Assurance
Healthcare & Counseling Center

Member Registration Form

This form can also be found online at: AssuranceHealth.org/forms

Please fill out and submit one form per family member. You may leave information blank that remains the same as the main account holder, such as address, emergency contact information, etc.

Member type:

- ○ Main Account Holder (person responsible for billing / other patients associated with this account)
- ○ Spouse of Main Account Holder
- ○ Dependent of Main Account Holder

Name of Main Account Holder (if spouse or dependent): _____

Basic Member Information

First Name_____

Last Name_____

Middle Initial_____Gender ○M ○F

Date of Birth_____

Main Phone_____

Alternate Phone_____

Alternate Phone_____

Emergency Contact Information

First Name_____

Last Name_____

Phone_____

Relationship to Member_____

Address (including City, State Zip)

_____

_____

_____

_____

Email Address

_____

I wish to begin membership on (date)*

_____

*1/1/2014 is the earliest available start date.

- ○ I prefer to pay my membership monthly**
- ○ I prefer to pay my membership annually

***Memberships paid monthly are required to pay via automatic withdrawl or recurring payment.*

Billing information will be obtained via phone or in person.

Mail or drop off completed forms to:
Assurance Healthcare & Counseling Center
ATTN: Member Registration
1020 S 40th Ave. Suite A
Yakima, WA 98908

Fax completed forms to:
509-823-4652

Email completed forms to:
registrations@assurancehealth.org

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Billing information and authorization

Membership information

Name(s) and birthdate(s) of members to be billed via this account:

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

Membership start date:_____ *(also your billing due date)*

Do you have medical insurance? □Yes □No

(If yes, please bring your ID card to your first visit so that we may expedite referrals and outside lab testing)

Billing Information

Billing frequency: □ Annually □Monthly

Option A: Credit Card or Debit Card

Name on Card:

Card Type: □Visa □Mastercard □American Express

Card Number: Expiration date:

Card billing address:

Option B: Automatic Funds Transfer

**Please note that it takes approximately three days from the payment processing date before the charge posts to your bank account.*

Name on Account:

Bank name: Acount type: □Checking □Savings

Account number: Bank Routing Number: (please attach a voided check to this form)

Authorization

Your monthly care fee covers the services specifically described in the Assurance Healthcare & Counseling Center Patient Services Guide. At times, however, your care may require durable medical supplies or Third-party services that are not covered by your monthly membership fee. To streamline your appointment check-out, please note that by providing the above billing information you authorize Assurance Healthcare & Counseling Center to automatically charge your card or draw on your bank account for any incidental items are charged at or near our cost and will be discussed with you in advance.

- By signing below, I hereby authorize Assurance Healthcare & Counseling Center (AHCC) to contact me using the information I have provided above. By signing below, I hereby authorize AHCC to initiate charges to my credit card, debit card or bank account for my periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my care fee plus the care fees of any individuals on my account.
- This Authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until AHCC has received written notification from me of its termination in such time and in such manner as to afford AHCC and my financial institution a reasonable opportunity to act on it.
- I understand that my participation in AHCC is continuous and that by signing below, I authorize recurring credit/debit card charges.
- I understand that a $25 fee will be charged to me for declined credit, debit card or automatic funds transfer transactions that are not honored.

Account Holder Signature:

Account Holder Printed Name:

Date:

Office use only

Patient number: Billing number: Registration fee: Date:

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Authorization to Email Protected Health Information

Although secure electronic messaging is preferred to unsecure email messaging for communication of protected health information, unsecure email communication containing sensitive health information can be sent between an Assurance Healthcare & Counseling Center (AHCC) provider and patient. If this form is completed and signed by the patient, then unsecure email communication regarding the patient's medical care and treatment may be used to transmit information between the patient and AHCC.

Authorize email communication

☐ I authorize the Assurance clinical staff to email me regarding the course of my medical care, treatment and diagnostic test results, excluding information concerning mental health, substance abuse and sexually transmitted disease.

☐ I further authorize the disclosure of information related to mental health, substance abuse and sexually transmitted disease.

