*	*$900.00*	**$810.00*
Plus 2 Children	*$85.00*	*$1,020.00*	**$918.00*
Plus 3+ Children	*$95.00*	*$1,140.00*	**$1,026.00*
Couple - 50 & above	**$125.00**	**$1,500.00**	***$1,350.00**
Plus One Child	*$135.00*	*$1,620.00*	**$1,458.00*
Plus 2 Children	*$145.00*	*$1,740.00*	**$1,566.00*
Plus 3+ Children	*$150.00*	*$1,800.00*	**$1,620.00*

***Discounted fee if paid in full Annually**

During the term of this agreement these fees are guaranteed and will not be increased. You may change your status as an individual or family at any time on 60 days' notice. You may not transfer your membership in the practice to any other individual.

4. Health Care Services Excluded from Membership Fee. The Membership fee does not cover the cost of any medical and health care services covered by your health insurance. The Membership Fee covers the cost of the enhanced services. Enhanced services are not covered by health insurance. You (or your insurance company) will be financially responsible for all medical and health care services received from the Practice or its staff. If you have health insurance, the Practice will bill your health care

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insurance for those health care services furnished to you and covered by your insurance. You will notify the Practice as soon as possible when your insurance agreements change. Nothing in this Agreement supersedes or modifies the terms or conditions of any agreements relating to your insurance.

5. Financial Responsibility. You will be financially responsible for any co-payments, co-insurance or deductible amounts due under your insurance and for medical and healthcare services which are excluded from your insurance coverage. You are also financially responsible for payment of any services excluded from your insurance coverage. Co-payments are due at the time of health care service as required by your insurer. Payment for any other amounts for which you are financially responsible will be set forth in an invoice mailed or delivered to you. Unless arranged otherwise in advance, any amounts shown in the invoice are due and payable within thirty days from the invoice date.

6. Protection of Your Health Information, E-mail Communications. We are committed to protecting your information from unauthorized use. The Practice is also subject to federal regulations under the Health Information Portability and Accountability Act (HIPAA). There are issues with privacy and the use of e-mail and the internet which you should understand before you use these media to either communicate with us, or to access your medical or billing information. See the paragraph on the fourth page of this agreement entitled “Privacy Issues and E-mail Communications.”

7. Health Insurance. The Practice is not intended to supplant your existing health insurance benefits. The cost of all services not provided by the Practice, such as professional services provided by other physicians, hospitalization, surgery and all other tests, procedures and services will be the responsibility of you or your health insurance program.

8. Mutual Satisfaction and Membership. The relationship between a physician and a patient is only effective when it is rooted in mutual trust, confidence and satisfaction. Accordingly, if you are not satisfied for any reason with your membership in the Practice, you may at any time withdraw your membership, end this agreement and your participation in the Practice on 30 days prior written notice delivered to the Office of the Practice. If the Practice believes for any reason it is unable to carry out its healthcare responsibilities to you, or if for any reason the Practice is discontinued, it may end the physician-patient relationship with you in the same manner by notice delivered to your address. The Practice may also end this Agreement and your participation in the Practice by providing 30 days’ prior written notice to you, if any of the following occur: you fail to pay the Membership fees or charges for health care services when due; you fail to abide by the terms and conditions of your insurance coverage; or you fail to abide by the policies of Member Plus Family Health. At termination of your membership for whatever reason whether initiated by you or by the Practice, any fees you may have paid in advance will be prorated based on the number of days you have participated in the Practice and returned to you.

9. Application Acceptance and Waiting Lists. This application becomes effective as an application when it and all attached documents requiring signature are signed by you and delivered to the Practice. It will become the member agreement you have with the Practice when it is accepted and signed by the practice and delivered back to you. It is the policy of the Practice to maintain a balanced patient census among seniors, middle-aged persons, young people, and families with children. If this application is received after one of these categories is closed, we will notify you and ask if you want to be put on a

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waiting list. If you are on a waiting list we will notify you when there is an opening. There is no charge for remaining on the waiting list.

10. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Washington, and if any provision is held to be invalid or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, unless the provisions held invalid or unenforceable shall substantially impair the benefits of the remaining portions of this Agreement.

The undersigned agrees to the terms of this Agreement.

APPLICANTS SIGNATURE:	**ACCEPTED BY:** **DATE:**
NAME (Please Print)	
DATE	

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MEMBER / FAMILY INFORMATION [Please list all who will be Members of Practice]		
YOUR NAME	AGE	ADDRESS (1)
NAME OF SPOUSE		ADDRESS (2)
NAME OF CHILDREN		CITY, STATE ZIP
		DAY PHONE NUMBER ( )
		EVENING PHONE NUMBER ( )
		BEST TIME TO CALL _____ AM PM

Payment Arrangements

Please select the payment cycle selected: ☐ Discounted Annual ☐ Monthly

Payment Method: ☐ Credit Card ☐ Electronic Funds Transfer [EFT] ☐ Check (for Annual Payment Only)

EFT: [Please complete authorization below and attach a voided check.]

I authorize my bank to transfer $_____ from my account to Member Plus Family Health monthly in accordance with the terms and conditions stated below. Please transfer my monthly payment on the 5th_____ 20th_____ (CHECK ONE) of every month.

NAME OF BANK _____

ACCOUNT NUMBER_____**ROUTING #**_____

SIGNATURE_____ **DATE** _____

NAME (Please Print) _____

Please attach a voided check to provide us with the required banking information for the electronic transfer. The first transfer will take place 15-30 days after the receipt of this application. Each month thereafter, the transfer will occur automatically unless terminated by you.

CREDIT CARD AUTHORIZATION	☐ **VISA** ☐ **MC** ☐ **AMEX**
CARD # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	**EXPIRATION DATE** _____ / _____
NAME ON CARD	

AUTHORIZING SIGNATURE

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Privacy Issues and E-mail Communications

If you use e-mail to communicate with me or my staff, or the internet to access your medical or billing information, please consider the following information about e-mail communications and sign the consent to electronic communications below:

I understand that e-mail is not a secure medium for sending or receiving potentially sensitive personal health care information. Although communications between patient and physician are subject to confidentiality requirements of Member Plus Family Health and applicable law, Member Plus Family Health cannot assure the confidentiality or protection of e-mail communications . E-mail sent to Member Plus Family Health (Dr. Gregory Keyes and Dr. Blain Crandell) may be accessed by individuals who are not directly involved in my care (for example, Member Plus Family Health employees performing system administrative functions). E-mail sent to me may be accessed by others (for example, by my employer if my e-mail address is provided by my employer, or by my internet service provider).

I understand that e-mail is not a good medium for urgent or time-sensitive communications. Time-sensitive communications should be handled by direct telephone contact or in person. At the direction of my physician, e-mail communications may become part of my permanent medical record. I understand the e-mail information described above and authorize Member Plus Family Health to send electronic mail to me at the following address:

_____, and agree to hold harmless and defend Member Plus Family Health from any unauthorized third-party access to such information. I understand that I can revoke this consent at any time.

I further understand that the Internet is not a secure medium for accessing personal, medical or financial information and that any Internet activities may be accessed by third parties. By accessing any personal, medical or billing information, through the Internet, I assume all responsibility for the security of the information I access via the Internet and agree to hold harmless and defend Member Plus Family Health from any unauthorized third-party access to such information.

APPLICANT'S SIGNATURE:
NAME (Please Print)
DATE