



MEMBERSHIP AGREEMENT

This Membership Agreement (“Agreement”) specifies the terms and conditions under which you, the undersigned patient (“You”), will participate in UH Select, an enhanced, personalized primary care experience offered by University Hospitals Medical Practices (“Practice”). This Agreement becomes effective on the date of your signature on this Agreement (the “Effective Date”).

1. **Membership Services.** Participation in UH Select entitles You to the following services (the Membership Services’):
 - a. **Same Day/Next Day Appointments With Physician.** Practice is able to accommodate most requests for same day weekday appointments with a physician employed by the Practice (“Physician”). Practice will make every reasonable effort to schedule You for an appointment with Physician on the same day You contact the Practice regardless of the nature of your symptoms. If a same day appointment is not feasible, Practice will schedule an appointment the next business day. During the Physician’s absence, the Practice shall ensure that a substitute physician will be available to You to the same extent as the Physician.
 - b. **24/7 Patient Navigator Services Access.** You will have direct telephone access to a Patient Navigator on a twenty four-hour per day, seven days per week basis. The Patient Navigator will discuss your health concerns with you and, depending upon the circumstances, arrange an office appointment for you, assist you in scheduling diagnostic testing or gaining hospital admission, or, if appropriate, speaking directly with Physician.
 - c. **E-Mail Access.** You will be given the Physician’s e-mail address to which non-urgent communications can be addressed. Physician or a designated staff member will respond to emails in a timely manner. During the Physician’s absence, the Practice shall provide the contact information of a substitute physician. **You understand and agree that email should never be used to access medical care in the event of an emergency, or any situation that You could reasonably expect may develop into an emergency.** You agree that You will call 911 in the event of any emergency.
 - d. **Written Summary of Office Visit.** After each office visit with the Physician, the Practice will promptly mail You a written summary of the visit and written care recommendations.
 - e. **Teleconferences and Webcam Conferences.** At Your request, the Physician will hold telephone or webcam conferences with You to review Your healthcare needs.
 - f. **Visitors.** Visitors and/or family members (“Visitors”) temporarily visiting You from out of town may, for up to a two-week period, use the services described in subparagraphs (a) and (b) above. Medical services rendered to Your Visitors shall be charged on a fee-for-service basis as described in Section 2 below.
 - g. **Specialists.** Physician shall closely collaborate and coordinate with local medical specialists to whom You are referred for specialty care. However, You understand that the Membership Services stated in this Agreement do not extend to the services provided by specialist physicians to whom you are referred.

h. Wellness Initiatives. You will be provided the following wellness services annually:

- i. A comprehensive physical examination
- ii. Cardiac evaluation and calcification scoring
- iii. Complete nutritional assessment by registered dietician
- iv. Additional offerings may be available a la carte

Practice may amend the list of Membership Services from time to time. However, Practice will provide You with an updated list of the Membership Services covered by this Agreement at least thirty (30) days prior to the date any change will take effect.

2. Service Locations. Please check the appropriate box to indicate the location(s) You intend to receive Membership Services:

- ☐ Cleveland, Ohio
- ☐ Cleveland, Ohio AND Boca Raton, Florida
- ☐ Cleveland, Ohio AND Naples, Florida

3. Fees; Billing. You agree to pay an annual fee of Two Thousand Dollars (\$2,000) ("Membership Fee") for the Membership Services upon execution of this Agreement. Practice will send you an annual invoice for the Membership Fee each year thereafter. Practice reserves the right to increase the Membership Fee up to Ten Percent (10%) each year. Any fee increase in excess of Ten Percent (10%) will require execution of a new Agreement.

4. Covered Medical Services; Exclusion of Certain Services. The Membership Fee only covers the provision of Membership Services described in this Agreement. The Practice will continue to accept and bill Your individual or group health plan, HMO, PPO, or other similar private health plan or coverage for medical services covered by such policies ("Covered Services"). You will remain financially responsible for any co-payments, co-insurance or deductible amounts required by your insurer for the provision of Covered Services.

5. Term & Termination; Exclusivity. This Agreement shall last for one (1) year commencing on the Effective Date and shall automatically renew for successive one-year periods unless You notify the Practice that you do not intend to renew the Agreement. Practice may terminate this Agreement and the physician-patient relationship in accordance with laws in the state You receive Membership Services. In such an instance, Practice will refund You a prorated portion of the Membership Fee. The Practice operates exclusively under the personalized, enhanced model of Membership Services described in this Agreement. You must maintain a current Agreement in order to remain a patient of the Practice. Termination of the Agreement by either party will result in removal from the Practice in accordance with laws in the state You receive Membership Services.

6. Insurance or Other Medical Coverage. Patient acknowledges and understands that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage. It will not cover hospital services, or any services not personally provided by Practice or Physician.

Patient acknowledges that Practice has advised that patient obtain or keep in full force such health insurance policy(ies) or plans that will cover Your general healthcare costs. You acknowledge that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that You may carry.

7. Assignment. You may not assign or transfer any rights You have under this Agreement.
8. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Ohio and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction shall be in Cleveland, Ohio.

☐ In addition to the Membership Services, I am also interested in medically necessary air transportation services through UH Select. By checking this box, I request that a UH Select staff member contact me with more information.

I agree to be bound by the terms and conditions of this Agreement and acknowledge that this document supersedes any verbal discussions I have had regarding my membership in UH Select.

Patient Signature

Date of Birth

Printed Name

Date

Program Contact Information

Primary Street Address

City

State

Zip

Primary Phone

Secondary Phone

Email Address

Please return the completed Membership Agreement to:

Fax: (216)201-7991

Email: UHSelect@UHhospitals.org

**Mail: UH Select Program
11000 Euclid Avenue
Lakeside 1020
Cleveland, OH 44106**