PLACER PRIVATE PHYSICIANS

Personalized family and sports medicine

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PLACER PRIVATE PHYSICIANS FEE TERMS

Placer Private Physicians ("Private Practice") and _____ ("Patient") have entered into a Placer Private Physicians Services Agreement ("Services Agreement"), and this Placer Private Physicians Fee Terms ("Fee Agreement") confirms the applicable Private Practice fees as follows:

Private Practice Fee. The fees for Private Practice's Personal Health Record Support and Amenities identified in the Services Agreement ("Practice Fee") are as follows:

☐ **Ages 0-19 years: $50.00 per month** (# of members_____)

☐ **Ages 0-19 years: $20.00 per month** (# of members_____)
(with at least one active parent membership)

☐ **Adult 20-44 years: $100 per month** (# of members_____)

☐ **Adult 45-64 years: $130 per month** (# of members_____)

☐ **Adult 65 years and older: $160 per month** (# of members_____)

☐ Nursing home residents or homebound adults: Monthly fee: $_____
(Practice Fee to be determined based on level of need. Please discuss directly with your physician)

Total monthly / yearly (circle one) membership fee: $_____

5% discount on all fees paid in full on annual basis

Payment Options:

For annual payment, the payment options are by personal check, credit card, or debit card. There is a 5% discount off the noted monthly fees for members paying annually.

For payment by monthly installment, a credit or debit card or electronic funds transfer ("EFT") account on file is required and will be automatically charged at the agreed-upon interval. As a courtesy, no additional cost is incurred for installment billing.

The Patient authorizes the Private Practice to charge any fee installments on the above-referenced credit card until such authorization is revoked by the Patient or this Agreement is terminated. Absent contrary instructions, the Patient authorizes the Private Practice to use the credit or debit card or EFT

account on file for the payment of any additional billing fees for professional services. Patient agrees to maintain Patient's credit or debit card or EFT account current and shall promptly notify Private Practice of any changes to Patient's payment method.

Services billed monthly or yearly and are paid via an automatic payment method. A three-month, non-refundable commitment fee equal to and counting toward the first three months of membership is due up front and in full at the time of registration.

☐ **PLEASE BILL MY CREDIT CARD: ____VISA _____MASTERCARD _____DEBIT CARD**

_____ANNUAL LY _____MONTHLY

Name on Card:_____ Card Number_____-_____-_____-_____

Expiration Date:_____ Billing Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

Authorized Signature:_____ Date:_____

☐ **PLEASE DEDUCT FEES FROM MY CHECKING ACCOUNT: (please attach voided check)**

_____ANNUALLY _____MONTHLY

BANK / ROUTING NUMBER:_____ ACCOUNT NUMBER:_____

Authorized Signature:_____ Date:_____

This Fee Agreement shall remain in effect for the duration of the Services Agreement.

PLACER PRIVATE PHYSICIANS:

Physician:_____

Signature:

_____

PATIENT:

Primary Member: _____

Signature:

_____

Membership Activation Date: _____