



Manchester Medical Center Primary Care Program Membership Agreement

This Agreement is made between Manchester Medical Center, PLLC (“the practice or MMC”) and the patient _____/_____ (Patient Name/DOB). MMC offers primary care services with OPTIMAL ACCESS to your primary medical provider in exchange for certain fees paid by the patient as described in this Agreement on the terms and conditions described below.

Agreement

1. **Membership Fee:** The membership fee is \$40 per month with the total of \$480 per patient for the service year due at time of enrollment. Initial payments are processed at the time of enrollment. Quarterly payments are an option with a \$5 processing fee per installment added for a total of \$125 each quarter. MMC reserves the right to increase the Membership Fee annually with 30 day written notice to the patient.
2. **Renewal:** This Agreement will automatically renew annually, unless the patient submits a written request to terminate prior to the end of the Service Year, which is defined as one calendar year from the date of the patient’s first scheduled visit/encounter with their provider and every yearly anniversary from that scheduled date. The terms of this Agreement will apply to all subsequent years, unless a new Agreement is otherwise provided to the patient by the practice in writing and signed.
3. **Termination:** This Agreement can be terminated via written notice by the patient or the Practice. If the patient terminates this Agreement prior to the end of their service year, any remaining annual or quarterly fees already paid will be forfeited.
4. **Insurance:** The annual access fee does not affect the co-payments, co-insurance or deductibles that you are required to pay in accordance to the terms of your insurance policy and coverage. It is the patient’s responsibility to understand the provisions of their own insurance policy. The patient (or the guarantor if under 18 years of age) will be responsible for any co-payments, coinsurance or deductible amounts required by your insurer. Failure to do so may result in discharge from the practice.
5. **Electronic Communications and Privacy:** Any communications between the patient and MMC shall remain secure as per the guidelines of the Health Insurance Portability and Accountability Act (HIPAA). The practice encourages all patients to utilize the Athena Patient Portal to ensure secure communication. Please note that traditional email and text messaging are not considered secure and your Personal Health Information (PHI) may be compromised. Should you choose to

communicate via email or text messaging, you are doing so at your own risk. Additionally, please note that any form of electronic communication should not be used for urgent or time sensitive matters. If you have an urgent or time sensitive matter, you must communicate with your provider via telephone or in person.

6. Arbitration; Class Action Waiver: Please read the full Arbitration section** below carefully, as it affects rights that you may otherwise have and provides for resolution of disputes through arbitration instead of court trials and class actions. Arbitration is more informal than a lawsuit in court, uses a neutral arbitrator instead of a judge or jury, and has limited discovery. Arbitration is also final and binding and subject to only very limited review by a court.

**Any past, present, or future claim, dispute, or controversy involving Manchester Medical Center arising out of or relating to this Agreement, including the validity, breach, interpretation, formation, arbitrability, inducement, or enforcement thereof, shall be resolved exclusively through binding Arbitration before a neutral arbitrator in the county where the Member resides. Each party will reasonably participate in the process of choosing the neutral arbitrator, who shall have the exclusive authority to resolve any claim(s) between the parties under any legal theory, whether based in contract, statute, tort, fraud, etc. Arbitration shall be conducted through Judicial Arbitration & Mediation Services (“JAMS”), or another arbitrator if not arbitrable through JAMS. JAMS rules in effect at the time of filing, including its Expedited Procedures, will apply to the Arbitration and can be found at: www.jamsadr.com. Arbitration shall be conducted only on an individual basis and not on a class or consolidated basis. Either party may bring an individual claim in small claims court in lieu of Arbitration if the suit qualifies.

**THE PARTIES FULLY UNDERSTAND THAT THEY ARE INTENTIONALLY AND VOLUNTARILY WAIVING THEIR RIGHTS TO (1) GO TO COURT; (2) HAVE A TRIAL BY JURY; AND (3) PARTICIPATE IN A CLASS ACTION. The parties acknowledge that this Agreement evidenced a transaction involving interstate commerce, and the Federal Arbitration Act shall govern this agreement to arbitrate. The neutral arbitrator has the authority to award whatever relief would be available in court under law or in equity. In the event of Arbitration, MDVIP will pay all costs related to the Arbitration; however, each party will pay its own attorneys’ fees, if any. This agreement to arbitrate shall survive termination of this Agreement.

**Acknowledgement of Arbitration: I acknowledge and understand that this Agreement contains an Agreement to Arbitrate. By signing this document, I understand that I will not be able to bring a lawsuit forward concerning any dispute that may arise which is covered by the Arbitration Agreement unless it involves a question of constitutional or civil rights. I agree to submit any such dispute to an impartial arbitrator.

By my signature below, I confirm that I have read, understood and agree to all the terms set forth in this Manchester Medical Center Primary Care Membership Agreement. I understand that the Service Year begins the date that this agreement is signed.

Patient Name (Print)

Signature

Date

Witness Name (Print)

Signature

Date

Patient Name: _____

Payment: Please select your payment preference:

_____ \$480 Annually _____ Check _____ Credit/Debit Card

Please make checks payable to Manchester Medical Center

_____ \$125 Quarterly-Automatic payment by credit/debit card every 3 months

____ Visa _____ Mastercard _____ Discover _____ AMEX

Card Number: _____ Expiration Date: ____/____ CCV _____

Name as it appears on card: _____ Zip Code: _____

Patient authorizes Manchester Medical Center, PLLC or the practice's designee to bill the Access Fee to the Patient's Credit/Debit Card as selected above.

Signature Authorizing Payment

If you have questions, please email us at primarycare@mmcv.t.com and leave your name, phone number and best time of day to reach you.