



Membership Program

A New Approach for Accessing Quality Affordable Healthcare

Freedom Health Group understands the frustrations with the high cost of health insurance, doctor office visits, and lab tests even when individuals have health insurance. Our focus is on providing our members with cost-effective access to address their healthcare issues in primary, preventive, and maintenance care without purchasing expensive health insurance. Issues like annual physicals, sport physicals, preventive care, health screening, immunizations, and health maintenance care for diabetes, cholesterol, and high blood pressure. If our members need to see a specialist, our staff will contact that specialist on their behalf and identify what a fair and reasonable cash price will be at the time of visit.

Available to Anyone - No health restrictions, no income restrictions, no pre-existing conditions, no health screening requirements, and no waiting period; just pay a low monthly pay your monthly membership fee. Membership starts when application and payment is received. Membership is ideal for individuals, self-employed individuals, single parents, families, and small businesses. While Freedom Health Group is not health insurance, it is recommended that individuals buy a high-deductible medical plan to help insure against financial distress caused by expensive health related issues such as heart attack, stroke, cancer, or major surgery.

Our Customer Service Goal: Members will receive the best customer service and best quality of care for their primary, preventive, and health maintenance needs at fair and reasonable prices.

Membership Costs

	<u>12 Monthly Payments</u> ^[2]
Individual/Single Parent ^[1]	\$ 79 per month
Family with children ^[1,2]	\$ 158 per month

[1] Individual is age 18 years and older. Children under 18 and living with their parent(s) receive free membership with a paid parent.

[2] Members are **REQUIRED** to set up automatic direct payments from their checking, savings account, or credit card. Membership is a 12 month commitment as this ensures advocate services are available for members to locate and negotiate with specialists' fair and reasonable price for services, plus maintaining facilities, equipment, and supplies used by members. The commitment also allows for afterhours telephone support.

Facility Hours of Operation and Location

Monday - Friday 7:00 a.m. to 5:00 p.m. Closed weekends and holidays. After hours phone assistance is available to members.

Spokane Valley 13607 E. Sprague Ave., Spokane Valley, WA 99216
 Phone 509-892-3113 Toll Free 877-766-5603
 Fax 509-892-3663
 Email info@freedomhealthgroup.com
 Online: www.freedomhealthgroup.com

Membership Benefits

Advocate and Consulting Assistance

Specialist^[3] – locating a specialist and negotiating affordable prices for services

Imaging – locating and negotiating affordable prices for x-rays and diagnostics

Case Management – coordinating care between various providers

Cost Identification^[3] – identifying the estimated cost of hospital-related services

Access to Direct Care Program

A portion of the membership fee is paid on behalf of the member to Independent Healthcare Providers offering Direct Care to the Freedom Health Group members at Freedom Health Group's facility. See details of the Direct Care Agreement provided by the Independent Healthcare Providers for services, restrictions, and limitations. Under the Direct Care program members receive lab tests priced at cost plus \$5.00 per test and vaccinations at fair and reasonable prices.

Access to Affordable Dental Care^[3]

Oral health is a critical part of the Member's overall health. Freedom Health Group has identified dentist that will charge a fair and reasonable price for general dental care. Members will save more than if they buy dental insurance in most cases.

Children – Free Membership and Primary Care^[3]

Children of individual members pay no membership fee and receive care as listed under the Direct Care program provided by Independent Healthcare Providers as part of their parent's membership.

Medical Records – Members may retrieve all or part of their electronic medical records at no cost.

Health Incentive Program^[3] – Have an annual physical, six month check up, two teeth cleanings a year, improve health score by 5 points, and be a member for 12 months can earn the member \$100 for getting and staying healthy.

^[3] *These benefits are not available to individuals under the Flex or Senior Membership programs.*

Right to Cancel – Members can cancel their membership within the first 30 days following receipt of their application by Freedom Health Group. After 30 days, the Member may cancel with written notice and may be charged a \$65 cancellation process fee. Members may cancel any time after their initial 12 month commitment is met and will not be charged a cancellation fee.

