Medical Membership Application

PRIMARY MEMBER:

(print on line below) ***Last name,*** ***First name*** ***Middle Initial*** ***Email***

_____ _____, _____ _____ _____

Street Address **City** **State** **Zip** **Telephone w/ area code** ☐ **Male** ☐ **Female**

_____ _____ _____ _____ _____ **DOB: ___ / ___ / _____**

If you wish to apply for membership for a spouse and/or unmarried children who are under age 18 please speak to a Prohealth Team member for an additional application.

Membership Fees
$59.99/month/person

Monthly Dues by Credit Card
Card Type: MC VISA DISC AMEX

Credit Card # _____
Credit Card Expiration: _____CCV: _____
Billing Zip Code: _____

Monthly Dues Bank Draft Information
Monthly dues (and other fees, as applicable)
Check or Savings acct # _____
Check # _____
Routing # _____
Driver's License Number: _____

For Office Use Only:
$59.99/per month/per person X _____ $_____
Payment Discount Options: $_____
___ Monthly
___ Semi-Annually
___ Annually

# of months receiving payment: _____

Method of Payment: _____ **TOTAL: $_____**

Date: _____ Emp: _____ Office: _____
Paid in office: ___ yes ___ no
Notes:

Auto-Recurring Payment Authorization Form

Please complete the information below:

I authorize ProHealth to charge/debit my account on the date of this application and monthly recurring payments thereafter of $59.99 on the _____ day of each month (or date signed on application) for the entire duration of my membership.
This is an authorization to automatically renew my 6 month membership on a month-to-month basis or my annual membership on a yearly basis until cancellation. I must call 850-435-4996 to cancel membership.

_____ _____ _____
Signature *Printed Name* *Date*

Terms and Conditions

1. **Membership Terms:** The minimum membership period is six (6) months, beginning on _____.
8. A member may cancel their ProHealth Medical Membership (PMM) by emailing customerservice@prohealthfl.com at least 30 days **prior to their monthly renewal date.**
Notices must be received before the end of business hours on the 30-day notice date in order to terminate for the following month. The member is responsible for payment of all fees, dues, and charges owed to ProHealth. Membership fees will not be prorated. **Membership fees will not be prorated for partial months.** If cancellation occurs before completing **the initial six-month term, a $25 cancellation fee will apply plus the balance of the remaining membership commitment.**
_____ **Initials**

2. Provider Referrals: Medical providers reserve the right to refer any patient to a physician, specialist, emergency room, hospital, and/or other appropriate facilities if they determine that the patient's condition is beyond their scope of training or experience.
_____ **Initials**

3.Membership Payments: All membership payments are due on the same day of the month as the member's original signup date. If payment is not received on that date, a late fee will be applied. If payment is not recorded within three (3)days of the due date, services will be suspended until the balance is paid in full. Members with unpaid balances, including late fees, will not be eligible to re-enroll until the full amount from the most recent statement is satisfied.
_____ **Initials**

4. Coverage of Outside Services: PMM does **not cover services rendered at other medical facilities outside its practice.** Any such services are the **financial responsibility of the member.**
_____ **Initials**

5. Amendments to Rules, Fees, and Regulations: ProHealth reserves the right to **amend its rules, fees, and regulations at any time**. Members will receive at least 30 days' notice via mail and/or email of any changes.

_____ **Initials**

6. Collection Costs: Should collection efforts be required, the member shall be fully responsible for payment of all costs of collection, including reasonable attorney fees.

_____ **Initials**

7. Suspension or Cancellation: ProHealth retains the right to suspend or cancel membership and/or impose fines of $25 plus costs on any member for: - Failure to pay dues or charges when due. - Returned checks. - Declined credit card payments.

_____ **Initials**

8. Membership benefits:

a. $0/Teladoc 24/7 Access
b. $0/visit co-pay
c. 15% discount on lab work
d. Unlimited visits at ProHealth Medical Care
e. Annual flu vaccine - FREE!
f. 10% off retail pricing of ultrasounds
g. Annual physical -FREE
h. One free CP24 per year
i. One free vascular age scan upon sign-up
j. One free EKG upon sign-up
k. Free B12 injections monthly

9. Basic healthcare services provided for:
(additional fees may apply)

a. Colds, sore throat, fever, flu-like symptoms
b. Minor emergencies
c. High blood pressure
d. Children's health (age 2+)
e. School and sport physicals
f. Diabetes management
g. Depression / anxiety
h. High cholesterol
i. Women's health
j. Arthritis, joint pain
k. Minor laceration repair
l. Acute and chronic care

10. Non-covered services include, but are not limited to, the following:

a. Cancer treatment
b. HIV treatment
c. Pain management (no narcotics)
d. Heart attack or stroke
e. Obstetric care
f. Children under 2 years of age
g. X-rays, MRI, CT scans
h. Immunizations

As such, patients joining the plan must agree to be referred when a medical problem is **outside the scope of general medical care** or for **pre-existing conditions requiring care by a specialist,** as determined by our Providers.

If you choose to **waive this consent**, you agree **not to hold ProHealth or its Providers liable** for any adverse outcomes resulting from failure to seek more definitive care.

_____ **Initials**

I have read and fully understand the contents of this document.

Member's signature _____ **Date** _____

Print Name _____ **Staff member name** _____

This agreement is not health insurance and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by the agreement. This agreement is not worker's compensation insurance and does not replace an employer's obligations under Chapter 440.

The PMM creates a practice model that has the potential to eliminate third party payers from the physician-patient relationship. The PMM does not indemnify for services provided by a third party.

Primary services may include, but not be limited to: office visits, annual physicals, ECGs, or other necessary primary care procedures. It might also include patient education and chronic disease management. The monthly fee includes access to the primary care provider for the services set forth in the agreement.

Application Updated: 4/13/2026