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 F M

Date of Birth ______________________

Mobile Phone ______________________

Home Phone ______________________

Alternate Phone ______________________

Email Address

____

Emergency Contact Information

First Name ______________________

Last Name ______________________

Phone ______________________

Relationship to Member ______________________

Address (including City, State, Zip)

____

____

I wish to begin membership on (date)

____

Do you have health insurance? ○Yes ○No

***If yes*, please present card so we can make a copy**

We currently do not prescribe or manage pain medications. Please list current medications below (list more on back if necessary):

____

____

How did you hear about Assurance?
(Name of person, radio, Facebook, news, etc.)

____

____

Mail or drop off completed forms to:
Assurance Healthcare & Counseling Center
ATTN: Member Registration
3611 River Road, Suite 200
Yakima, WA 98902

Fax completed forms to:
509-823-4652

Email completed forms to:
info@assurancehealth.org

Assurance Membership Agreement

We want our membership to be clear to you, without all the confusing legal terms that come with contracts.

By signing at the bottom of this page, you are saying that you agree and understand all statements below and have reviewed and agree with our entire packet of registration forms, privacy forms, agreements and disclosures. Those forms are available at our clinic front desk or online at https://assurancehealth.org/disclosures

Agreement – find the longer version under *"Patient Agreement & Disclosure Statement"*

- I acknowledge and understand that I am voluntarily becoming a patient / member of Assurance Healthcare & Counseling Center, and that this agreement cannot be transferred to another person or entity.
- 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 read, understand, and agree with the Patient Agreement, mainly that in exchange for a monthly membership payment, I get the privilege of being a member at AHCC, that my records will remain private, and that I'll be honest about my health care history and decisions to help my provider better care for me.

HIPAA and Email Communication – find the longer versions under *HIPAA Agreement & Email Authorization*

Can we leave you a voicemail regarding private health information? (Circle one) Yes No

If yes, at what phone number(s)? ____

Can we speak to another person(s) about your medical condition that you mention below? (Circle one) Yes No

What about information regarding mental health, sexually transmitted disease, HIV status and/or reproductive medicine? (Circle one) Yes No

If we can speak to other people about your health, what are their names? (print names below)

____

Can AHCC email you regarding your health information? (Circle one) Yes No

If yes, write your email address, or put "same as in registration" ______________________________________

Billing Information and Authorization – find the longer versions under the same name

- AHCC has permission to automatically deduct my membership fee from the payment method I provide.
- AHCC has permission to automatically deduct any extra fees incurred that are $20 or less.
- AHCC will communicate with me prior to deducting any extra fees that are more than $20.
- I understand that there is a 6 month minimum membership requirement. Terminating membership early may result in early termination fees.
- I understand that I will be charged a $25 late fee for any membership dues not paid on time, and that membership dues that remain unpaid for 32 days will result in automatic termination of membership.

Account Holder Name (Print): ____ Date of Birth: _____________

Signature____ Date Signed: _____________

Please list any dependents (age 12 and under) that are included in this membership:

____