Sometimes there are Concerns

Freedom Health Group is committed to outstanding customer service. There may be a time when things do not always connect between the member, staff, and or the healthcare provider. A feedback form is located on our web site and in the reception area. Submit the completed form to senior management to review and help get the issue resolved quickly.

Disclaimer – What Freedom Health Group Corporation DOES NOT OFFER

Freedom Health Group Corporation DBA Freedom Health Group is not and does not purport to be a health plan, discount health plan, and does not offer, represent, or otherwise sell or provide coverage for health insurance, pre-paid healthcare plan, or prescription drug plan. A paid membership in Freedom Health Group does not constitute or grant the member and or dependents of the membership program access to a prescription drug plan, hospital coverage, in-patient or out-patient care services, specialty care, or diagnostic testing performed in or out of a hospital or specialist office.

Freedom Health Group Membership Terms and Conditions

The applicant (including spouse and or dependents) and hereafter referred to as (“Members”) of Freedom Health Group managed by FREEDOM HEALTH GROUP CORPORATION (FHG) agrees to the following terms and conditions for receiving membership benefits as well as access to services offered by Independent Healthcare Providers located within FHG’s facility and are not employees of FHG.

1. Members have read and fully understand that FHG membership **is not** construed as, or to be interpreted as a health insurance plan, pre-paid health plan, or prescription drug plan, nor is FHG responsible for processing claims or submitting claims to third party insurance companies, federal or state insurance agencies.
2. Members understand that membership is granted through a monthly fee requiring a 12-month commitment. The 12-month commitment ensures advocate services are available for Members to locate and negotiate with specialists’ fair and reasonable price for services Members may need. This commitment is waived if any portion of the membership fee is paid by the Member’s employer.
3. Members understand the services of primary, preventive, and urgent care are provided by independent healthcare providers through a Direct Care program exclusively for FHG Members. FHG pays for the Members Direct Care program from a portion of the monthly fee collected.
4. Members agree that they are the sole individuals responsible for their health and treatment sought, and that they will follow the recommendations of the providers related to the maintenance of their health.
5. Members agree not to sue or file suit on behalf of themselves or their dependents, or take other legal action against the independent providers whom they sought out for treatment of a specific illness without first agreeing to arbitrate their case with the provider(s).
6. Members agree to hold FHG harmless for the healthcare and thereby understand and acknowledge that FHG and its staff have no direction, control, or authority to govern members care and or treatment prescribed by the Independent Healthcare Provider.
7. Members may cancel with written notification after 30 days and understand they will be charged a \$65 process cancellation fee. Cancellation fee is not charged to the Member if any portion of the membership fee is paid by their employer or if they have been members for at least 12 months.
8. Members understand that they will be charged all bank fees plus \$20 by FHG for non-sufficient funds (NSF) if they fail to maintain adequate funds to cover the monthly payment obligations. If more than one NSF is received by FHG over a six month period, FHG may elect to terminate the Members membership.

Freedom Health Group Corp. - Membership Application

(Please Print)

Applicant's Last Name		First Name	M.I.
Address		City	State Zip
Home Phone	Mobile Phone	Work Phone	
Employer		Date of Birth	/ /
Applicant's E-mail			
Spouse Last Name		First Name	M.I.
Spouse DOB	/ /		
Spouse's E-mail		Contact Phone No:	

List of Legal Dependents (Age 1-17)

- Last Name, First, M.I. _____ [] Male [] Female Date of Birth ___/___/___
- Last Name, First, M.I. _____ [] Male [] Female Date of Birth ___/___/___
- Last Name, First, M.I. _____ [] Male [] Female Date of Birth ___/___/___
- Last Name, First, M.I. _____ [] Male [] Female Date of Birth ___/___/___
- Last Name, First, M.I. _____ [] Male [] Female Date of Birth ___/___/___

If you have more than five dependents, please fill out the dependent section on a second application.

