Patient/Physician Cooperatives

PATIENT PHYSICIAN COOPERATIVES MEMBERSHIP APPLICATION

P.O. Box 230609, Tigard, OR 97281
membership@patientphysiciancoop.com
Phone: 1-866-549-4199 Fax: 1-866-234-8707

PRIMARY APPLICANT

NEW ENROLLMENT ☐ CHANGE FORM ☐

Last Name		First Name		Middle Initial
Sex	Date of Birth (MM/DD/YYYY)	Identification Type	ID Issued By	ID Number
Home Address		City	State	Zip
Mailing Address (if different than home address)		City	State	Zip
Cell Phone	Home Phone	E-Mail Address		
Employer			Employer Paid?	
Service Plan*	Rate†	Tobacco Use?	Provider	PCP Phone

BENEFIT SELECTION

Select the desired services for each additional member of your household:

Last Name		First Name		Service Plan	Rate
Relationship to Primary	Sex	Date of Birth	Tobacco Use?	Provider	PCP Phone

Last Name		First Name		Service Plan	Rate
Relationship to Primary	Sex	Date of Birth	Tobacco Use?	Provider	PCP Phone

Last Name		First Name		Service Plan	Rate
Relationship to Primary	Sex	Date of Birth	Tobacco Use?	Provider	PCP Phone

Last Name		First Name		Service Plan	Rate
Relationship to Primary	Sex	Date of Birth	Tobacco Use?	Provider	PCP Phone

Last Name		First Name		Service Plan	Rate
Relationship to Primary	Sex	Date of Birth	Tobacco Use?	Provider	PCP Phone

† Rates vary based on selected provider
*All service plans include a one-time enrollment fee of $20

Office Use Only	
Agent:	Effective Date:

For more information, or for assistance with this form please contact us at **866-549-4199** or e-mail **membership@patientphysiciancoop.com**

BILLING AGREEMENT

INITIAL CHARGES

Billing Method Credit/Debit ☐ Bank Draft ☐ Cash/Check ☐	Amount	Check #

MONTHLY CHARGES

To set up draft payments fill out your credit / debit information in the form below. If drafting from a checking or savings account attach a voided check to your signed application and mail it to PPC PDX Cooperative at: P.O. Box 230609, Tigard, OR 97281, or fax it to: 866-234-8707

Billing Method Credit/Debit ☐ Bank Draft ☐ Employer ☐	Amount	Billing Date	Employer	
Name of Account Holder	Bank Name		Routing #	Checking Account #

Name on Credit / Debit Card	Card Type		
Card Number	Expiration Date (MM/YY)	CCV Code	
Billing Address	City	State	Zip

TERMS & AGREEMENTS

I (we) authorize the financial institution above to honor and pay these monthly charges. I (we) understand that in order to cancel these payments, I (we) must provide written notice to Patient/Physician Cooperatives no less than 30 days before the next scheduled payment. Until such notice is received, I (we) agree that you shall be fully protected in honoring any such charge/draft.

Account Holder's Signature _____ Date _____

MEMBERSHIP AGREEMENTS

CO-OP MEMBERSHIP AGREEMENT

I agree to a one year membership in the Patient / Physician Cooperatives through which I shall have access to all the benefits and privileges of the Co-op and its Business Affiliates. By signing below I hereby state that I have read and agree to the Terms and Conditions outlined in this packet.

Name (Print) _____ Signature _____ Date _____

PROVIDER SERVICES AGREEMENT

I agree to a one year contract with my selected Provider for access to primary care services. I understand any request to change providers prior to the end of my12 month contract must be submitted in writing to be reviewed & approved by Member Services.

Name (Print) _____ Signature _____ Date _____

LAB SERVICES AGREEMENT

I agree to a one year contract with my selected Provider for access to Lab Services. I understand any request to change providers prior to the end of my12 month contract must be submitted in writing to be reviewed & approved by Member Services.

Name (Print) _____ Signature _____ Date _____

HIPAA AUTHORIZATION

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends. Therefore, pursuant to 45 CFR 164.50l(a)(l)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____ , an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the following authorized entity, its affiliates, employees and agents:

MRSB / SPA / PPC
P.O. Box 1838
Splendora, TX 77372
(866) 549-4199

TERMINATION

This authorization shall terminate on the first to occur of: (I) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

Name (Print) _____ Signature _____ Date _____

AGENT SIGNATURE

Name (Print) _____ Signature _____ SS# _____

MEMBERSHIP TERMS

CO-OP + PRIMARY CARE SERVICES

New Enrollments:

This is an annual contract. New members pay a one time set-up fee of $20, along with the first month's Co-op membership and Provider Services fee. Subsequent monthly fees will be set up as drafts from your debit/credit card or your checking/savings account. Your billing date is determined by the date of your initial payment.

Membership Rates:

One-time enrollment fee: $20

Co-op Membership:

$20 per month (includes PPC Provider Network access and patient advocacy)

Co-op Membership Plus:

$35 per month (includes basic membership benefits plus additional discounts, nationwide provider network access & Teladoc)

Provider Rate:

Average of $39* per month per member (*rates vary based on selected provider)

Medical Services Include:

Scheduled visits with your selected Provider for typical primary care services including, but not limited to:

- Preventative care
- Annual physicals
- Management of chronic medical conditions (such as diabetes, high blood pressure, high cholesterol, thyroid)
- Well check visits for children

Please refer to the Physician Member Profile provided, or speak with your selected Provider for more information on specific services or exclusions.

PPC Enrollment Terms and Conditions:

By signing the Co-op Enrollment Form you agree to the following terms and conditions:

- Membership is effective immediately upon successful processing of initial payment.
- Members cannot be seen by a Physician/Provider until the membership effective date.
- Persons signing up for the Co-op cannot be seen by a Physician/Provider on the day of enrollment unless they are enrolling in office at the time of their appointment.

Payment Terms:

- Credit card, debit card, cash or check are accepted for the initial enrollment payment.
- Monthly fees must be paid by credit card or debit card, or a draft from checking or savings account each month.
- All drafts or credit / debit charges will be made monthly based on the date of initial payment.
- Any payments or drafts that are refused by the bank or credit card will be considered delinquent. And any bank charges for an overdraft will be the responsibility of the member.
- To remain a current and active member, all fees must be paid on the specified pay date each month. If at any time the member Co-op fee is past due, the member's Provider will be notified & any appointment costs must be paid in full at the time of your visit (appointment/service charges at Provider's cash rate), until the Co-op member fees are paid and current.
- To reactivate your membership you must pay any past due membership fees in full, as well as any late fees.
- Co-op membership is an annual agreement and members are responsible for all fees for one full year.
  If a member wants to "opt out" of the Co-op before the end of the 12-month contract, a request must be submitted in writing 30 days in advance of when you wish to opt-out of the program providing reasons for the request. Your request will be reviewed by Member Services and you will be notified of their decision.

All disputes or complaints must be submitted in writing to Member Services. All disputes will be handled in a timely manner and recommendations are binding for both parties.

Upon signing of this Agreement, the member agrees to the above terms and conditions. (Signatures on file from the declarations and signature page which is attached to this document). Signatures are on the Enrollment Form.