Patient Agreement & Disclosure Statement

Assurance
Healthcare & Counseling Center

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