Santa Cruz
Direct Primary Care

Membership Agreement and Consent to Treat

Decision to Join: I acknowledge and understand that I am voluntarily becoming a member of Santa Cruz Direct Primary Care (herein "Santa Cruz DPC") and that this agreement is non-transferable. The effective date of my Santa Cruz DPC membership is the date on which I sign this document. I have reviewed the services provided by Santa Cruz DPC and have had the opportunity to ask questions and receive answers regarding those services.

Consent to Treat: I acknowledge and hereby authorize Santa Cruz DPC (Jeannine Rodems, MD and Adam Yarme, MD) to use and/or disclose my health information which specifically identifies me, or which can reasonably be used to identify me, to carry out my treatment, payment and healthcare operations. Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the administration and use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of the member, including but not limited to diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

I acknowledge and understand that this consent is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation.
A photocopy or electronic copy of this consent shall be considered as valid as the original.

Direct Primary Care is NOT insurance: I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage, nor is it a contract of insurance, and that it provides only the health care services specifically provided by Santa Cruz Direct Primary Care for the single low cost monthly fee. I understand that Santa Cruz DPC strongly recommends that I maintain health insurance for services not provided by this agreement in order to cover unpredictable or catastrophic expenses or medical services beyond the scope of those provided by Santa Cruz DPC.

What is not included: Membership benefits do not include any services provided by other health care providers, institutions, or organizations. Specialist care, including OB, surgery, emergency department visits or emergency services, imaging, non-clinic lab testing, and medications are also not included.

Charge Responsibility: I understand and accept that I am responsible for all charges incurred for health care services provided by Santa Cruz Direct Primary Care. Santa Cruz DPC will not bill insurance carriers for services provided. I acknowledge and understand that I am responsible for any charges incurred for services outside of Santa Cruz DPC, including but not limited to emergency department visits, hospital and specialist care, imaging and laboratory tests, equipment and medications.

Billing Details: I acknowledge that membership fees are due on the first of each month and apply to the entirety of that month without proration. In addition to the monthly membership fee, I acknowledge and agree to pay established charges related to hospital visits, skilled nursing, copies of medical records, returned checks and other administrative and compensatory fees. These are available on request and are subject to change without notice.

Late Payments: In the event that I am unable to pay my bill at the time of billing, I understand that I will be charged a $30 late fee for each late payment. Members who miss payment for two (2) consecutive months will be terminated from the membership service agreement and will have to wait nine (9) months to reinstate their membership or pay an additional $100 reinstatement fee. As Santa Cruz DPC grows and adjusts to the needs of patients and the health care environment, it is possible that we will need to make changes to our services and fees. Santa Cruz DPC reserves the right to change (add or discontinue) services or change the fee schedule at any time. Members will receive written notice of at least sixty (60) days prior to changes taking effect.

No Show Fees: All cancellations must be completed at least 12 hours prior to your appointment. If you do not show up for an appointment or are significantly late to the appointment, you may be charged a $25 fee for a missed visit. Exceptions to this fee may be granted at our discretion.

Termination: I acknowledge that membership in Santa Cruz DPC is designed and intended to be continuous, though members may terminate their membership at any time. If a member terminates their membership, they will have to wait nine (9) months to reinstate their membership or pay $100 reinstatement fee. Santa Cruz DPC will reimburse members any fees collected in advance for the months following termination of membership. Please request the termination in writing, with at least a five (5) days notice before the next payment. Santa Cruz DPC does not offer prorated refunds for partial months.

I acknowledge and understand that Santa Cruz DPC may terminate my membership by providing me thirty (30) days written notice in accordance with the laws of the State of California. Santa Cruz DPC will not terminate the membership agreement on the basis of health condition or protected status.

This is a private letter of agreement between Santa Cruz DPC (Jeannine Rodems, MD and Adam Yarme, MD) and you/your family. This letter (signed by each responsible party) and attached list of household members signed by the household's financially responsible person constitutes the full terms of your membership.

Jeannine Rodems, MD
Adam Yarme, MD

Accepted By:

_____ _____

Signature of Patient (Responsible party) Date

_____

Printed Name of Patient

Name of Family Member	Date of Birth

Santa Cruz
Direct Primary Care

Consent for the Treatment of Minors:

I hereby authorize and give consent to Santa Cruz Direct primary care physicians and staff to evaluate and treat my child. This permission includes treatment, minor procedures, injections, immunizations, and prescriptions written.

Santa Cruz Direct Primary Care physicians and staff prefer that all minors seeking treatment be accompanied by a parent/legal guardian for the first visit. After the initial appointment, a minor may be seen at Santa Cruz Direct Primary Care for treatment without the parent/legal guardian present if this consent is complete and box is checked below:

☐ I also authorize and give consent to Santa Cruz Direct Primary care physicians and staff for medical evaluation and treatment of my child if a parent or legal guardian is not present.

This authorization must be completed annually until the minor is 18 years of age. Authorization and consent to medical treatment of minors is also under the jurisdiction of state and federal laws, and special requirements or exceptions to parental consent may apply.

Date: _____

Name of Child: _____DOB: _____

Printed Name of individual signing consent: _____

Signature: _____

Relationship to child: _____

Phone number: _____