River Ridge
FAMILY HEALTH

# Patient Membership & Financial Agreement

**Practice Name:** River Ridge Family Health Provider: Elizabeth Berry FNP-BC

## 1. The DPC Model

River Ridge Family Health operates as a Direct Primary Care practice. This means we do not accept insurance or participate in any state or federal programs (like Medicare/Medicaid). By signing this, you understand that **this agreement is a contract for medical services, not a health insurance policy.**

## 2. Membership Fees

- Monthly Fee: Your membership fee is billed on monthly from the start of services.
- Payment Method: Membership fees are paid via automatic debit (ACH) or credit card. A valid payment method must be kept on file. Cash or Check can be accepted with prior arrangement made between the practice and patient.
- Initial Enrollment: A one-time, non-refundable enrollment fee of $100 (Individual) or $200 (Family) as well as first month's membership is due upon registration.

## 3. What is Included

Your membership fee covers:

- Office visits with no co-pays.
- Direct communication with your doctor via phone, email, or secure portal.
- Same-day or next-day appointments for urgent needs.

## 4. What is NOT Included (Third-Party Costs)

You are responsible for costs related to services provided outside this office, including:

- Laboratory testing and Imaging (X-rays, MRIs).

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- Specialist consultations and Hospitalizations.
- Prescription medications and Vaccinations.

5. **Cancellations & Re-enrollment**

- Cancellation: You may cancel your membership at any time with [30 days] written notice.
- Re-enrollment: If you cancel and wish to return later, a re-enrollment fee will apply, subject to practice capacity.

6. **Medicare Acknowledgment (If Applicable)**

If you are a Medicare beneficiary, you understand that your physician has "opted out" of
Medicare. You agree not to submit claims to Medicare for services provided by this practice.

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**Acknowledgement:** I understand the terms of this membership and authorize River Ridge Family Health to charge my payment method on file for the recurring monthly fee.

**Patient Signature:** _____ **Date:** _____

**Print Name:** _____