Thrive Direct Health Care

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

Patient Agreement

Last modified 05/20/2020

Thrive Direct Health Care
708 E Morris ST, ste B
La Conner, WA 98257
www.thrivedirecthealthcare.com

Terms

• I acknowledge and understand that I am voluntarily becoming a Thrive Direct Health Care member for direct primary care (DPC) services on behalf of myself or individuals for whom I am a parent or legal guardian. I understand that this agreement is not made under duress and is non-transferable.

• I have received and reviewed the attached and separate documents labeled “Member Services Guide,” and “a la carte menu” which describes the types of services provided. I have had the opportunity to ask questions and receive answers about its content.

• I acknowledge and understand that the monthly membership fee is paid in consideration for the services outlined in the Member Services Guide. I understand that if my care requires services or supplies that are not included in my membership, the fees for these services or supplies will be discussed with me in advance and I will be responsible to pay these fees in full at the time of service.

• I acknowledge and understand that **this agreement does not provide comprehensive health insurance coverage** nor is it a contract of insurance. **It only provides for primary care health care and/or specialty pain management services as specifically described in the Member Services Guide.** I recognize that I am encouraged to obtain conventional private individual, catastrophic, or comprehensive health insurance or health share through a third party.

• I acknowledge and understand that the monthly fee paid to Thrive Direct Health Care does not cover the cost of prescription drugs, hospitalization costs, major surgery, dialysis, high level radiology (CT, MRI), rehabilitation services, or procedures requiring general anesthesia, or similar advanced procedures, services or supplies and that I am responsible for any charges incurred for those services performed outside of Thrive Direct Health Care. This Agreement is for ongoing primary care only, and the Patient may need to visit the emergency room or urgent care from time to time.

• The Healthcare Provider will make every effort to be available at all times via phone, email, other methods such as “after hours” appointments when appropriate, but Healthcare Provider cannot guarantee 24/7 availability. I acknowledge that I will attempt to use this access as appropriate based on urgency and need.

• I acknowledge and understand that Thrive Direct Health Care **will not** bill my insurance carrier. I understand that I may personally submit expenses to my insurance carrier for reimbursement of services and will need to pay a $10 administration cost of providing necessary codes.

• I acknowledge that my primary insurance is not Medicare Part B.

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Payment

• I acknowledge and understand that to become a Thrive Direct Health Care member, I must submit my enrollment forms, which shall include my authorization for automatic monthly payment of my monthly membership fee.

• I acknowledge and understand future membership fees will be automatically deducted on the 28th day of each month or closest business day. This day of the month is considered payment for that current month of services with or without actual use of services in that month. In the event payment is not received (ie., card decline or insufficient funds), Thrive Direct Health Care will notify me through my given contact information and will charge a $25 late fee for payments received after 5 business days past the due date unless prior arrangements are made prior to the due date. After 2 failed months of membership fees, membership will automatically be canceled and past due fees will need to be processed to bring membership back to balance.

• Membership dues and structure can only be changed once per year and all patients will receive a 60 day written notice prior to any changes to the membership fee schedule. Fees may only be changed once per year per current WA State DPC law (RCW 48.150).

• I acknowledge and understand that should I choose to pay membership fees ahead of time, my funds will be placed in a bank trust account per the terms set forth in current WA State DPC law (RCW 48.150) and upon cancelation date the unused prorated fees will be processed within 10 business days. See Cancellation policy below.

• I acknowledge and understand that according to current WA State law, I cannot use my Health Savings Account or Flexible Spending Account to pay for membership fees until this law is changed.

Cancellation of Membership Services

• I acknowledge and understand that Thrive Direct Health Care may add or discontinue services included in the fee at any time and for any reason with written notice.

• I acknowledge and understand that Thrive Direct Health Care may cancel this Member Agreement for cause due to non-payment of fees or for unruly, threatening, or inappropriate behavior by providing me written notice. Any pre-paid monthly fees will be prorated from the date of cancellation and returned to me within ten (10) business days as outlined in the Member Services guide. Thrive Direct Health Care will not cancel this Member Agreement solely on the basis of health status. The Patient may terminate the agreement at anytime and is required to provide notice of cancellation in writing. A cancelation form will be provided within 24-48 hours of notice. Should the Practice terminate the agreement, they shall give a written notice, thirty days prior to termination to the Patient and shall provide the patient with a list of other providers in the community in a manner consistent with local patient abandonment laws. The reasons for the Practice to terminate the agreement with the Patient includes:

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(a) The patient fails to pay the direct fee under the terms required by the direct agreement;

(b) the patient has performed an act that constitutes fraud;

(c) the patient repeatedly fails to comply with the recommended treatment plan;

(d) the patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct practice; or

e) the direct practice discontinues operation as a direct practice.

