1704 FOREST DRIVE, CORBIN, KY 40701 * (606) 620-9770 * WWW.DOCSHOPPE.NET

EMPLOYEE ENROLLMENT FORM

Company Name ______________________________

Employee's Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth
Street Address			
City	State	Zip Code	
Phone ☐ Cell ☐ Home	Email		

Choose Membership Plan: ☐ Individual ($75 /mo) ☐ Couple* ($150 /mo) ☐ Family* ($225 /mo)

I understand that no form of communication is 100% secure. I consent to the transfer of my confidential health information (and that of any of my enrolled family members) by way of email, phone, text or electronic patient portal. I understand that membership in The Doc Shoppe is voluntary and can be discontinued by either party for any reason at any time. Furthermore, I have read and consent to the **PATIENT AGREEMENT** (available at www.docshoppe.net/resources) which is the official written contract between myself (including my dependents) and The Doc Shoppe. I understand that additional costs may be incurred outside of my business membership and I am personally responsible for these payments.

X ______________________________ Date ______________

* Enroll Spouse and/or Children below (Dependent Child = under 26 years old, living at home)

Spouse's (or Dependent Child's) Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth
Dependent Child's Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth
Dependent Child's Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth
Dependent Child's Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth
Dependent Child's Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth
Dependent Child's Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth
Dependent Child's Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth
Dependent Child's Last Name	First Name & Middle Initial	☐ Male ☐ Female	Date of Birth

Please return this completed form to your Employer or HR department.

PATIENT AGREEMENT

GENERAL & DEFINITIONS

- I acknowledge and understand that the person listed below is voluntarily becoming a Member of The Doc Shoppe, PLLC and that this agreement is non-transferable.
- I understand that membership refers to all services (including, but not limited to, healthcare and administrative tasks) that the Member may receive from The Doc Shoppe.
- I recognize that Bruce Jung, M.D. is the owner and primary physician of The Doc Shoppe.
- I understand this agreement and all its terms shall apply to Dr. Jung, all employees, healthcare providers (including other physicians, nurse practitioners, and physician assistants) and representatives of The Doc Shoppe.
- I understand that at times other physicians or physician-extenders may provide care to the Member in Dr. Jung's absence or unavailability and they will be subject to these same terms and agreement.
- I understand these Terms & Agreement shall replace and make void any previous Member Terms & Agreement with The Doc Shoppe.
- I understand that I am entitled to a copy of this document should I request one.

SCOPE OF PRACTICE & AVAILABILITY

- I understand that Dr. Jung and The Doc Shoppe provide a limited set of health care services in the specialty of Family Medicine and the Physician's ability to provide care may be limited by training, experience, equipment, supplies, outside facilities (i.e. hospitals) and other unforeseen situations.
- I understand that Dr. Jung has the ultimate right to decide what services The Doc Shoppe provides and that The Doc Shoppe may add or discontinue the services it provides at any time at the discretion of the Physician.
- I acknowledge that I may require health care and related goods outside of The Doc Shoppe and that Dr. Jung may recommend outside care or services for some health issues.
- I recognize that Dr. Jung may be unavailable by phone or in-person at times due to vacations, illness, technical malfunctions or other unforeseen situations.
- I understand that should Dr. Jung become unavailable, The Doc Shoppe will attempt to arrange alternative coverage with another health care provider but this coverage cannot be guaranteed at all times.

