PACIFICA
MEDICINE & WELLNESS

Wellness Plus New Patient Registration

Patient Information

Last name: [ ] Male [ ] Female	First name:	MI:	DOB:
Home address:	City:	State:	Zip:
Billing address: [ ] Same as home	City:	State:	Zip:
Phone (home): ( )	Phone (cell): ( )	Phone (work): ( )	
Email address:			
I authorize Pacifica Medicine to email me re: my medical care: [ ] Yes [ ] No			
Employer:			
Emergency contact name:	Phone: ( )	Relationship:	
Medication allergies:			
Medications currently taking:			

Enrollment

Enrollment start date: / / (the 1st of next month)		
Enrollment type: [**X**] Wellness Plus		
Medical Insurance Company:	Insured Family Member:	
Insurance ID#:	Group ID #:	
How did you hear about Pacifica Medicine & Wellness?		

Billing Information

Please fill out for head of household only*

One-time registration fee: _____ adults (> 18 yo) x $100 = _____ *This fee can be charged to your credit or debit card (see next page) or you **can send a check** made out to **Pacifica Medicine & Wellness** with your registration paperwork*

Monthly Subscription cost per household: _____ people age 0-26 x $10 = $_____
_____ people age 26-49 x $30 = $_____
_____ people age 50-64 x $50 = $_____
_____ people age 65 & over $60 $_____
Total Monthly Subscription cost: $_____

NOTE: Monthly subscription fee will be charged on the 1st of the next month unless other date indicated here: ___/___/____.

BILLING OPTION 1 : Automatic Funds Transfer ** ***Please attach a voided check to this form****

Please note that it takes up to 3 days from the payment processing date before the charge posts to your bank account.

Name on account:

Bank name: Account type [ ] Checking [ ] Savings

Account number:	Bank routing number:

BILLING OPTION 2: Credit card or Debit card

Name on card:
Card type: [ ] Visa [ ]MasterCard [ ] Card number: Expiration: / /
Card billing address: [ ] Same as home [ ] Other:
3-digit code on card:
[ ] Please add me to the billing account of an existing Pacifica Medicine patient associated with the above credit card.

Authorization

Your monthly subscription fee covers Wellness Plus services specifically described in the *Pacifica Medicine & Wellness Patient Services Guide*. Any additional charges like insurance copays will be paid on the day of service.

By signing below, I hereby authorize Pacifica Medicine & Wellness to contact me using the information I have provided above.
By signing below, I hereby authorize Pacifica Medicine & Wellness to initiate charged to my credit card, debit card or bank account for my periodic membership fee. I understand that the transaction amount is the total of my care fee plus the care fees of any other individuals on my account.
I understand that my membership in Pacifica Medicine & Wellness is continuous and that, by signing below, I authorize recurring credit/debit charges or bank account funds transfers.
I understand that a $25 fee will be charged to me for a declined credit card, debit card or for an automatic funds transfer transaction that is not honored.

ACCOUNT HOLDER SIGNATURE: _____ **DATE:** / /

PLEASE MAIL COMPLETED FORMS TO:
Pacifica Medicine & Wellness
PO Box 2940
Poulsbo, WA 98370

Patient Agreement & Disclosure Statement

Terms

I acknowledge and understand that I am voluntarily becoming a Pacifica Medicine & Wellness patient and that this agreement is non-transferable.

I have reviewed the *Pacifica Medicine & Wellness Patient Services Guide* and I have had the opportunity to ask questions and receive answers regarding its content.

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 *Pacifica Medicine & Wellness Patient Services Guide*.

I acknowledge and understand that I am responsible for the monthly subscription fee and any charged incurred for health care services performed outside of Pacifica Medicine & Wellness, including but not limited to emergency room, hospital and specialty services, imaging services or laboratory tests sent to third party labs. The payment for adult vaccinations or shots administered at Pacifica Medicine & Wellness and for third party laboratory fees not covered by my insurance will be my responsibility and are due and payable at the time of service.

I acknowledge and understand that Pacifica Medicine & Wellness must maintain a record of 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 at pacificamedicine.com or upon request.

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.

I acknowledge and understand that my monthly subscription fee may increase based on the Pacifica Medicine age-based fee schedule. This increase would take effect the month after any qualifying birthday.

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 Pacifica Medicine & Wellness. **Monthly fees will continue to accrue until written termination notice is received.** Any pre-paid monthly care fees will be prorated to the date that Pacifica Medicine & Wellness has received my written termination and refunded to me within thirty (30) business days.

In addition, I acknowledge and understand that Pacifica Medicine & Wellness may terminate this *Patient Agreement* for cause due to non-payment of fees, or for unruly, threatening or inappropriate behavior by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and returned to me within thirty (30) business days. Pacifica Medicine & Wellness will not terminate this *Patient Agreement* solely on the basis of health status.

I acknowledge and understand that Pacifica Medicine & Wellness 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.

Rights & Responsibilities

I understand that I have the right to receive accurate and easily understood information about Pacifica Medicine & Wellness health care services, health care professionals and health care facilities. If I speak a language different from my clinician, have a physical or mental disability or do not understand something, I understand that Pacifica Medicine & Wellness will make its best effort to provide assistance so I can make informed health care decisions. If I require interpreter services beyond what can be provided by Pacifica Medicine & Wellness, 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 Service 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 care fee. I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.

I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Pacifica Medicine & Wellness health care 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 Pacifica Medicine & Wellness services, I agree to notify Pacifica Medicine & Wellness 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 health care 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 Pacifica Medicine & Wellness provider(s) and to have my health care information protected. I understand that Pacifica Medicine & Wellness 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 and receive a copy of my personal medical record and may request that my health care provider(s) amend my record if I feel it is inaccurate or incomplete by contacting Pacifica Medicine & Wellness.

I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care clinician(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities. I agree to first bring any complaints to the attention of Pacifica Medicine & Wellness staff and to participate in the Pacifica Medicine & Wellness complaint and grievance process.

In order to receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to my Pacifica Medicine & Wellness health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Pacifica Medicine & Wellness health care clinician(s) of any health care services I receive outside of Pacifica Medicine & Wellness (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 Pacifica Medicine & Wellness health care clinician(s) about protecting the health and safety of myself and others.

By my signature below, I agree to become a Pacifica Medicine & Wellness patient & I agree to the terms outlined in this Patient Agreement.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **Signed by [ ] Patient [ ] Parent [ ] Guardian**

Acknowledgement of Privacy Practices (HIPAA)

Acknowledgement

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 Pacifica Medicine & Wellness' Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Pacifica Medicine & Wellness has the right to change the Notice of Privacy Practices and that I may contact this office 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 health care operations. I further understand that Pacifica Medicine & Wellness is not required to accept my requested restrictions, but if they are accepted then I understand that Pacifica will honor my request unless it is an emergency.

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

Authorization to Communicate Protected Health Information - Check all that apply:
Pacifica may leave a detailed message on voicemail at my home #: (_____) _____
Pacifica may leave a detailed message on voicemail at my cell #: (_____) _____
Pacifica may speak with another person (spouse, family member) about my medical condition **including / excluding** information related to mental/behavioral health, substance abuse, sexually transmitted disease, HIV status and reproductive medicine: Name/Relation: _____ 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 Pacifica should I change one or more of the telephone numbers listed above.

PATIENT SIGNATURE: _____ **TODAY'S DATE:** / /

PATIENT NAME: _____**DATE of BIRTH:** / /

PATIENT'S REPRESENTATIVE: _____**TODAY'S DATE:** / /

RELATION 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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