Patient representative's email address (*please print*):

_____

Signature required on the next page

Change email address

☐ I am changing the email address to be used for communications with Assurance

New email address (*please print*)

_____

Signature required on the next page

Discontinue email communication

☐ I no longer wish to communicate via email **signature required on next page**

- I understand that any email transmission between my provider and me/the patient will become part of my medical record (which AHCC privacy policies still remain in affect). These email transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
- I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, membership or eligibility for AHCC benefits if I refuse to sign this Authorization.
- I understand that, once information is disclosed pursuant to this Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

Alert for Electronic Communication

Patients and/or personal representatives who want to communicate with their health care providers by email should consider all of the following issues before signing an Authorization to Email Protected Health Information:

1. Email at AHCC can be forwarded, intercepted, printed and stored by others.
2. Email Communication is a convenience and is not appropriate for emergencies or time-sensitive issues.
3. Highly sensitive or personal information should only be communicated by email at the patient's discretion (i.e. HIV status, mental illness, chemical dependency, etc.)
4. Employers generally have the right to access any email received or sent by a person at work.
5. Staff other than the health care provider may read and process email.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Communication guidelines muse be defined between the clinician and the patient, including (1) how often email will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for email.
8. Email message content must include (1) the subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and (2) clear patient identification including patient name, telephone number and date of birth or patient identification / account number (if known) in the body of the message.
9. AHCC will not be liable for information lost or misdirected due to technical errors or failures.

I have read and understand the Alert for Electronic Communications and agree that email messages may include protected health information about me/the patient, whenever necessary.

_____ _____

Patient/representatives signature Date

_____ _____

Patients printed name Date of birth

_____ _____

Patient representatives name Relationship

please note that this Authorization is not valid unless completed in full. This Authorization will not expire unless revoked in writing

Patient ID / Account # (for administrative use only)_____

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Patient Agreement & Disclosure Statement

Terms

- I acknowledge and understand that I am voluntarily becoming an Assurance Healthcare & Counseling Center (AHCC) patient and that this agreement is non-transferable.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance and that it provides only the health care services specifically described in the *AHCC Patient Services Guide*.
- I have reviewed the *AHCC Patient Services Guide* and I have had the opportunity to ask questions and receive answers regarding its content.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of AHCC including but not limited to emergency room, hospital and specialty services and that AHCC will not bill insurance carriers for any services provided by AHCC.
- I acknowledge and understand that AHCC must maintain a record my health information and must protect the privacy of my health information as per the terms of the *Notice of Privacy Practices*. I understand and acknowledge that this policy is available for my review at any time at http://assurancehealth.org or upon request.
- I acknowledge and understand that I may terminate this *Patient Agreement* at any time and for any or for no reason by providing written notice to AHCC**.** Monthly fees will continue to accrue until written termination notice is received. Any pre-paid monthly care fees will be prorated to the date AHCC has received my written termination and refunded to me within ten (10) business days. AHCC will not terminate this *Patient Agreement* solely on the basis of health status.
- I acknowledge and agree to pay my monthly care fee on or before its due date. In the event that I am unable to pay my fee(s) on time, I understand that I will be charged a $25 late fee and that my service agreement may be terminated.
- In addition, I acknowledge and understand that Assurance may add or discontinue services or may increase my fee schedule at any time (but no more than once per year), and that I will be given, in writing, at least sixty (60) days notice of such fee schedule changes.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the Medicare Opt-out Agreement for review and signature prior to my first appointment. *(The Opt-out Agreement does not prevent me from receiving current or future Medicare benefits from non-AHCC providers; neither I nor my AHCC health care provider(s) will seek reimbursement from Medicare for the medical services I receive from AHCC)*

Rights & Responsibilities

- I understand that I have the right to receive accurate and easily understood information about AHCC's healthcare services, healthcare professionals and healthcare facilities. If I speak a language different from my clinician, have a physical or mental disability or do not understand something, I understand that AHCC will make their best effort to provide assistance so I can make informed healthcare decisions. If I require interpreter services beyond what can be provided by AHCC, professional interpreters may be provided at an additional cost to me.

