



# Healthy Living Community

## -2020 Membership Agreement- MEMBERSHIP RENEWAL

**Form due date: Jan. 1st, 2020**

Thank you for being an integral member of Healthy Living Community as we transitioned to our new model of care in 2019. We are excited for you to continue as a member in 2020!

Optimal health cannot be achieved alone, and we are excited to continually offer not only holistic patient-centered care, but opportunities for community involvement and connection through classes, monthly gatherings, and support groups. We are also eager to grow the resources we have available for members such as: low-cost supplements, healthy food offerings, and healing community spaces.

With your membership payment, you are sustaining all the wonderful services Healthy Living Community is able to offer to patients at all income levels.

Please note, this form is due before you schedule an appointment with Dr. Kerry in 2020. We will not allow scheduling unless we have an updated Membership Agreement on file.

For your convenience, forms can be returned by: mail, in person at the clinic, through the ChARM patient portal, by emailing to [pearl@healthylivingfamilymedicine.com](mailto:pearl@healthylivingfamilymedicine.com) or faxing it to 503-376-3790.

Name : \_\_\_\_\_ Age: \_\_\_\_\_

Names and ages of additional family members seen by Dr. Kerry, who will be included in your monthly membership payment:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

Phone Number: (        ) \_\_\_\_\_

Email: \_\_\_\_\_

I would like to join the Healthy Living Community newsletter email list to receive information regarding upcoming community events and clinic news.

☐ Yes    ☐ No

Note: Newsletters will be limited to 2-3 emails per month.

### Membership Payment

You have the option to pay your membership fee in monthly installments, or as one lump sum annually. We ask that you please choose a payment amount that reflects your *current financial capabilities* and *healthcare service usage* (how often you see or contact Dr. Kerry!). If you are making a

payment for all family members, please write the monthly or annual amount you will be paying for each member.

*-Please select your payment preference-*

☐ **Monthly Payments**

Membership fee paid in monthly installments. The **minimum** monthly membership payment has changed to \$10 per member per month\*\*.

How much would you like to pay per month: \$ \_\_\_\_\_ (Consider \$10, 15, 20, 25, 30, 35, 40)  
If applicable, please list all family members and their monthly membership payment amounts below:

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Please note: Autodraft of monthly payments will occur on the 5th of every month. If you would like withdrawals to be made on a different date, please let us know here: \_\_\_\_\_

\*\*If the minimum membership amount does not feel feasible for you, or your family, at this time we invite you to please speak with Dr. Kerry. We are open to discussing alternative membership payments amounts or opportunities for trade/barter.

☐ **Annual Payment**

Membership fee paid in one lump sum. The **minimum** annual membership fee is \$120 per member.

How much would you like to pay this year: \$ \_\_\_\_\_ (Consider: \$120, 180, 240, 300, 360, 420)  
If applicable, please list all family members and their annual membership payment amount below:

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**Pay-By-Appointment Information:**

Another component of our new clinic model involves paying for an appointment at the time of your visit on a sliding-scale, that ranges from paying our full cost for a visit to whatever amount your financial situation allows. You may submit paperwork to insurance for possible reimbursement, but HLC will no longer bill insurance directly.

For planning purposes, we ask that you make an estimate of what you anticipate being able to pay for a visit with Dr. Kerry.

For your reference, we have calculated that our actual cost for a 60 minute appointment is \$240 (factoring in Dr. Kerry's time, clinic staff time, admin costs, space rental and upkeep).

Note: This is not a commitment to pay a certain amount, this is only a prediction to help us with financial planning. Thank you for putting thought into this response!

I predict that I (or my family member), will pay this amount for an appointment when I come in to see Dr. Kerry: \$ \_\_\_\_\_ (Please see enclosed HLC Services Price List for more details)

**Payment Information:**

In order to make monthly or annual membership payment(s), we will require bank account or credit card information on file in order to make automatic withdrawals from your account. This information will remain confidential and only be used to make authorized withdrawals.

Bank Account or Credit Card Information:

**Bank Account (our preference - by not paying credit card fees we keep our costs lower):**

Bank/ Credit Union: \_\_\_\_\_

Is this account: ☐ Business ☐ Personal

Name of the Account Holder: \_\_\_\_\_

Phone Number of Account Holder: \_\_\_\_\_

Email address for Receipts: \_\_\_\_\_  
(if different then patient email)

Account Type: ☐ Checking ☐ Savings

Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

**Credit Card**

Type of Card: ☐ Visa ☐ Mastercard ☐ American Express

Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

3 digit Security code: \_\_\_\_\_

Address: ☐ Same as above

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## Patient Care Fund

I would like to add the amount below onto my monthly payment, or make a one time donation, to Healthy Living Community's Patient Care Fund, and support the care of others who may be unable to afford it at this time.

We are currently working on acquiring a non-profit status. We are very excited about this possibility. Although donations to the Patient Care Fund are not tax-deductible at this time, we appreciate your generosity to help others in receiving unique, holistic, patient-centered care with Dr. Kerry.

I would like this donation to be: ☐ Added to my monthly payment ☐ One time donation

☐ \$5 ☐ \$10 ☐ \$20 ☐ \$60 ☐ \$120 ☐ \$240 ☐ Other: \$ \_\_\_\_\_

Support a fellow patient's appointment costs: 15 min = \$60, 30 min = \$120, 60 min = \$240.

## Office Policies

☐ I have reviewed the updated office policies online on the Healthy Living Family Medicine website. I understand that by becoming a member, I am agreeing to these policies.

## FAQ's

☐ I have read/reviewed the FAQ sheet and am aware of what the new Healthy Living Community clinic model entails. I understand that this FAQ may be updated as new questions arise.

## Terms and Conditions

☐ I have read/reviewed the attached Terms and Conditions. I understand that by becoming a member, I am agreeing to these terms.

## Agreement

By signing this form I understand that I am agreeing to become a member starting the date of signage. I acknowledge that in order to remain a patient of Dr. Kerry's I must re-submit this membership agreement annually, and that by becoming a member I am committing to a full year of membership. I agree to allow Healthy Living Community to withdraw from my bank account or charge my credit card the amount above with the indicated frequency.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Healthy Living Community in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Healthy Living Community may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$25 charge for each attempt returned NSF which will be initiated as a

separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form.