CONTRACT FOR PARTICIPATION

Please initial each statement and sign and date the bottom.

_____ 1. Doctors Care is **NOT** an insurance company. **Doctors Care has been designed for temporary assistance** and is not intended to either take the place of health insurance or be a **long-term** solution for receiving health care.

_____ 2. If Doctors Care backdates for me to cover hospital or physician bills in the past 90 days, I must notify all physicians and hospitals within 14 days of receiving my Doctors Care card or the backdating will be void.

_____ 3. The first 90 days of the Doctors Care program are a probationary period to ensure proper usage of the program (i.e. following the terms of this contract).

_____ 4. I will treat all partner physicians and their staff, as well as Doctors Care staff and volunteers with the highest degree of respect and gratitude. I understand this program is due to generous volunteer medical providers agreeing to care for patients with no reimbursement from Doctors Care. Participation in the program is a privilege for those who agree to follow these guidelines.

_____ 5. I agree:

a. To use only the Primary Care Physician (PCP) assigned.
b. To make my first PCP appointment within my first month of eligibility.
c. To **set an appointment for all visits** to the Doctors Care Clinic, PCP, and specialists.
d. To **call and cancel** any appointment that cannot be met with a minimum of 24-48 hours notice.
e. That any referral to a specialist must be approved through the Doctors Care administrative office.
f. That if I do not call and do not show for an appointment, I must abide by the rules of the office and pay their late fees to stay on the Doctors Care program. I also acknowledge that three (3) or more missed PCP appointments or one (1) missed specialty appointment may result in removal from the Doctors Care program.

_____ 6. I am responsible for the percentage of the bill listed on my card.

a. I will be prepared to pay the full amount at the time of service or make payment arrangements *in advance* with the physician's office or hospital.
b. If I do not pay my percentage of the bill in a timely manner and the bill goes to a collection agency, I will be responsible for the full amount (100%) of the charges for the services provided.
c. Non-payment will cause me to be terminated from the Doctors Care program.

_____ 7. Prescriptions discounted under Doctors Care are **only** filled at the pharmacy of the hospital listed on my card. My card will NOT be accepted at any other pharmacy besides my hospital pharmacy.

a. I must call my pharmacy 72 hours before I need to pick up a refill.
b. If medications are not available at my pharmacy, I will have to go elsewhere to get my prescription(s) and pay full price.
c. Only generic medications are covered for my co-pay. Brand names are not covered.
d. Certain medications **will not** be covered. These include over-the-counter drugs, mental health medications, birth control medications, supplies that can be purchased without a prescription, appetite suppressants, weight loss drugs, nicotine replacement therapy, acne therapy for patients over the age of 18 years old, and erectile dysfunction medications.

_____ 8. Doctors Care providers do not treat chronic pain through the use of medication. I understand that if I ask any Doctors Care provider for narcotic medication to treat chronic pain, I will immediately be terminated from the program.

_____ 9. X-ray and lab tests must be completed **only** at my assigned hospital unless otherwise pre-approved by the Patient Care Coordinator or Program Director.

_____ 10. The following are the criteria for using the emergency room or urgent care:

a. I must first call my PCP (even after hours) and follow his or her instructions.
b. Urgent Care is only covered with Doctors Express Urgent Care in Englewood.
c. The emergency room must only be used if it is a life- or limb-threatening illness.
d. I am responsible for the full charges of the emergency room physicians.
e. Abuse of the emergency room is grounds for removal from the Doctors Care program.

_____ 11. Mental health services are available to me.

a. These services require that I am under the care of a Primary Care Physician.
b. Sessions will be on a sliding fee scale based on my percentage payment responsibility.
c. While medication management is available through the mental health services, I understand that mental health prescriptions are not covered through Doctors Care.

_____ 12. I agree to follow through with all treatment recommendations of Doctors Care providers or to request a second opinion by calling the Patient Care Coordinator if I do not agree with treatment recommendations. Not doing so is considered disrespect to the provider.

_____ 13. It is my responsibility to keep my Doctors Care card current.

a. My first 90-day card will be automatically sent a week before the expiration date, assuming my probation period has been successful.
b. I understand a new application will be sent to me the month prior to my expiration date for all other periods. However, if I do not receive an application, I must call and ask for one to be sent.
c. I will be responsible for submitting my renewal paperwork, including resubmitting financial information that has not changed, every six months.
d. If I do not want to continue my coverage, I will notify the Patient Care Coordinator. Failure to do so means that I will not be eligible for future backdating should I need services again.
e. I understand that there is a two-year lifetime maximum amount of time any adult may be on the Doctors Care program.

_____ 14. I will notify Doctors Care within 10 days if any of the following occur:

a. I have a change in address or phone number.
b. I become eligible for Medicaid, Medicare, or any other insurance.
c. My financial situation changes (i.e. employment begins or ends; money is received from an insurance settlement, lawsuit, or inheritance, etc.)
d. My household size changes due to marriage, divorce, separation, adoption, birth, or any other reason.

_____ 15. When medical services received through Doctors Care are from an accident or illness which later results in an insurance or lawsuit settlement, I agree to reimburse the medical providers their full charges within 10 days of receipt of the settlement.

_____ 16. I understand that Doctors Care does not cover medical supplies, glasses, ambulance, emergency room physicians, dental charges, certain medications, elective care, and adult physicals or preventative care.

Abuse of any of the above statements or any false information given to a Doctors Care staff or my physician will result in the immediate removal of me and my family from the Doctors Care program.

I understand all of the above and agree to abide by these regulations.

_____ _____

Signature Date

_____

Please print name