

# Lifeway Concierge Medicine Membership Agreement

I wish to become a member of the Lifeway Concierge Medicine. I fully understand that the Lifeway Concierge Medicine program comprises services, amenities and benefits that are not covered by Medicare or other health insurance plans. These services are outlined in the Lifeway Concierge Medicine Introduction. Medical services that are covered by Medicare and other health insurance providers are not part of the Lifeway Concierge Medicine program.

## Lifeway Enhanced Care - \$2000

Member agrees to pay the annual membership fee. **An initial non-refundable payment of the first 6 months of membership is required upon joining Lifeway Concierge Medicine.** Subsequent payments may be paid by monthly bank draft. When paying by check or credit card, payments must be made annually or semi-annually. The membership begins when we receive the initial payment.

**If a payment is 30 days past due a \$100.00 late fee will be charged.**

1. Members are financially responsible for medical services received from Lifeway Concierge Medicine and Lifeway Family Physicians that are outside the membership program. Services covered by insurance or Medicare will be submitted to the insurer. Members continue to be responsible for any co-payments, co-insurance and/or deductibles as required by the insurer.
2. Neither Lifeway Family Physicians nor the member will seek reimbursement for the annual Lifeway Concierge Medicine membership fee from their medical insurance company or Medicare. Some flexible spending accounts may cover the annual membership fee.
3. Renewal and Termination – Unless otherwise terminated, this agreement shall automatically renew each year. If the member or Lifeway Concierge Medicine wishes to leave the membership program for any reason, we require **thirty (30) days written notice prior to the next scheduled payment.** If the member terminates before the end of their term and they have not received their annual Comprehensive Wellness Exam, they will receive a prorated portion of the annual fee. Failure to pay the membership fee may result in automatic disenrollment when the account becomes 60 days past due.
4. Lifeway Concierge Medicine will provide advance notice of any change in membership fees and/or policies.

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**Printed Name of Member**

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**Signature**

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**Date**

# Lifeway Concierge Medicine Payment Authorization

**\*PLEASE CHOOSE ONE PAYMENT OPTION AND \*SIGN BELOW\***

I choose to pay by **Check** (check one box)  semi-annual  annual payment  
**\*\* Please attach your check made payable to Lifeway Family Physicians \*\***

I choose to pay by **Bank Card** (check one box)  semi-annual  annual payment  
**Card Type:**  Visa  MasterCard  Discover

Name on Card \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_  
Card Number \_\_\_\_\_ Phone # \_\_\_\_\_  
Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_ Zip Code \_\_\_\_\_  
Amount \$ \_\_\_\_\_

I choose to pay **monthly** by **Electronic Fund Transfer** directly from my **Checking Account**  
**\*\*\* THIS OPTION IS AVAILABLE AFTER PAYMENT OF THE FIRST 6 MONTHS OF MEMBERSHIP (NON-REFUNDABLE) \*\*\***

**FOR MONTHLY TRANSFER:** Please attach a **voided check** to this document (NOT A DEPOSIT SLIP)

Financial Institution \_\_\_\_\_ Name on Account \_\_\_\_\_  
Routing/Transit Number \_\_\_\_\_ Account Number \_\_\_\_\_  
Amount per Month \$ \_\_\_\_\_

LIFEWAY CONCIERGE MEDICINE is hereby authorized to debit the Financial Institution and account identified above. LIFEWAY CONCIERGE MEDICINE is further authorized to obtain information from the Financial Institution pertaining to transactions designated by this document, and to credit the account if a payment is debited in error.

I acknowledge that the origination of all ACH transactions must comply with the provisions of United States Law.

I recognize that if I fail to provide complete or accurate information on this document, processing may be delayed and/or my preauthorized debit may be erroneously transferred. In the event that funds are erroneously transferred due to my failure to provide complete or accurate information on this document, I hereby hold LIFEWAY CONCIERGE MEDICINE harmless for the recovery of such erroneous transfers, notwithstanding any reasonable attempts made by LIFEWAY CONCIERGE MEDICINE to correct such errors.

This authorization is to remain in full force and effect until LIFEWAY CONCIERGE MEDICINE has received written notification from me of its termination, in such time and in such a manner as to afford LIFEWAY CONCIERGE MEDICINE and the Financial Institution reasonable opportunity to act on it.

\_\_\_\_\_  
**\*\*Signature\*\***

\_\_\_\_\_  
**\*\*Date\*\***