	<u>No. of</u>		<u>Monthly Payments</u> ^[2]	
	<u>Individuals</u>			
Individual ^[1]	_____	x	\$ 79 per month	[] Check Box if Employer is paying ALL or PART of the membership fee.

***** Membership is free for children under 18 living with their parent(s) and are Members *****

[1] An individual Adult is age 18 years and older. Direct care services provided by Independent Healthcare Providers.

[2] Monthly payments **must be** set up through automatic direct payment from member's checking or savings account or credit card.

First payment due with application and **must** complete and submit an **Authorization for Direct Payment** form.

Mail completed application, first month membership payment, and completed authorization for direct payment form to:

Freedom Health Group Corp. 13607 E Sprague Ave., Spokane Valley, WA 99216.

I understand that membership is a 12 month commitment (commitment waived if any portion of membership is paid by employer) and I have read the terms and conditions of membership program The individual(s) signing for their dependents do so at their own free will and rights as parents and/or legal guardian of the individual(s) under the age of 18 years old. With my signature below I AGREE, ACCEPT, APPROVE, AND UNDERSTAND such terms and conditions for myself as well as my dependents.

Applicant's signature: _____ Date: / /

Spouse's signature: _____ Date: / /

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2. Members understand that membership is granted through a monthly fee under a 12-month commitment. The 12-month commitment ensures advocate services are available for Members to locate and negotiate with specialists’ fair and reasonable price for services Members may need. This commitment is waived if any portion of the membership is being paid by the Member’s employer.
3. Members understand the services of primary, preventive, and urgent care are provided by Independent Healthcare Providers through a Direct Care program exclusively for FHG Members. FHG pays for the Members Direct Care program from a portion of the monthly fee collected. Independent Healthcare Providers **are not** employees of FHG.
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Authorization for Direct Payment

For the purposes of honoring debits or credits for collection of membership access fee initiated by:
FREEDOM HEALTH GROUP CORPORATION
DBA FREEDOM HEALTH GROUP
 PO Box 921
 Spokane Valley, WA 99037

I hereby authorize FREEDOM HEALTH GROUP to initiate debit entries to my DEPOSITORY financial institution or my CREDIT CARD, named below and to debit the same to such account. I understand that I have the right to receive notice of each debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than \$200.00. This Authorization will remain in effect until I notify FREEDOM HEALTH GROUP in writing at the above address to terminate and FREEDOM HEALTH GROUP has a reasonable time to act on the termination. After my CREDIT CARD or DEPOSITORY has been charged, I understand I have the right to have the amount of the erroneous debit immediately credited to my account by my CREDIT CARD or DEPOSITORY, provided I send written notice of such debit entry in error to my CREDIT CARD or DEPOSITORY within 15 days following issuance of the account statement or 60 days after posting, whichever occurs first.

I elect to use my Bank Account for making monthly payments.

Name of DEPOSITORY (Bank) Where Debit is Authorized		City	State	Zip Code of Bank
Routing/ABA Number	Checking <input type="checkbox"/> Savings <input type="checkbox"/>	DEPOSITORY (Bank) Account Number		Payments Mode Monthly <input type="checkbox"/>
Authorized Signature		Date Signed	Debit Date Each Month <input type="checkbox"/> 1 st or <input type="checkbox"/> 7 th Amount each debit \$	

I elect to use my Credit Card for making monthly payments.

I hereby authorize Freedom Health Group Corporation to charge my credit card the following amount of \$_____ on the 1st of each month for the next 11 months beginning _____.

Card Type: Visa MC - Card # _____ CVV Code # _____
(Last 3 digits on back)

Name on Card _____ Exp. Date ___/___/___

Mailing Address (Where credit card statement is mailed) _____

City/State/Zip Code _____

Cardholder Authorized Signature _____ Date _____