THRIVE DIRECT HEALTH CARE

Dr. Brianna Wilson, DNP, ARNP, FNP-BC

Date Joined/updated: _____

Provider Assisted Weight Loss Program Member

This membership has a 6 month minimum participation which allows for total program costs to be divided equally across 6 monthly payments.

Primary Enrollee Name: _____ DOB: _____ Age: _____
Payment Account will be under this name.

Payment by check, automatic bank withdrawal or Visa/MasterCard

Submit only the authorization for ongoing automatic monthly payments page and payment information

Total initial consult:		
	$150	Was paid at time of consult unless Medicare B Original
Recurring Fees		
Subtotal Membership Fees: (Minimum 6 months)	$ /mo	Limited $105/mo (Insurance covering labs) Members ($65/mo members) Basic $155/mo (Members $105/month) Advanced $225/mo (Members $25 OFF) VIP $400/mo (Members $25 OFF)
☐ Add on: (minimum 6 months)	$ 300/mo	Semaglutide - Compounded. Pricing includes 4 vials with the pricing spread out over 6 months at a discounted rate while on membership.
☐ Add on: (minimum 6 months)	$ 400/mo	Tirzepatide - Compounded. Pricing includes 3 vials with the pricing spread out over 6 months at a discounted rate while on membership.
☐ Add on: (minimum 6 months)	___$200/per pick up ___$250/per pick up	Semaglutide - Microdosing Tirzepatide - Microdosing
Add on:	$150/ per pick up	Oral Semaglutide

Total:_____

Thrive Direct Health Care
Account Set-up and Payment Worksheet

Account Holder Name:_____DOB: _____
Date Joined/updated: _____

Automatic Payment Set-up

TERMS

- I understand that membership fees include services and expenses spread out over a 6 month timeframe and that there is a minimum of 6 months of membership.
- I understand that my monthly membership fees will be automatically processed by Thrive Direct Health Care on the same day of each month noted below as payment for services for the following 30 days which may not occur in the same calendar month.
- I understand that this Authorization will remain in effect until a full 6 months (and 6 payments) has passed and a new agreement is signed to continue the extension or to discontinue the program.
- I understand that it is my responsibility to keep my credit card/debit card information up to date. I understand that if payment is late that services provided by Thrive Direct Health Care will be held until payment is up to date. If this is not corrected within 5 calendar days a late fee of $25 will also be charged.
- I understand and authorize that a $25 fee will be charged to me for non-sufficient funds or any event preventing payment.
- A superbill may be requested to seek reimbursement from insurance. This will be by request only and only allotted for after the first 3 months and at 6 months or program completion. There is no fee for this superbill while on the 6 month program. Any superbills for dates following the 6 months will have a $10 fee per superbill as this takes a large amount of admin time to complete.

☐ One time fee for intake $_____PAID_____, ($150 - 40-60 min consult; current DPC members - Free; Medicare B covered by normal billing. Copays apply)

☐ Recurring total monthly fee $_____. Starting date:_____

☐ Other recurring total monthly fee $_____.

Total recurring charges: $_____.

I have read and understand the above payment terms and agree to the terms. I hereby authorize Thrive Direct Health Care to store the account on file and initiate credit/debit card transactions or automatic bank withdrawals on a monthly basis for the above total monthly fee for 6 months minimum. I authorize my financial institution to honor these transfers. Should I need to cancel for any reason, the balance of any charges that remain and have not been paid will be prorated and processed at time of termination plus a $100 early termination fee. This may include a past due balance for the medication and supplies, visits, or nutritional consult.

Signature of membership holder: _____
Date:_____

Thrive Direct Health Care
Account Set-up and Payment Worksheet

Account Holder Name:_____DOB: _____
Date Joined/updated: _____

Payment Authorization

Authorization for automatic recurring payment

Select Option: *We do not allow single month payments at this time.*

O Monthly Recurring Payments in the amount of $_____ which includes any additional fees as noted in the worksheet.

O Complete payment for whole 3 months in advance: $_____

O Complete payment for whole 6 months in advance: $_____

Day of the month for processing:_____

_____

O Credit O Debit Card Type: O Visa O Mastercard O Other: _____

Name on Card:_____

Card Number: _____ EXP:_____ 3 Digit Security Code:_____

Billing Zip Code:_____

OR

O Banking Account: *or Voided check attached

Bank: _____

Name on Account:_____

Routing Number: _____

Account Number: _____

OFFICE USE ONLY
O Elation Card on file
O Set up recurring membership
O Spruce invite sent
O Elation Passport invitation set
O Membership documents scanned
O Set up a 6 month reminder 2 weeks prior to ending date in Tabflows
O Set up first 2 months of visits and nutrition consult