Annual Membership Agreement & Terms for Payment of Annual Membership **Fee**

Personalized Wellness Health Care Program

Amethyst Medical Group/Winni M. Loesch MD, FAAFP AMG/Dr. Loesch

Member/Patient Name **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have engaged the Amethyst Medical Group (AMG) and its physician, Winni M. Loesch, MD, FAAFP to provide a Personalized Wellness Health Care Program (PWHCP) to me for a period of one year beginning  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that an Annual Membership Fee of $1,500 is assessed to pay for these “non covered services and benefits”. As used in this Agreement, the term “Service Year” refers to the One (1)-year period beginning on the date above and continuing (auto renewal) every 1-year period after that, unless I choose not to renew the Agreement as provided below.

I may renew this Agreement for subsequent Service Years by paying the Annual Fee for the applicable Service Year.  I have read and understand this Agreement. I acknowledge that this Agreement will automatically be renewed and will continue for future Service Years unless I notify AMG/Dr. Loesch of my intention to terminate. I acknowledge that either I or AMG/Dr. Loesch may terminate this Agreement at any time upon 30 days written notice. If either party terminates this Agreement, the Annual Fee may be pro-rated. However, if the annual Comprehensive Wellness Evaluation has been completed, there will be no refund.

The terms of this Agreement will apply to all such subsequent Service Years, unless AMG/Dr. Loesch and I agree otherwise, in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature Date

Member Name **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**✓ Billing Frequency:**

* I will pay annually. I will make one payment of $1500
* I will pay semiannually. I will make a payment of $750 now and the remaining balance of $750.00 (on or about six months from my initial date of enrollment.
* I will pay Quarterly. I will pay one-quarter now $375. The remaining fee due of $375 will be Charged (auto deducted) each subsequent quarter (three month intervals charged One- quarter at a time at three-month intervals from date of enrollment.

**✓ Method of payment:**

1. ❑ Voided Personal check enclosed. For Semiannually and Quarterly payments, please

enclose a voided personal check so we may set up automatic withdrawal from your

checking account.

I hereby authorize AMG/Dr. Loesch to provide me \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Patient) the Preventive Wellness Health Care Program for an annual membership fee of $1,500. AMG/Dr. Loesch may withdrawal from the checking account provided, under the terms I have indicated above.

1. ❑ Personal check (Full Annual Payment) of $1,500 enclosed. Please make check payable to

AMG/Winni Loesch, MD

Check Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ❑ Credit Card:

I hereby authorize AMG/Dr. Loesch to provide me \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Patient) the Preventive Wellness Health Care Program for an annual membership fee of $1,500. AMG/Dr. Loesch may charge the following Credit Card under the terms I have indicated above.

**⭘** MasterCard **⭘** Visa **⭘** American Express **⭘** Discover

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder (Payer) Printed Name Cardholder (Payer) Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number Exp Date Security Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Cardholder (Payer) Billing Address City State Zip Code

( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Daytime Phone Number

Please sign & return with your indicated form of payment

Enclosures: Pre-Addressed/Stamped Envelope

Release of Information Consent Form