Barbara A. Hrach MD – ExtraCare

229 W. Pueblo St. Santa Barbara, CA 93105
Phone: (805) 898-0500 | Fax: (805) 898-0501
www.santabarbaradoctor.net

CLEAR ENTIRE FORM

MEMBERSHIP APPLICATION AND AGREEMENT

Thank you again for your interest in enrolling in "Barbara Hrach, MD – ExtraCare" This membership application and agreement describes the services and terms that Dr. Hrach will provide you as a member of the Barbara Hrach MD – ExtraCare program.

Dr. Hrach will continue to be your physician while you are a member of the practice. Dr. Hrach will be responsible for providing you with comprehensive internal medicine services and orchestrating the care you receive from other healthcare providers.

SERVICES

As a member of Barbara Hrach MD – ExtraCare you will receive the following services:

- Comprehensive Internal Medicine Services/Laboratory Services
- Lifestyle and Wellness Assessment
- Extended Physician Visits
- Immunizations
- Little or no waiting
- Same Day/Next Day Appointments
- Video appointments when appropriate
- Cell Phone and email access to Dr. Hrach
- Care Coordination and Logistical Support
- Customized Treatment Research and Information
- Free use of the Santa Barbara TeleMedicenter Virtual Exam Room
- Monthly Health Bulletin email

MEMBERSHIP TYPE AND FEES

Membership Types: Annual or Monthly	**Annual Fee**	**Monthly Fee**
Individual	☐ $2,750	☐ $250/month for 12 months
Couple	☐ $5,000	☐ $450/month for 12 months
Dependent Child #1 (age 10-26)	☐ $1,000	☐ $100/month for 12 months
Dependent Child #2 (age 10-26)	☐ $1,000	☐ $100/month for 12 months
Dependent Child #3 (age 10-26)	☐ $1,000	☐ $100/month for 12 months
Dependent Child #4 (age 10-26)	☐ $1,000	☐ $100/month for 12 months
TOTAL Membership Fee Due:		/month

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PAYMENT METHODS (PLEASE CHOOSE ONE)

☐ **Annual Payment:**

_____ Enclosed check #_____ in the amount of $_____
_____ Pay by Credit Card in the amount of $_____

OR

☐ **Monthly Payment**:

Credit Card in the amount of $_____per month

Credit Card #:_____
Exp. Date:_____
CVV #:_____

AUTOMATIC MEMBERSHIP RENEWAL

☐ **Check here if you would like AUTOMATIC RENEWAL of your annual contract**

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MEMBERSHIP COVERED UNDER THIS AGREEMENT

ENROLLEE MEMBER #1

Full Name:			Date of Birth:
Address:			Gender: ☐ MALE ☐ FEMALE
City:		State:	ZIP:
Home Phone:	Cell Phone:		Work Phone:
Email:			

ENROLLEE MEMBER #1

Full Name:			Date of Birth:
Address:			Gender: ☐ MALE ☐ FEMALE
City:		State:	ZIP:
Home Phone:	Cell Phone:		Work Phone:
Email:			

ENROLLEE MEMBER #3

Full Name:			Date of Birth:
Address:			Gender: ☐ MALE ☐ FEMALE
City:		State:	ZIP:
Home Phone:	Cell Phone:		Work Phone:
Email:			

ENROLLEE MEMBER #4

Full Name:			Date of Birth:
Address:			Gender: ☐ MALE ☐ FEMALE
City:		State:	ZIP:
Home Phone:	Cell Phone:		Work Phone:
Email:			

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ENROLLEE MEMBER #5

Full Name:			Date of Birth:
Address:			Gender: ☐MALE ☐FEMALE
City:		State:	ZIP:
Home Phone:	Cell Phone:		Work Phone:
Email:			

ENROLLEE MEMBER # 6

Full Name:			Date of Birth:
Address:			Gender: ☐MALE ☐FEMALE
City:		State:	ZIP:
Home Phone:	Cell Phone:		Work Phone:
Email:			

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AGREEMENT AND AUTHORIZATION

By signing below you agree the terms of the Membership Application and Agreement and the Terms and Conditions below.

Please sign below (each enrollee member):

X _____ _____ _____
Signature Printed Name Date

X _____ _____ _____
Signature Printed Name Date

X _____ _____ _____
Signature Printed Name Date

X _____ _____ _____
Signature Printed Name Date

X _____ _____ _____
Signature Printed Name Date

X _____ _____ _____
Signature Printed Name Date

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TERMS AND CONDITIONS

Enrollment Term and Renewal: The term of this Agreement shall begin immediately upon receipt of the signed Agreement and payment and continue for one year. You will receive a renewal application prior to your anniversary month, unless you have agreed to automatic renewal of your annual contract. Your membership in the practice is guaranteed so long as payments are received as agreed upon. Please note that this is a limited membership practice and failure to abide by the above terms and conditions could result in removal from the program. The membership fee pays for the services provided by Dr. Hrach as outlined in this agreement which are non-covered services under Medicare, Medicaid or private insurance plans. It is your responsibility to confer with your health care plan administrator for advice regarding admissibility of this fee for insurance coverage. The membership fee may be increased on an annual basis. Dr. Hrach shall provide you written notice of any increase prior to the renewal of this Agreement. This agreement may be terminated by you or Dr. Hrach at any time on thirty (30) days written notice. In the event that this agreement is terminated by Dr. Hrach prior to the end of the current membership term, Dr. Hrach shall refund to you a prorated amount of the unused portion of the Membership Fee.

Participation in Health Plans: Dr. Hrach is contracted with Medicare and some other private insurance companies. Dr. Hrach will submit claims and accept payments from your health insurance plan for all covered professional medical services rendered to you as part of this agreement. By signing above, you agree to assign insurance benefits for services rendered by Dr. Hrach. You may be responsible for any deductibles or denied services at the discretion of Dr. Hrach.

Acknowledgement of Privacy Policy: By accepting the Agreement and these terms and conditions you acknowledge that your health care information will be governed by the Barbara A. Hrach, M.D. Notice of Privacy Practices which may change from time to time and is available on our website at www.santabarbaradoctor.net.