MEMBERSHIP FEES

- I understand that being a member of The Doc Shoppe requires payment of an ongoing, recurring membership fee and that the Member (or a sponsoring employer) must continue to pay membership fees to receive services and health care from The Doc Shoppe and the Physician.
- I acknowledge that if under an employer-sponsored plan, the employer and the employee are entirely responsible for managing any payroll deductions that may be related to The Doc Shoppe and this membership.
- I understand that the Member will be provided a limited set of services at no charge, including basic communications with the Physician and The Doc Shoppe, nurse and doctor visits at the clinic during regular business hours, some lab and diagnostic testing (www.DocShoppe.net/Lab-Price-List), coordination of care and referrals to other providers, annual flu shot and medical equipment lease (including, but not limited to crutches, splints and slings).
- I understand that the services and goods included in the membership fee are at the full judgment and discretion of The Doc Shoppe and that these services and goods may change without notice.
- I understand that some Doc Shoppe services, including but not limited to after-hours visits (not during regular business hours), house calls, some labs, procedures, and medications, may require payment of an additional fee.
- I acknowledge that if the Member's membership fees are 60 days past-due from the date of billing, the Member's membership and services will be cancelled.
- I acknowledge that The Doc Shoppe may change the amount of the membership fee at any time in the future, but will notify me in writing, by email, portal or other electronic means of any changes at least 30 days prior.
- I acknowledge that if joining as an individual (not sponsored by an employer), a registration fee is required upon joining The Doc Shoppe and this fee is non-refundable.
- If joining as an individual (not sponsored by an employer), I understand that upon cancellation of this membership, I will be refunded any pre-paid membership fees remaining on the account beyond the first two months calculated on a pro-rated basis from the date of cancellation. Any refund due will be issued within 30 days from the date of cancellation.
- If joining on an employer sponsored plan, I understand that any and all membership fees paid by my employer, or payroll deductions related to this membership, are non-refundable.

SERVICES FEES & OUTSIDE CARE

- I understand that some Doc Shoppe services, including but not limited to after-hours visits (not during regular business hours), house calls, some labs, procedures, and medications, may require payment of an additional fee. These fees are subject to change without notice, but The Doc Shoppe will always disclose any charges prior to rendering service.
- I understand that I am entirely responsible for any charges the Member may incur related to health care services received outside of The Doc Shoppe, including but not limited to other physicians, emergency rooms, hospitalization, diagnostic testing, specialty services and prescription medications.
- I acknowledge that The Doc Shoppe will not reimburse me for any charges the Member may incur for any outside care received or paid.

INSURANCE, HEALTH PLANS & MEDICARE

- I acknowledge and understand that The Doc Shoppe is NOT a health insurance plan, nor a substitute for health insurance.
- I acknowledge that the Physician and The Doc Shoppe encourages, but does not require, all members to have some type of health insurance plan to help pay for health care services incurred outside of The Doc Shoppe.
- I acknowledge that The Doc Shoppe does NOT participate in, or accept payment from, any health insurance plan; including but not limited to Medicare, Medicare Advantage plans, Medicaid, PPOs, HMOs or Tricare.
- I understand that The Doc Shoppe cannot guarantee reimbursement for any Doc Shoppe services and resultant charges from any third-party health plans, including insurance plans and savings accounts (health savings or flexible spending).
- I acknowledge that if I elect to receive services (including but not limited to diagnostic tests, labs, other physicians, medications) outside of The Doc Shoppe using a health insurance plan, including services that are ordered by the Physician or The Doc Shoppe, I assume full responsibility for properly submitting appropriate insurance information and to pay for any associated costs (such as pre-authorization related fees).

MEDICARE

- I acknowledge that The Doc Shoppe is not a contracted provider for any Medicare Advantage Plan and that Doc Shoppe services will not be covered by these plans.
- I agree to never seek reimbursement for payments made to The Doc Shoppe from Medicare or Medicare Advantage health plans.

CANCELLATION, LACK OF PAYMENT, REFUNDS & RE-ENROLLMENT

- I acknowledge that the Physician and I have an absolute and unconditional right to cancel this Agreement and Doc Shoppe membership at any time for any reason.
- I understand if membership fees are unpaid 60 days after the scheduled payment or billing date, this membership may be cancelled and the Member will no longer be a member of The Doc Shoppe.
- I must provide The Doc Shoppe a written or email notice of cancellation and understand that membership fees will continue to be billed or auto-paid until The Doc Shoppe receives such notice.
- In addition, I understand that The Doc Shoppe may terminate this Agreement and this membership at the sole discretion of the Physician by providing me with written notice of cancellation.
- I understand that if this membership is cancelled by myself or The Doc Shoppe, I will still be responsible for any past-due balances owed - including membership fees or service fees.
- I acknowledge if a member re-joins The Doc Shoppe after a cancellation (actively or by lack of payment), he/she/they may be required to pay an additional Re-Enrollment fee in addition to other standard charges.

