



Full Legal Name _____

Date of Birth _____

Today's Date _____

Email Address _____

Phone Number _____

Secondary Phone Number _____

Mailing Address _____

Why are you interested in VANTAGE Concierge Medicine? (Please describe your health goals or specific needs.)

What are you looking for in a healthcare provider?



What specific services are you the most interested in?

3. Membership Selection

Please select your preferred membership tier:

Essential Access * Includes: Annual Comprehensive Physical Examination, unlimited visits, and baseline wellness screenings.

Premier Access * Includes: All Essential Access benefits PLUS direct 24/7 mobile access to the physician and advanced personalized wellness planning.

Important Note on Billing

Actual membership pricing, billing cycle, and payment details (e.g., credit card or ACH setup) will be securely discussed with a billing specialist during your initial consultation upon successful review of this application.

4. Agreement and Authorization

I agree to the Membership Terms and Conditions and authorize Vantage Concierge Medicine to review this application.

I certify that the information provided is accurate and complete to the best of my knowledge.



Applicant Signature: _____

Date: _____

SERVICE AGREEMENT

1. Services

Vantage Health PLLC (The Practice) agrees to provide the Patient with concierge medical services ("Services").

2. Membership Fees

- **Monthly Membership Fee:** The Patient agrees to pay a monthly membership fee as agreed upon in the attached documentation (Vantage Credit Card Form).
- **Term:** The term of this agreement is monthly with no long-term commitment required.
- **Automatic Renewal:** This Agreement will automatically renew for subsequent months unless either party provides written notice of termination at least 30 days prior to the end of the then-current term.

3. Insurance and Billing

- **Non-Insurance Model:** The Services provided under this Agreement are not covered by health insurance, Medicare, Medicaid, or any other third-party payer. The Practice does not participate in any insurance plans or panels.
- **Separate Billing:** The Patient understands they will receive separate bills for medical services, tests, or procedures not included in the concierge membership.

4. Termination



- **By Either Party:** Either party may terminate this Agreement at any time in writing.
- **Penalties:** There is no long term commitment or penalty for cancellation.

5. Disclaimer

- **Not a Substitute for Emergency Care:** This Agreement does not cover emergency care. In the event of an emergency, the Patient should call 911 or go to the nearest emergency room.
- **Scope of Services:** This Agreement covers the specific Services outlined in Section 1. Additional medical services may be available but are not included in the membership fee.

6. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State of Michigan.

7. Entire Agreement

This Agreement constitutes the entire agreement between the Practice and the Patient. It supersedes any prior agreements or understandings. Any changes must be made in writing and signed by both parties.

Signatures

By signing below, the Patient acknowledges that they have read, understood, and agreed to the terms and conditions of this Vantage Health LLC Concierge Medicine Service Agreement.



Patient Signature: _____ Date: _____

I hereby authorize Vantage Health PLLC to confidentially and securely store my credit card information. I understand and agree that my credit card will be billed monthly at the agreed upon rate as documented below. I am aware that there may be additional fees if the credit card payment fails to process. I will update Vantage Health PLLC if there are any changes to my credit card, or billing address.

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

VISA MasterCard Discover American Express Debit

Cardholder Name _____

Card Number _____

Expiration Date _____ CVV _____

Cardholder Signature _____ Date _____