DPC Member Registration Form

Last Name:	Referred by:
First Name:	
Middle Name:	How did you learn about DPC?
Legal Name (if different from above):	
Date of Birth (MM/DD/YYYY):	
Marital Status (check one box): Single ☐ Married ☐	**Sex (check one box):** Male ☐ Female ☐ Other ☐
Email address	
☐ *I consent to having my medical information sent to my email address (We cannot guarantee security of messages)*	
Personal Contact Information: Street Address	
Suite or Apt Number	
City	
State	
Zip Code	
Mobile Phone	
Home Phone	
Work Phone	
Employment Contact Information: Employer Name	
Street Address	
Street Name	
City	
State	
Zip Code	
Work Phone	
Pharmacy Contact Information:	
Preferred Pharmacy Name	
Pharmacy Address	
Pharmacy Phone Number	
Pharmacy Fax Number	
Billing Information: Member : ☐ Third Party: ☐ Employer: ☐ Billing Phone #: Billing email:	Billing First Name: Billing Last Name: Billing Card #: CVC Code: Card Expiration Date: Billing Start Date:
☐ *Credit card monthly auto-payment required for membership fees. I hereby authorize Lagniappe Medical Center to deduct the payment amount monthly on the Start Date indicated above from my Debit/Credit card account.*	
Emergency Contact Information	Name: Relationship: Contact phone #1: Contact phone #2:

The above information is true to the best of my knowledge and I understand that I am financially responsible for any balances beyond the membership plan at the cash pay rate. Minimum of six month membership required.

Member Signature _____ **Date:** _____

Direct Primary Care Membership Cancellation Form

Membership to be Cancelled		
Last Name: First Name: Middle Initial:		
Date of Birth:	Sex: □ Male □ Female	DPC #
Home Address: City: State: ZIP:		
Phone: ( )		Email address:
If additional memberships need to be cancelled, please use the back of this form.		

Cancellation Date	
Membership is cancelled effective on :	**Date I want my membership to end:**

Cancellation Policy

Direct Primary Care Agreements with recurring dues may be cancelled at any time and for any reason. You can cancel your membership by providing written notice to us at 395 S.Shore Drive,B.C.,MI 49014 **or through our website. We recommend that you mail the cancellation notice by certified mail and keep a record for you files. Or, you may deliver the notice directly to the clinic manager at your membership clinic. (The days and times for in-clinic cancellations are subject to change depending upon the availability of the clinic manager.) If you deliver the notice in person, please be sure to get a receipt for your records.**

A cancellation postmarked at least 5 business days prior to your next billing date should result in no further recurring billing. If less than 5 business days, you may be billed one more time. If this occurs, S. Shore DPC **will refund the additional billing. To ensure that we have accurate information about the account being closed, we recommend you print and use the online form.**

During the 12 month period after the patient signs this Direct Primary Care agreement, we may terminate the direct primary care agreement for one of the following reasons:

a. Patient fails to pay the direct primary care dues under the terms required by this direct primary care agreement
b. Patient performs an act that constitutes fraud
c. Patient repeatedly fails to comply with a recommended treatment plan
d. Patient is abusive and/or presents an emotional or physical danger to the staff or other patients; or
e. The provider discontinues operations as a direct practice
f. Provider feels you may not be a good fit for their clinic

In the event that we elect to terminate this direct primary care agreement under this section, we will provide patient with notice and opportunity to obtain care from another provider. If patient cancels membership twice within one year, the provider reserves the right to deny acceptance of patient into the provider's direct primary care membership at their clinic.

Let us know

I am cancelling my membership (check all that apply)

□ **I can't afford the membership dues**
□ **I want to change my doctor/provider**
□ **I wasn't using the services enough to justify the cost.**
□ **I'm Moving**
□ **Customer Service**
□ **Other** _____

Your Signature

□ **I have read, understand, and agree with the Cancellation Policy.**
□ **I have had an opportunity to ask Provider's staff any questions I have.**
□ **I want to cancel my membership to the Direct Primary Care program.**

Print Name:	
Signature:	Date:

Questions (269)242-0088 **FAX** (269)242-0087