Medi-Eagle
EXPRESS HEALTHCARE
QUALITY CARE, BEYOND LIMITS

Patient Enrollment

Basic Information (Enter information of person being enrolled, even if a minor, see pg. 2)		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Sex: □ Male □ Female	SSN (If none, enter "N/A"):
Home Address:	City:	State: ZIP:
Home Phone: ( )	Alternate Phone: ( )	□ Work □ Mobile
Email:		

Demographic Information (Used for account registration ONLY)
Marital Status: □ Married/Domestic Partner □ Single □ Divorced □ Legally Separated □ Widowed □ Decline answer
Do you speak English? □ No □ Yes If yes, how well? □ Very well □ Well □ Not well
Preferred Language: Do you require an interpreter? □ No □ Yes
• Are you **hearing** impaired? □ No □ Yes ⇨ Are assistive devices required? □ No □ Yes
• Are you **visually** impaired? □ No □ Yes ⇨ Are assistive devices required? □ No □ Yes

Insurance Coverage	
To confirm that you are eligible to enroll in Direct Primary Care: □ I do not have Medicaid coverage, Medicare, or other insurance coverage. □ I have insurance AND my deductible* is more than $3000/individual. (Please fill out insurance information below↓.)	
Insurance Carrier Name:	ID #:
Subscriber Name (Person with insurance coverage):	Group #:
Subscriber Date of Birth:	Relation to patient: □ Self □ Spouse/Partner □ Child □ Other:

To enroll other family members fill out the next page.

I certify that all the information provided by me on this form is true and correct.	
Print Name:	
Authorization Signature:	**Date:**

Additional Member #_____ □ Adult □ Child		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Sex: □ Male □ Female	SSN (If none, enter "N/A"):
Alternate Phone: ( )	□ Work □ Mobile	
Marital Status: □ Married/Domestic Partner □ Single □ Divorced □ Legally Separated □ Widowed □ Decline answer		
Do you speak English? □ No □ Yes If yes, how well? □ Very well □ Well □ Not well		
Preferred Language:	Do you require an interpreter? □ No □ Yes	
• Are you **hearing** impaired? □ No □ Yes ⇨ Are assistive devices required? □ No □ Yes		
• Are you **visually** impaired? □ No □ Yes ⇨ Are assistive devices required? □ No □ Yes		

Additional Member #_____ □ Adult □ Child		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Sex: □ Male □ Female	SSN (If none, enter "N/A"):
Alternate Phone: ( )	□ Work □ Mobile	
Marital Status: □ Married/Domestic Partner □ Single □ Divorced □ Legally Separated □ Widowed □ Decline answer		
Do you speak English? □ No □ Yes If yes, how well? □ Very well □ Well □ Not well		
Preferred Language:	Do you require an interpreter? □ No □ Yes	
• Are you **hearing** impaired? □ No □ Yes ⇨ Are assistive devices required? □ No □ Yes		
• Are you **visually** impaired? □ No □ Yes ⇨ Are assistive devices required? □ No □ Yes		

To add more family members, you may attach additional copies of this form.

Parent or Guardian if Enrollee is a minor (18 or younger)		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Sex: □ Male □ Female	Alternate Phone: ( ) □ Work □ Mobile

Membership & Billing Information

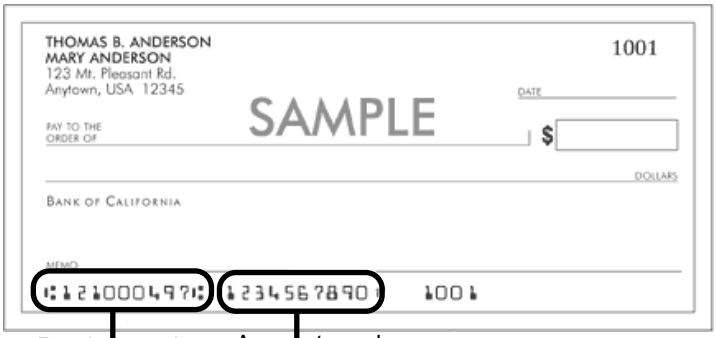
Desired Start Date:	Bill me using my (choose one only): □ Credit Card or Debit Card □ Bank Account

Credit Card or Debit Card Information

Card type: □ MasterCard □ Visa (Other card types not accepted.)
Cardholder's name:
Card number:
Expiration Date—Month: Year:
Billing Address (if different from above):

Bank Account Information

Account holder's name:
Bank name:
Account number:
Routing number:



Authorization Statement: I authorize Medi-Eagle Express Healthcare to charge my credit card, debit card, or bank account on a recurring basis for my Membership Plan until I have canceled my membership in writing. If my credit card company or bank declines charges and I do not make payment by the 1st of the month, then my membership is canceled immediately.

