



110 N 1st St, Broken Arrow, OK 74012  
(918) 994-5140 Phone  
(918) 994-5150 Fax

**Individual and Family Premium Care Agreement**

Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Record ID: \_\_\_\_\_

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**Care Agreement Fees and Stipulations:**

\$39.00 per month per individual

**OR**

\$119.00 per month per family (4 or more individuals)

Family is defined as adult parent(s) living in home and their dependent children under age 19.

Any adult, age 19+, living in the home will require separate care agreement and fee payment.

No Copay for office visits.

**VIP Care:** 24/7 Direct access to your provider. During office hours, the provider can be reached through the online patient portal or by calling the office at (918) 994-5140. After hours, the provider is always available via the portal or by calling (918) 994-5140 and selecting option #4.

**Open Access:** As an additional level of convenience, we offer same day appointments, walk-ins, and extended hours until 6pm Monday - Thursday.

**After Hour Services:** For urgent situations that often arise after normal clinic hours, the provider may elect to see patients in the clinic, or refer patients to an ER/Urgent Care better equipped to handle the patient's needs.

**Labs:** Contract patients will have the option to pay our discounted rates, or bill their lab tests to their insurance plan. Typically, our contracted rates can save patients hundreds of dollars on routine blood tests that are often subject to insurance deductibles. Payment is due at time of service.

Initial \_\_\_\_\_

**Services Included**

All Office visits for illness, follow-ups, procedures, or medication refills

Lab Draw Fees	EKG	Spirometry	Nebulizer treatments*
Finger Stick Glucose Test	Injection fees*		

**In-House Services Offered at Discounted Pricing:**

Strep Test	Flu A/B Test	Hemocult Test
RSV Test	Procedure Supplies**	Splint/Cast Supplies**
Injectable Medications*	Nebulized Medications*	Urinalysis

\*Patient/Guarantor will pay for injectable and nebulized medications at time of service. Prices vary based on medication and dose. If a patient brings their own medication and supplies, there will be no charge for the administration.

\*\*Supplies needed to perform procedures, such as suture kits, suture material, steri-strips, splinting material, and casting material are not included in this Agreement. Payment for these items is due at time of service.

**The price of the above discounted in-house services will be discussed with patient/guarantor before administration of medication or performance of procedure. Payment is due for any and all agreed upon services at time of visit. Prices are subject to change at any time. A price paid previously is not a guarantee of future price for service.**

**Availability of services, tests, procedures, and medications are subject to change without notice. The unavailability or discontinuation of a previously rendered service, procedure, medication, or test does not void or alter this Agreement.**

**Services Excluded**

Price of Vaccines, Vivitrol injections, and IV Fluid Administration are excluded from the Agreement.

**For Uninsured Children Only:** Uninsured children qualify for access to vaccines through the CDC Vaccines For Children program at no additional cost.

Initial \_\_\_\_\_

**IMPORTANT! PLEASE READ AND INITIAL:**

**A minimum payment in the amount equal to 2 months of the Agreement fee is due on the date of execution. A credit or debit card is required and will be billed automatically on a monthly basis. The transaction date will be set to the numbered day of the month the Agreement is executed unless otherwise specified by patient/guarantor. No refund of paid fees will be authorized. Agreement does not expire but may be cancelled at any time after 6 months from date of Agreement execution by patient/guarantor. If cancelled prior to 6 months, remaining fees are due at time of cancellation. Inability to process payment via patient/guarantor credit or debit card will result in cancellation of Agreement unless new approved payment option is provided by patient/guarantor within 10 business days.**

Initial \_\_\_\_\_

**INDIVIDUAL AND FAMILY CARE AGREEMENT**

\_\_\_ Individual @ \$39.00 per month = \$\_\_\_\_\_ per month

\_\_\_ Family @ \$119.00 per month = \$\_\_\_\_\_ per month

Total per month: \$\_\_\_\_\_ Due today: \$\_\_\_\_\_ (2 months of fees)

Total due today PAID with \_\_\_\_\_ CHECK / CARD / CASH

First monthly transaction scheduled for \_\_\_\_/\_\_\_\_/\_\_\_\_.

Transaction will process on the \_\_\_\_\_ day of each calendar month thereafter until cancelled.

By signing this agreement, \_\_\_\_\_ agrees to all terms and conditions of this Agreement, to pay a minimum of 6 months of Agreement fees even if no services are rendered in that time, and if fails to pay 6 months of Agreement fees, acknowledges that the remaining balance will be sent to collections.

X \_\_\_\_\_  
Patient/Guarantor Signature Date

X \_\_\_\_\_  
Jacob Callison PA-C  
Member Manager  
Broken Arrow Diagnostic Medicine, PLLC Date

X \_\_\_\_\_  
Witness Date

**Broken Arrow Diagnostic Medicine**  
110 North 1<sup>st</sup> Street, Broken Arrow, OK 74012, (918)994-5140