- In the event of membership termination, I understand that I must complete a written Membership Cancellation Form. Any differences in payment between my billing date and the date of cancellation will be refunded to me via the payment method I have chosen for my monthly membership fee. I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my membership cancellation.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my AHCC clinician(s). I also understand that I am responsible for communicating clearly and respectfully with my clinician. Should I become dissatisfied with my care or AHCC's services, I agree to notify AHCC immediately so my concerns may be addressed in a timely manner.
- I understand that I have the right to know all of my treatment options and to participate in my healthcare decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions.
- I understand that I have the right to speak in confidence with my AHCC provider(s) and to have my healthcare information protected. I understand that AHCC will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review incomplete by contacting AHCC.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my healthcare clinician(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of healthcare services and facilities. I agree to first bring any complaints to the attention of AHCC staff and to participate in the AHCC complaint and grievance process. Unresolved complaints may be brought to the attention of the Office of the Insurance Commissioner for the State of Washington by calling the Consumer Advocacy department at (800)-562-6900 (TDD 360-586-6241) or by email at cad@oic.wa.gov.
- In order to receive the best possible care, I agree to be actively involved in my healthcare decisions and to disclose all relevant information to my AHCC healthcare clinicians(s) so they can help me achieve my health goals. I also agree to inform my AHCC health care clinician(s) of any healthcare services I receive outside of AHCC (such as emergency room, specialist, or hospital services).
- I understand that I am responsible for not exposing myself or others to disease or danger. I understand that I can receive information from my AHCC health care clinician(s) about protecting the health and safety of myself and others.

By signing below, I agree to become an Assurance Healthcare & Counseling patient / member & I agree to the terms outlined in this Patient Agreement.

Signature: Date:

Printed Name:

Signature by: ☐Patient ☐Parent ☐Legal Guardian

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Acknowledgement of Privacy Practices (HIPAA)

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of Assurance Healthcare & Counseling Center's (AHCC) Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Assurance Healthcare & Counseling Center has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I further understand that AHCC is not required to accept my requested restrictions, but if they are accepted than I understand that AHCC will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgment in order to receive treatment at AHCC.

Authorization to Communicate Protected Health Information – check all that apply:

☐ Assurance may leave a detailed message on voicemail at my home #: (_____)_____-_____

☐ Assurance may leave a detailed message on voicemail at my cell #: (_____)_____-_____

☐ Assurance may speak with another person (spouse, family member) about may medical condition

☐ including /

☐excluding information related to mental health, sexually transmitted disease, HIV status and reproductive medicine:

Name/Relationship: _____ phone#: (_____)_____-_____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify AHCC should I change one or more of the telephone numbers listed above.

_____ _____ _____/_____/_____

Signature | Patient (printed) name | Date of birth

_____ _____

Representative Name | Relationship to Patient

For administrative use only:

We are unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

☐ patient declined to sign ☐ Emergency situation ☐ communication barriers ☐other _____

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Private Contract – Medicare Opt-Out

I, Richard Edgerly, MD, have not been excluded from Medicare under [1128] §§1128, [1156] 1156 or [1892] 1892 of the Social Security Act.

I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by Assurance Healthcare & Counseling Center and Richard Edgerly, MD.

I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what Assurance Healthcare & Counseling Center and Richard Edgerly, MD may charge for items or services furnished.

I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask Assurance Healthcare & Counseling Center or Richard Edgerly, MD to submit a claim to Medicare.

I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by Assurance Healthcare & Couseling Center or Richard Edgerly, MD that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The expected or known effective date and expected or known expiration date of the opt-out period is January 1, 2014 (effective date) and December 31, 2015 (expiration date).

I the medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)

I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

I Richard Edgerly, MD will retain the original contract (original signatures of both parties are required) for the duration of the opt-out period.

I Richard Edgerly, MD will supply CMS with a copy of this contract upon request.

I Richard Edgerly, MD understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

*Signature required on next page....

_____ _____

Richard Edgerly, MD Date

_____ _____

Patient's Signature Date

_____ _____

Patient's Legal Representative Signature Date

_____

Patient or Legal Representative Printed Name