Authorization Signature:	**Date:**

Let us know…

I found out about Direct Primary Care from (Check all that apply):

□ Friends & Family
□ Another doctor/clinic
□ Newspaper / Magazine Ad
□ Mailer
□ Internet Ad
□ Other: _____

Questions?(713) 425-3907

Please mail or FAX this form to: Medi-Eagle Express Healthcare
ATTN: Micaela Gordon
4202 Berry Cove Circle
Richmond, TX 77406
FAX (949) 655-8672

Office Use Only

□ Enrollment form(s) completed & signed
□ Payment form completed & signed
□ Consent to Treat completed & signed
□ Privacy Policy/HIPPA completed & signed
□ Appointment form completed & signed

Annual Review Date:

Revised: 10/31/2020

Required For Enrollment (one form per adult):

Patient Rights & Responsibilities

Member Rights

1. You have the right to respectful and fair service from Medi-Eagle Express Healthcare providers and staff. This care should be considerate of your cultural and personal beliefs. If you feel you have not been treated with respect, please talk to the clinic manager.
2. You have the right to be provided information concerning your health status, condition, and/or treatment options.
3. You have the right to refuse treatment and be informed about the potential consequences of the refusal.
4. You have the right to be informed, up front, about how much a recommended test or procedure will cost.
5. You have the right to an interpreter, at no cost to you, if you do not speak or understand English.
6. You have the right to cancel your membership. To cancel, you must fill out and turn in the Membership Cancellation Form.
7. You have the right to seek and maintain insurance coverage for services not provided by your membership.

Member Responsibilities

1. Communicate respectfully to Medi-Eagle Express Healthcare staff.
2. Provide complete and accurate information about past and current health status, any medications, any allergies, and any services received outside of Medi-Eagle Express Healthcare (such as hospitalizations or visits to the emergency room).
3. Ask questions if you do not understand what the provider is saying about your medical status or treatment plan.
4. Come to appointments on time or call ahead if you cannot come to the appointment.
5. Tell Medi-Eagle Express Healthcare staff about changes in address, phone number, and health insurance information.
6. Provide current credit card, debit card, or bank account information to pay membership fees. If a charge is rejected by the bank, Medi-Eagle Express Healthcare will discontinue membership.
7. Provide accurate monthly or yearly income to Medi-Eagle Express Healthcare staff and notify staff of changes in income as soon as possible.
8. Following the treatment plan recommended by your provider.

Terms of Agreement

- This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described in the Included Services List. Medi-Eagle Express Healthcare may make changes to the Included Services List from time to time. If any changes are made, Medi-Eagle Express Healthcare will inform you in writing.
- MEEH will not bill an insurance carrier for services covered under your membership.
- MEEH may change membership fee sliding scale rates. If changes are made, MEEH will give you 60 days written notice.
- MEEH may change individual membership fee rates, based on the sliding scale and the results of annual income reviews.
- MEEH may terminate membership at any time. You will be notified in writing, with 30 days notice, of any such decisions.

Financial Policy

- MEEH will charge your credit card/debit card or deduct membership fees from your bank account on a regular basis.
- You are financially responsible for any procedure, test, or service provided that is not listed in the Included Services List. MEEH may make changes to the Included Services List from time to time. If any changes are made, MEEH will inform you in writing.
- If charges are sent to collections due to non-payment, your MEEH membership may be subject to review and cancellation.

Your Signature

- I have read, understand, and agree to the Rights, Responsibilities, Terms of Agreement, and Financial Policy for the Direct Primary Care program.
- I have had an opportunity to ask MEEH staff any questions I have.

Print Name:	
Signature:	**Date:**

Mail to: Medi-Eagle Express Healthcare, ATTN: Micaela Gordon, 4202 Berry Cove Circle Richmond, TX 77406 **Fax to:** (949) 655-8672

Revised: 10/31/2020

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Member Responsibilities

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- MEEH may change individual membership fee rates, based on the sliding scale and the results of annual income reviews.
- MEEH may terminate membership or the Direct Primary Care program at any time. You will be notified in writing, with 30 days notice, of any such decisions.

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- I have had an opportunity to ask Medi-Eagle Express Healthcare staff any questions I have.

Print Name:	
Signature:	**Date:**

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