Carelife Medical

(Dba of medical Clinics of West Virginia)

Self-Pay Plan*

Basic Primary Care Access Program

☐ **$60 per month ($15 per week per patient)** [1]

- Full access to clinic during office hours[2]
- No co-pay or additional medical evaluation fees.
- 20% reduced charges from our "self-pay pricing" for any labs ordered. [3]
- 30% reduced charges on any in-office procedure (ex. Injections, splints) [4]
- Care coordination with other providers and facilities.

*This is NOT an insurance plan. This is only for patients of Carelife Medical who are non-Medicare, non- Medicaid or without adequate private insurance. Health Savings Accounts may be used. Internal practice policies and rules apply. This program gives the patient access to the medical practice and is not specific to not guarantees medical visit with any clinical provider.

1.For adult patients 18 year of age or older: any additional adult family member (spouse, parents/grandparents) at $52 per person. Patient (signee) agrees to automatic monthly withdrawals (credit card payers) for 1-year enrollment with automatic rollover. To cancel, enrollee must contact office manager. Hospitalization visit are not included in this plan.

2. Patients will be scheduled and seen as per clinic availability and medical priority. Prescheduled appointments will be preferred. Office will be closed on specific federal and religious holidays and/or holiday weekend. Normal office hours Monday-Friday 9:00 am to 5:30 pm. Saturdays visits by appointments only. Sundays Closed.

3. Due to variability of test, charges will be different per lab test ordered and will depend on patient's medical needs and the providers medical decision making

4.The exact procedure and charges depend on patient's clinical needs and availability of medical supplies.

Please list name(s) of any additional family member(s) and age:

_____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

Monthly Payment: $_____

NAME OF PRIMARY PATIENT_____ SIGN_____ DATE_____

INTERNAL OFFICE USE:

Check if initial payment made: _____ Cash_____ CC Amount paid: $_____ Date:_____

STAFF NAME & SIGNATURE:_____