



# GracePointe Healthcare PLLC

*Modern medicine the old fashioned way*

## **Premium Smart Care Plan\***

\_\_\_\_\_ \$89 enrollment fee (\$69 for existing patients) plus \$99 per month for 12 months, with automatic bank draft (ACH). (This payment option does not include Comprehensive Screening Exam\*\*\*.)

**or**

\_\_\_\_\_ \$1,188 paid in full (12 months) – enrollment fee will be waived. Includes *FREE Comprehensive Screening Exam\*\*\** with basic labs/diagnostic tests\*, plus PSA or PAP Test and EKG. (\$275 value).

For a fee of \$1,188 or \$99 per month for 12 months (the "Base Fee"), our Premium Smart Care Plan allows you to be scheduled for routine office visits *with no office visit fee* (\$69 savings), which will include any necessary basic lab work/diagnostic tests\*\* each visit. Also includes (i) *free prescription refills* (\$25 savings), (ii) *free phone consults* (\$50 savings), (iii) *3 free Housecalls per year* (\$300 savings), (iv) *additional Housecalls at \$100* (\$100 savings), and (v) *direct access to your provider's email address and cell phone 24 hours a day/7days a week*. (Non-basic lab work, retail products, medications, supplements or immunizations are charged at standard rates.)

**I \_\_\_\_\_, agree to pay the \$89 or \$69 enrollment fee plus \$99 per month starting on today's date for the Premium Smart Care Plan or \$1,188 in full (enrollment fee waived) as noted above. This prepaid plan entitles me to discounted fees on services at GracePointe Healthcare, as set forth herein. I will still be responsible for other services not discounted as specifically mentioned above. At the end of one year, I may renew this contract but the fees and terms may change, at GracePointe Healthcare's sole discretion. I understand that:**

- **If I receive services under this agreement and either fail to make a monthly payment or fail to make payment for the full annual fee, I will be responsible for all charges for services I incurred at the standard non-discounted rate as well as an early termination fee of \$250.**
- **I will owe a \$35.00 fee for any checks or ACH withdrawals that have insufficient funds.**
- **Payment for anything not covered under the Smart Care Plan is due at time of service.**
- **24 hours notice is required for appointment cancellations and there is a \$49 charge if less than 24 hours notice is given or if I fail to show up for the appointment.**
- **All amounts paid for the Smart Care Plan are nonrefundable.**

***I understand that this is intended to be a legally binding contract that becomes binding when executed by the undersigned and accepted by GracePointe. This agreement (together with any Addendums executed in connection herewith) is the final agreement between the parties and no other agreements, written or verbal, are binding. Unless the parties have executed a Family Coverage Addendum, this agreement covers only the undersigned and may not be assigned or transferred. I have read, understand and agree to the terms and conditions of this agreement.***

**Signed \_\_\_\_\_ Date \_\_\_\_\_**

\* Our Smart Care Plans are private one year contracts between GracePointe Healthcare and the patient, which are executed after payment has been made and initial services rendered. At present, insurance will not reimburse for the prepaid plans and this is not a type of insurance, it is only a prepaid discount plan. GracePointe Healthcare makes no guarantees regarding reimbursement by insurance companies and does not file insurance claims or sign insurance contracts. Medicare and Medicaid patients are not permitted to file claims per government regulations.

\*\*Basic labs/diagnostic tests include: CBC, CMP, Lipid Panel, Urinalysis and vital signs.

\*\*\*Free Comprehensive Screening Exam includes:   » PSA or PAP Test and EKG.   » Height, Weight, BMI, Pulse, Blood Pressure, Temperature, Pulse Oximetry, etc.   » Health Risk Factors: Diet, Exercise, Safety, Alcohol, Contraception, etc.   » Disease Prevention: Stroke, Coronary Disease, Cancer, Illness, etc.   » Physical Exam   » Health Maintenance: Review immunizations, etc.   » Recommendations/Referrals



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## AUTHORIZATION AGREEMENT FOR DIRECT DEBIT (ACH DEBITS)

**Gracepointe Healthcare PLLC**

COMPANY TAX ID NUMBER \_\_\_\_\_

I (we) hereby authorize **Gracepointe Healthcare PLLC** herein called COMPANY, to initiate debit entries in the amount of \$\_\_\_\_\_.00 monthly starting on \_\_\_\_\_ and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) [ ] CHECKING [ ] SAVINGS account indicated below and the depository named below, herein called DEPOSITORY BANK, to debit and/or credit the same to such account. This Authorization Agreement is executed in connection with, and as an Addendum to, the Smart Care Plan agreement entered into between myself (ourselves) and the Company, for the purpose of making monthly payments towards the annual Base Fee.

DEPOSITORY BANK \_\_\_\_\_

BRANCH \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ROUTING NUMBER \_\_\_\_\_

ACCT NUMBER \_\_\_\_\_

This authorization is to remain in full force and effect until the COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY BANK a reasonable opportunity to act on it. Any termination hereof will not terminate the Smart Care Plan agreement.

NAME(S) \_\_\_\_\_  
(PLEASE PRINT)

SIGNED \_\_\_\_\_ SIGNED \_\_\_\_\_ Date \_\_\_\_\_

Please staple to this form a voided check to verify bank account information for deposits into a Checking Account or a deposit slip for deposits into a Savings Account.

FIRST TENNESSEE BANK

Pay to the order of \_\_\_\_\_

DATE \_\_\_\_\_ 2048

\$ [ ] Dollars

VOID

**FIRST TENNESSEE BANK**

⊠ 084000026 ⊠ 2048 00-09050398 ⊠

\_\_\_\_\_

ROUTING NUMBER

ACCOUNT NUMBER