Membership Form

Oregon Mobile Healthcare will provide non-emergent medical services under the following terms and conditions. Membership is not solicited from persons who receive welfare medical benefits and such membership constitutes a voluntary contribution

1. **MEMBER:** Membership covers a single individual.

2. **SERVICE:** Enrollment into Oregon Mobile Healthcare LLC membership program gives members access to in home non-emergent medical treatment, telephone help, and in-home checkups. Our staff provide symptom relief of diseases a doctor has already diagnosed for you and common aliments limited by our treatment protocols.

3. **MEMBERSHIP FEE:** is a subscription fee and is based on plan selected. Please see the attached plan outline for more information. Members can upgrade from the basic plan to the other plans at any time by paying the difference between the plans

4. **OTHER CHARGES MAY APPLY:** Members are responsible for all fees not covered in their subscription plan.

5. **SERVICE AREA:** Oregon Mobile Healthcare serves Klamath Falls, Keno, Midland, Olene, Merrill, and other outlying areas. Members who live more than 35 miles outside Klamath Falls will be considered on a case by case basis due to delays of service.

6. **ENTIRE CONTRACT/CONTRACT CHANGES:** This membership form constitutes the entire agreement between the Oregon Mobile Healthcare LLC and its members. No changes shall be valid until approved by an Executive Officer and approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. In the event Oregon Mobile Healthcare LLC is unable to provide or complete any service listed in this agreement due to any cause beyond its control, including but not limited to weather conditions, geographical restraints, third party service providers, or commitment to other clients. Oregon Mobile Healthcare LLC shall not be responsible for any damages, costs, or replacement services.

7. **EFFECTIVE DATE OF AGREEMENT:** Membership is effective after completed agreement is signed and payment is received. Continued membership is dependent upon recurrent billing and length of program enrollment. Membership purchases are non-refundable and non-transferable.

MEMBERSHIP INFORMATION:

Name: _____
Birth Date: ____/____/_____ Phone: _____
Address: _____
City: _____State: ____ Zip: _____
Insurance Provider: _____
Healthcare Provider: _____
Membership Plan: ☐ Assisted Living Plan $600.00 ☐ Premier Plan $300.00 ☐ Basic Plan $120.00

MEMBERSHIP APPLICATION AND FINANCIAL RESPONSIBILITY: Please include me in the Oregon Mobile Healthcare LLC membership program. I have read and understood the terms of this agreement. The member affixing his or her name hereunder assumes financial responsibility for all services provided by Oregon Mobile Healthcare LLC, pursuant to this agreement.

Signature: _____ Date ____/ ____/ _____

Membership Form

Medical Screening

Height: _____

Weight: _____

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other: _____

Allergies
Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list: _____
Are you allergic to foods or substances? ☐ Yes ☐ No If yes, please list: _____

Current Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Conditions

Please check if you have or had any of the following:

☐ Arthritis	☐ Asthma	☐ Cancer
☐ Chronic Bronchitis	☐ Congestive Heart Failure	☐ COPD
☐ Deep Vein Thrombosis	☐ Dementia	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Heart Disease
☐ Hepatitis	☐ High Cholesterol	☐ HIV
☐ Hypertension	☐ Irritable Bowel Syndrome	☐ Kidney Disease
☐ Liver Disease	☐ Lung Disease	☐ Obesity
☐ Septic Shock	☐ Stroke	☐ Ulcers

☐ Other: _____

Have you ever smoked? ☐ Yes ☐ No
If yes, do you still smoke? ☐ Yes ☐ No
If no, when did you quit? ____/____/_____

Have you ever consumed alcohol? ☐ Yes ☐ No
If yes, do you still drink? ☐ Yes ☐ No
If no, when did you quit? ____/____/_____

For Internal use only	
Executive Officer Approval	☐ Approved: _____ Date: ____/____/_____ ☐ Denied: _____ Date: ____/____/_____
Payment Received	X_____ Date: ____/____/_____