•Unless membership has been canceled, as set forth above the Agreement will automatically renew for successive monthly terms upon the payment of the monthly fee at the end of the contract month. Fees will automatically increase by age bracket per current set rates.

• I acknowledge and understand that I am free to cancel this Member Agreement at any time and for any unspecified reason by providing a written notice to

1. Thrive Direct Health Care, PO BOX 2104, La Conner, WA 98257 or
2. info@thrivedirecthealthcare.com or drwilson@thrivedirecthealthcare.com; or kay@thrivedirecthealthcare.com
3. via fax at 360.399.6870 or via mail slot on the door at the clinic location.

- **Monthly fees will continue to accrue on a daily basis until the written cancellation form is received.** Any pre-paid fees will be prorated to the date of cancellation and refunded to me within ten (10) business days.

• I acknowledge and understand that if I cancel this Member Agreement, I may not re-enroll until 3 months after the date of my written cancellation and I must have a paid visit within the same month of re-enrollment. Thrive Direct Health Care makes no representations that I will be able to re--enroll at some future date.

Rights and Responsibilities

• I agree to disclose all information relating to my health condition and to actively collaborate with my health care provider to understand my treatment options and develop the best course of action.

• I understand that my enrollment in Thrive Direct Health Care is a commitment to my ongoing health and wellness. I agree to commit to those plans for my medical care, which have been agreed upon by me and my provider. **I understand that I am an active member of my own health care and results are variable dependent upon my active participation in my health.**

• I understand that I will be forthright with regard to my prescription medication and my use of them.

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• I understand that it is my responsibility to ensure that Thrive Direct Health Care has correct and updated contact information (e.g. mailing address, email, phone etc.) for my account.

• I understand that it is my responsibility to inform Thrive Direct Health Care of any changes to my credit/debit card or bank account information to allow timely processing of payment.

• I understand that the monthly fee is intended to cover Thrive Direct Health Care provider's availability to provide services as well as the individual services provided and that the monthly fee is due for months under the Member Agreement even if I do not communicate with Thrive Direct Health Care providers or see them during a particular month.

• I understand that I am responsible for all bills associated with services provided outside the direct agreement, whether provided by Thrive Direct Health Care or another organization or individual.

• I agree to arrive on time for my appointment. If I do not arrive on time, my provider may not be able to spend as much time with me as I may need.

• I understand that I have the right to receive accurate and easily understood information about Thrive Direct Health Care health care services, health care professionals, and health care facilities.

• I understand that I have the right to speak in confidence with my Thrive Direct Health Care provider and to have my health care information protected. I understand that Thrive Direct Health Care 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 amend my record if I feel it is inaccurate or incomplete by contacting my Thrive Direct Health Care provider.

• In the event I wish to cancel my membership, I understand that **I must notify Thrive Direct Health Care in writing of my intent to cancel by methods mentioned above**. If my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation. If I pay in advance, any difference between the date of cancellation and the end of my billing cycle will be refunded to me via the payment method I have chosen for my monthly fee and within the Terms mentioned above in regards to reimbursement and according to the attached member service guide.

• I understand that if I am dissatisfied for any reason, I may contact the Office Manager, Kay Dalton-Ward, to address any complaints to kay@thrivedirecthealthcare.com or 360.630.5141; I agree to first bring issues to the attention of Thrive Direct Health Care and Dr Brianna Wilson, DNP.

•I understand that I may address any **unresolved** complaints 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 or by e-mail at cad@oic.wa.gov

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Membership Agreement Signatures

By my signature below, I agree to become a Thrive Direct Health Care member and I agree to the terms outlined in this Member Agreement. Parents or guardians of members under age 18 may sign on their behalf as their representative. A separate registration must be completed for each patient in a family. This Member Agreement will become effective when fully signed by the prospective Member and accepted by Thrive Direct Health Care.

Signature: _____ Date: _____

Primary Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

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Additional Membership Agreement Signatures

Signature: _____ Date: _____

Primary Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Primary Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Primary Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Primary Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Primary Member Name: _____DOB:_____

Signature by: ☐Member ☐ Parent ☐ Legal Guardian

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