Lake Men's Health Center

Membership Application

General Information

First Name: _____

Last Name: _____

Date of Birth: _____

Social Security Number: _____

Primary Phone: _____

- This is my: Home / Cell / Work *(please circle one)*

Alternate Phone: _____

- This is my: Home / Cell / Work *(please circle one)*

E-mail: _____

Street Address: _____

_____

City, State, Zip Code: _____

_____

T-shirt Size: _____

Primary Insurance: _____

Secondary Insurance: _____

Referral Source: _____

_____

Payment Options

The cost of the annual fee for the Lake Men's Health Center may be eligible for reimbursement through some HSA's, FSA's, or other similar health accounts. It is your responsibility to receive approval from your health insurance benefits coordinator as to the amount that may be reimbursable.

I elect to pay the annual fee as follows (please place a checkmark in the blank preceding the payment method you prefer):

Option 1

☐ **One lump sum of $2,000 payable as follows (select one):**

- ☐ My check is attached
- ☐ Charge my debit or credit card
  (complete the card information below)
- ☐ Invoice my employer for the lump sum annual fee:
  - **Employer Name:** _____
  - **Employer Contact:** _____
  - **Address:** _____

    _____
  - **Phone Number:** _____

Option 2

☐ **Twelve (12) equal monthly installments of $175 (total of $2,100) on the (choose one) ☐ 1st or ☐ 15th of each month.**

- **Please circle debit/credit card:**
  Visa / MasterCard / Discover / AmEx
- **Cardholder Name:** _____
- **Billing Address:** _____
- **Card Number:** _____

  _____
- **Security Code:** _____ **Expiration Date:** _____

I acknowledge receipt of a copy of the Membership Agreement, this Application, and the attached Required Comprehensive Disclosure Statement. By my signature below, I agree to the terms and conditions contained in the documents, including without limitation, the payment plan listed above. I further authorize Our Lady of the Lake Physician Group, L.L.C. to charge my debit/credit card in accordance with the payment schedule stated above.

Member's Signature: _____ **Date:** _____

Submit completed application to MHC@fmolhs.org or to fax to (225) 765-9462

Disclosure Statement >

Lake Men's Health Center
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Required Comprehensive Disclosure Statement

Direct Access Agreement Disclosures:
You should obtain and maintain insurance for services not provided under the Lake Men's Health Center Membership Agreement. The Practice will not bill a health insurance issuer for any services covered under the membership agreement. You are responsible for the payment of the fee specified in the membership agreement according to the payment terms set forth in the Agreement. Any services that are not specified in the membership agreement shall be charged to you and/or your insurance company.

The contact information for the Louisiana State Board of Medicine is:

Louisiana State Board of Medical Examiners
A 630 Camp Street, New Orleans, LA 70130
T (504) 568-6820

Lake Men's Health Center

Membership Agreement

This Agreement sets forth the terms and conditions under which you, the undersigned member, may participate in the Lake Men's Health Center.

Our Lady of the Lake Physician Group, L.L.C. (the Practice) will provide you with the following services:

Annual Health Review

You will be provided with one health review per year. The Annual Health Review will include a comprehensive health history, physical examination, complete lab panel and other office testing as indicated. The nurses will draw your blood for lab work in the office prior to the date of your visit. Following completion of the physical examination, you will have an individualized consultation that delineates your current health and physical status. You are responsible for scheduling the pre-appointment blood draw and your appointment for the Annual Health Review. The review is a no cost service; neither you nor your insurance plan will be charged for this service. All other visits to the Practice will be billed to your insurance plan, unless you choose to pay for the visit out-of-pocket.

Access/Communication

You will have direct access to the Practice providers during normal business hours Monday through Friday. You can contact the Practice by telephone, text, email, or e-visit (through the online patient portal described below). You can walk-in for an office visit (no appointment necessary). Please be aware that email and text messages through personal email or cell phones are generally unsecure. The Practice will not be liable for any loss, breach, hacking, or security incident pertaining to your medical information sent via unsecured email or text messages. The communications services described in this paragraph are not intended for emergency medical needs. If you have a medical emergency, dial 911 or report to the nearest emergency room.

Appointments

The Practice will use its best efforts to schedule any appointments necessary on the same day that you make the request or, if that is not possible, on the following normal office day. Immediately upon arriving for a scheduled office visit you will be seen by the Physician or Nurse Practitioner with minimal wait.

Online communication

You will have access to an online patient portal (Epic MyChart) that will enable you to communicate with the Practice in a secure manner and to review your health record.

Additional Services

The Practice will not be responsible for providing specialized testing performed outside of the Practice, unless otherwise specified. The Practice will coordinate appointments for specialized testing; examples include Executive Wellness Exam, MRI, PET SCAN, and CT Angiography.

Fees

For these services, you will pay, at your option, (i) $2,000 per year in one lump sum; or (ii) $2,100 per year, payable in 12 equal monthly installments of $175. The annual fee will be collected through automatic ACH debit or credit charge. If you elect to pay the lump-sum fee and terminate this Agreement prior to your Annual Health Review, a prorated share of the lump-sum payment will be refunded to you. If you terminate the Agreement after your Annual Health Review, you will not be entitled to a refund. If you pay the fee through monthly installments, no refund will be made for sums paid prior to the date of termination.

Additional Charges

The Practice will notify you, prior to their administration or delivery, of any additional charge for supplies, medications, or specific vaccines that are not included under this Agreement.

Member Acknowledgments

You acknowledge that: From time to time, due to emergency situations such as medical emergencies and natural disasters, the Practice may not have a Physician or Nurse Practitioner available. Services offered under this Agreement are beyond the coverage of any insurance plan you have, and the Practice will not seek reimbursement from your plan for services covered under this Agreement. The Practice may bill your insurance plan for services provided to you that are not covered by this Agreement, and you and/or your plan will be financially responsible for such services. The annual fee does not affect the co-payments, co-insurance, or deductibles you are required to pay under the terms of your insurance coverage. You agree that you will not seek reimbursement of the annual fee from your insurance plan, unless such fee is covered by your plan. The Practice makes no representations whatsoever that the fees paid under this Agreement are or are not covered by your own health insurance or by other third party plans that might provide you coverage.

Terms and Termination

You will receive the services for one (1) year. This Agreement will automatically renew from year to year unless you notify the Practice in writing that you do not wish to renew. You may terminate this Agreement at any time by giving written notice. The Practice may terminate this Agreement if you fail to pay the fee; you have performed an act that constitutes fraud; you have repeatedly failed to comply with the recommended treatment plan; you are abusive and present an emotional or physical danger to the staff or other patients of the Practice; or the Practice discontinues operation as a direct practice.

By signing the attached Membership Application, you agree to the terms of this Agreement, which represent the entire agreement and understanding between you and the Practice.

This Agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described. A Comprehensive Disclosure Statement is attached.