Belt Line Medical Clinic
"Personalized Medicine For A Healthier You"

Direct Care Membership Agreement

Select Provider:

☐ **Dr. Harman P Kaur**

Monthly membership subscription dues for an individual are as follows:

$99/ month or $1088 for 1 year membership ($100 off when you enroll in membership for 12 months)

Please notify us, if enrolling spouse or another family member at the same time: ☐ Yes ☐ No

Please Print

First Name, MI, Last Name:		
Date of Birth (mm/dd/yyyy):		Gender: ☐ Male ☐ Female ☐ Other
Home Address:		City State ZIP Code
Telephone:	Cell: Home:	Other:
E-mail address:		

TERMS OF THIS AGREEMENT

I acknowledge and understand that –

☐ I enter into this membership agreement voluntarily and this agreement is non-transferable to any other person;

☐ I have reviewed the listing of Direct Care services and I acknowledge that I have had the opportunity to ask questions and receive answers regarding Clinic services;

☐ This agreement does not provide health insurance coverage of any kind, nor is it a contract of insurance and that it provides only the health care services specifically offered by my selected Direct Care provider;

☐ I am responsible for all medical and health care charges not included in this membership agreement, at the time of service, including off-site charges, Labs, injections, vaccinations, or medication prescriptions filled in the clinic;

☐ Direct Care providers must maintain a record of my health information and must protect the privacy of my health information as per the terms of the *Notice of Privacy Practices*;

☐ I agree to pay my membership subscription dues on or before the due date each month, and in the event that I am unable to pay my fee(s) on time, I understand that this membership agreement may be terminated immediately;

☐ I may terminate this agreement at any time and for any or for no reason, by providing written notice to Belt Line Medical Clinic 4321 N beltline road, suite 500, Mesquite, Texas 75150; in addition, I acknowledge and understand that my selected Direct Care provider may terminate this agreement at any time by providing written notice to me; Termination will result in refund of the prorated amount based on # of months remaining in membership X 728/12.

☐ Specific Clinic services may be added or discontinued at any time, without notice; additionally, my member subscription dues may be increased with notice provided, no less than sixty (60) days in advance;

By signing below, I hereby authorize my selected Direct Care provider to contact me using the information I have provided on this agreement form.

I hereby authorize Belt Line Medical Clinic to initiate charges to my credit card, debit card or automatic bank withdrawal for my recurring monthly membership dues (including my spouse or dependent if I have selected this option), unless my employer has agreed to make payment on my behalf.

I understand that my participation in Direct Care Membership is continuous and that, by signing below, I authorize recurring auto-draft or credit/debit card charges until my written notice of termination has been received.

_____ _____

Signature Date

*Please indicate below your preferred payment option **if necessary:***

☐ **Auto-draft**

Financial Institution Name: _____

Routing #:_____ Account # _____

Amount of debit authorized: $_____

Withdrawal date: ☐ First day of month OR ☐ $1088 due if signing up for 1 year membership (discount applied)

☐ **Credit card** – please check which Credit Card you will use: ☐ Visa ☐ MasterCard

- Credit card/Debit card #_____ Exp:_____ CVV: _____

Signature: _____

Date: _____

Charge date: ☐ First day of month OR ☐ $1088 due if signing up for 1 year membership

(discount applied)

Thank you. We appreciate your trust and look forward to taking care of you.