COMMUNICATIONS, HIPAA & PRIVACY

- I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and its subsequent regulations I have certain rights to privacy regarding my "personal health information" (herein referred to as "PHI").
- I acknowledge that the Physician and The Doc Shoppe will keep the Member's PHI confidential and private.
- I understand that the Member's PHI can and will be used by The Doc Shoppe to (1) conduct, plan and direct medical treatments and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, and (2) conduct normal healthcare operations such as quality assessments and physician certifications.
- I understand that any and all methods of correspondence may be used by the physician and The Doc Shoppe to generate information for the member's medical records.
- I understand that The Doc Shoppe offers, but does not require, some forms of communication (including web-based un-encrypted email, text message, picture messaging, social media platforms, voice-mail, online video conferencing and fax services) in discussion of PHI that cannot reasonably be guaranteed to be fully secure.
- I acknowledge that The Doc Shoppe will only use the contact information (phone numbers, e-mail addresses, user names, etc.) provided by me upon registration, on the Authorization to Receive PHI and Accompany a Minor form or in subsequent updates.
- I acknowledge that The Doc Shoppe advises the Member against using employer-owned or operated computers or email in communications with The Doc Shoppe and that The Doc Shoppe will not assume any responsibility or consequences created from use of employer-owned computers or email.
- I acknowledge that The Doc Shoppe recommends that members do NOT communicate health information about sensitive health topics (such as sexually related activities, HIV/AIDS or substance abuse issues) through unsecured (internet-based or otherwise) means.
- When using electronic methods (email, website, etc.) the Member should reasonably expect to hear a response within 24 hours during regular business hours. If the Member has not received a response, the Member should contact The Doc Shoppe by phone or another means of communication.
- I agree not to hold The Doc Shoppe or its Physician(s) liable or accountable for any loss, injury, damages, costs, or expenses which are sustained or the result of any technical failures with respect to email or electronic services including, but not limited to (1) technical failures attributable to any internet service provider, (2) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages, (3) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, (4) any interception of e-mail communications by a third party, or (5) member's failure to comply with The Doc Shoppe's guidelines regarding use of electronic communications set forth in this agreement.
- I acknowledge that email and other forms of online communication are not an appropriate means to discuss any potentially urgent or emergency medical needs or other time-sensitive issues. I should call 911 or visit the nearest emergency room should I reasonably suspect a medical emergency.

I have read and consent to, the **PATIENT AGREEMENT**
which is the official written contract between myself (including my dependents) and The Doc Shoppe.

_____ _____ / _____ / _____
Signature of patient (or parent / guardian) **Date**

Authorization to Receive Personal Health Information

My personal health information (often referred to as PHI) may be released to, or obtained from, the following individuals:

_____ _____

_____ _____

_____ _____

Furthermore, I agree to the use of these phone numbers and/or email addresses as means by which personal health information (concerning me or my dependents) may be transmitted to me by voice or by message.

_____ _____
Phone number Alternate Phone number

_____ _____
Email address Alternate Email address

_____ _____ / _____ / _____
Signature of patient (or parent / guardian) **Date**

Authorization to Accompany a Minor

I authorize the following people to bring my dependent minor(s) to The Doc Shoppe for diagnosis and treatment in my absence. Personal health information (PHI) regarding my dependent minor(s) may be given to these authorized individuals.

_____ _____

_____ _____

_____ _____

Name(s) of my dependent minor(s):

_____ _____

_____ _____

_____ _____ / _____ / _____
Signature of parent / guardian **Date**