



## ProMedX POLICY CONTRACT

\*ProMedX is considered Direct Primary Care and is **NOT** a tax-deductible substitute for health insurance coverage demanded by the Affordable Care Act.

This is a Contract between **ProMedX, LLC ("ProMedX")** and

Name/Company Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_ Gender: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Hereinafter referred to as "Policy Holder", in which person agrees to pay ProMedX the fees identified below in exchange for ProMedX policy coverage, which provides unlimited access to the ProMedX "Provided Services" as described below.

**1. Description of ProMedX:** ProMedX is a state certified minor medical policy that allows access to affordable medical care for minor injuries, minor illnesses, preventative medicine, yearly physicals, wellness checks, and more for a monthly fee.

**2. Policy options:** Person may choose from the following:

**50/20 policy** - \$50.00 fee is charged monthly and a \$20.00 exam fee is charged at each visit. (this policy allows the policy holder to have a **low-cost visit** and unlimited access to ProMedX in-clinic "provided services" **at no additional charge**).

**20/50 policy** - \$20.00 fee is charged monthly and a \$50.00 exam fee is charged at each visit. (this policy allows the policy holder to have a **low monthly premium** with unlimited access to ProMedX in-clinic "provided services" at a **50% discount** off of cash price, if provided services are needed).

**2. Definition of Provided Services:** Medical examination, medications, procedures, lab work, x-rays, dental services, and referral network for which ProMedX provides coverage (see "Provided Services").

**3. Services NOT Covered by ProMedX:**

- Treatment for life/limb threatening events such as gunshot wounds, heart attacks, serious infections, etc. or management of chronic conditions such as cancer.

- Costs for medical services, treatment and/or hospitalizations at any facility other than MinuteMed Walk-In Clinic Locations.
- Special diagnostic studies such as outside x-rays, labs, ultrasounds, mammograms, MRIs, CT scans, PET scans, and other special x-rays that are not provided at the Clinic. (\*certain lab work and radiological studies are offered with ProMedX policy and have been discounted to patient through MinuteMed Walk-In Clinic. See "Provided Services").
- Physical, speech, and occupational therapy, chronic pain management, weight loss, psychiatric emergency, major psychiatric management, out of clinic pharmacy costs, or workers' compensation services.
- Vision, hearing, or obstetric services.
- Any condition that the attending provider believes should, in the best interest of the person, be treated by another provider or facility.

**4. Policy Fees:** Person/employer agrees to pay the following costs to ProMedX on the terms outlined below: **(check all that apply)**

\_\_\_\_\_ **Registration fee of Fifty (\$50.00) dollars per person/employee listed in contract.**

\_\_\_\_\_ **Monthly payment/payments for each employee/person listed in contract.**

\_\_\_\_\_ **Immediate family members (2 generations only) listed in contract. (Starting the month of sign up with a maximum of \$200.00/month.)**

\_\_\_\_\_ **Exam fees and services in the "provided services" at the time of the visit before being discharged from the clinic.**

\_\_\_\_\_ **Payment of Ten (\$10.00) dollars on either the 1<sup>st</sup> or 15<sup>th</sup> of every month for dental services *if chosen*.**

**Policy holder/family members:** (\*additional family/company enrollment form available if needed)

- |                                  |                        |                                |                                |  |
|----------------------------------|------------------------|--------------------------------|--------------------------------|--|
| 1. _____<br>name (policy holder) | _____<br>date of birth | <input type="checkbox"/> 50/20 | <input type="checkbox"/> 20/50 | <input type="checkbox"/> dental \$10/month |
| 2. _____<br>name                 | _____<br>date of birth | <input type="checkbox"/> 50/20 | <input type="checkbox"/> 20/50 | <input type="checkbox"/> dental \$10/month |
| 3. _____<br>name                 | _____<br>date of birth | <input type="checkbox"/> 50/20 | <input type="checkbox"/> 20/50 | <input type="checkbox"/> dental \$10/month |
| 4. _____<br>name                 | _____<br>date of birth | <input type="checkbox"/> 50/20 | <input type="checkbox"/> 20/50 | <input type="checkbox"/> dental \$10/month |
| 5. _____<br>name                 | _____<br>date of birth | <input type="checkbox"/> 50/20 | <input type="checkbox"/> 20/50 | <input type="checkbox"/> dental \$10/month |

**6. Payment of Policy Dues:** Policy holder agrees to pay registration and first months Policy Fees at the time this Contract is signed. Policy holder further agrees to pay monthly Policy Fee by either the 1<sup>st</sup> or 15<sup>th</sup> of each month, as well as all other Policy Fees (added persons or dental fees) by allowing ProMedX to automatically withdraw the funds from the bank account identified in policy contract. Policy dues may either be paid by policy holder or employer OR a combination of both.

**\*\*Policy holder agrees to pay \$ \_\_\_\_\_/month. Employer agrees to pay \$ \_\_\_\_\_/month.**

**7. Term of Contract:** ProMedX and Policy Holder agree that the term of this Contract is for **6 months with 50/20 policy** and **1 year for 20/50 policy**, beginning on the day this Contract is signed. Thereafter, the Contract will automatically renew on a monthly basis unless cancelled, in writing, by either party. Upon termination or cancellation of this Contract, Policy Holder must pay all owed policy fees and fees that may have incurred prior to the date of termination or cancellation.

**8. Fee for Services:** Person agrees to pay an EXAM fee of Twenty (\$20.00)/Fifty (\$50.00) dollars for each occasion on which a Person seeks services, as well as all other Policy Fees (discounted labs, medications, x- rays, and prescription meds) whether or not they are Covered Services, at a Clinic. **Exam and policy fees shall be made payable to the Clinic at which the services are provided, and NOT to ProMedX.**

**9. Locations at Which ProMedX Policy May Be Used:** ProMedX may be used at the following MinuteMed Walk-In Clinic ("Clinic") locations in Lafayette, Louisiana:

- 3619 Ambassador Caffery Parkway Bldg. E (\*by Bed Bath and Beyond)
- 2912 Johnston Street (\*by Mel's Diner)
- 314 Youngsville Hwy (\*by Kart Ranch)

**\*In the event additional locations of Clinics open, then the ProMedX policy benefits will automatically apply at those Clinic locations.**

**10. Claims and Disputes:** Policy holder is not required to submit any claims to ProMedX in order to receive policy benefits. Policy holder is only required to pay the monthly fees to ProMedX and the exam fee and discounted services fee to the Clinic. All claims will be resolved between ProMedX and the Clinic. However, in the event ProMedX has questions or needs additional information about the services sought and received by a Policy holder subject to this Contract, Policy holder agrees to cooperate fully and to provide all information requested by ProMedX.

**11. Entirety, Severability, Governing Law, and Venue:** This Contract constitutes the entire agreement between ProMedX and Policy holder, and it may only be changed or amended in a writing containing the signatures of both parties. In the event that any provision of this Contract is deemed unlawful or invalid by a court of competent jurisdiction, then that clause shall be stricken from this Contract as if it was never included herein, and the remaining provisions of the Contract shall remain in full force and effect. This Contract shall be governed by Louisiana law, and the parties agree that the only venue in which disputes of any kind may be resolved is in a court of proper jurisdiction in Lafayette Parish, Louisiana.

This Contract was agreed and signed upon on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, and is effective as of this day.

**ProMedX, LLC**

By its duly authorized representative  
(sign, print name, date)

\_\_\_\_\_

**Person**, signing individually and as the authorized representative  
and Responsible Party for all Persons listed on this Contract  
(sign, print name, date)

\_\_\_\_\_