Charis Care

Member Registration

23601 Highway 99, Suite A, Edmonds, WA 98026
(206) 714-4476 • (425) 732-4476 (fax)
www.charisclinic.com

Member Information

Last Name: Middle Initial: Home Address:

First Name: Suffix: Street:

Date of Birth: Male Female City: State: Zip:

Social Security :

Email:

May we communicate with you via email?

Preferred Phone: Billing/Mailing Address: ☐ Same as Home Address

Alternate Phone: Street:

City: State: Zip:

Emergency Contact #1

Name: Phone:

Relationship to Member:

Emergency Contact #2

Name: Phone:

Relationship to Member:

Insurance Information (If applicable)

Insurance Company:

Guarantor/Policy holder:

Subscriber ID #: Group Name: Group ID #:

Carrier Address: Carrier Phone:

Member Relationship to Policy holder? ○ Self ○ Spouse ○ Child ○ Other:

Fees

Set Up Fee:
The initial set up fee is $50. If a family registers at the same time, the total set up fee for all family members is $100. I**f a member ends his or her membership or lets the membership lapse, there will be another set up fee charged if the member wants to register again.**

Monthly Membership Fee:
The membership fee is as follows:

Child (ages 0-17)	$39/per month
Adult (ages 18-64)	$49/per month ($55/mo starting 1/1/2012)
Senior (ages 64+)	$59/per month

The membership fee must be paid by pre-authorized credit/debit card payments, which are described below.

Visit Fees:
There is no additional charge for up to six visits per year. (For example, if you register on May 15, 2011, there is no additional charge for up to six visits between May 15, 2011 and May 15, 201s.) **There is an additional visit fee of $10 per visit for each visit in excess of six visits per year.** The visit fee must be paid by cash, check or credit/debit card at the time of each visit. There are no visit fees for child immunization visits.

Incidental Fees:
The membership fee covers services stated in our Charis Care Member Services Guide. If your care requires supplies or services that are not covered by the membership fee, you will be responsible for those charges. In all cases, these supplies or services will be discussed with you in advance.

Member Registration Process

- At registration, you must pay the set up fee and the first month's membership fee.
- You may pay this amount by cash, check or credit/debit card. Please make checks payable to Charis Family Clinic. (A credit/debit card is required for the monthly membership fee.)

Recurring Payment Authorization

- I authorize payment of the membership fee every month from my credit/debit card for the following member:

  Member First and Last Name:

- I understand that the membership fee will be charged each month on the day that corresponds to my enrollment date, or as soon thereafter as practical. For example, if I register on June 15, the membership fee billing date will be the 15th of each month.
- I understand that my credit / debit card will be charged for any incidental fees that I incur or have incurred on my account since my last billing date.
- I understand that this authorization will remain in effect until Charis Family Clinic has received written notice from me for cancellation. I have the right to stop payment of a specific transfer if I give written notice to Charis Family Clinic at least 3 days before the scheduled withdrawal.
- I understand and authorize that a $25 fee will be charged to me for declined credit or debit card transactions. If this is not corrected within 5 days a $50 re-enrollment fee will also be charged. **I understand that I and I alone am responsible for keeping my credit/debit card information up to date. _____Initial**
- I understand that I will need to find another health care provider within 30 days of the date the clinic notifies me that my credit/debit card was declined (and payment not corrected). **_____Initial**

I understand and will comply with the above payment terms. I authorize Charis Family Clinic to initiate credit/debit card transactions as stated above. I authorize my financial institution to honor these transfers.

Printed Name_____
Signature_____ Date: _____

Charis Care
Member Agreement
Disclosure Statement

23601 Highway 99, Suite A, Edmonds, WA 98026
(206) 714-4476 • (425) 732-4476 (fax)
www.charisclinic.com

General Terms

- I understand that I am voluntarily entering into a direct agreement with Charis Family Clinic for primary care services on behalf of myself and or individuals for whom I am legal guardian. This agreement is non-transferable.
- I have reviewed the "Charis Care Member Services" guide, which describes the types of services provided. I have had the opportunity to ask questions and receive answers.
- **This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described. You are encouraged to obtain and maintain insurance for services not provided by Charis Care.**
- I understand that I pay a direct fee to Charis Family Clinic as consideration for providing primary care services. Primary care means routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury.
- I understand that the initial set up fee for enrollment is $50. If a family registers at the same time, the total set up fee for all family members is $100. **If a member ends his or her membership or lets the membership lapse, there will be another set up fee charged if the member wants to register again.**
- I understand that there is no additional charge for up to six visits per year. **There is an additional visit fee of $10 per visit for each visit in excess of six per year.** The visit fee must be paid by cash, check or credit/debit card at the time of each visit. There are no visit fees for child immunizations.
- I understand that Charis Family Clinic does not provide services, procedures, or supplies such as prescription drugs, hospitalization, specialty visits, chronic pain management, chemical dependency, major surgery, dialysis, radiology (X-ray, CT, MRI), rehabilitation services, or procedures requiring general anesthesia, or similar advanced services, procedures, or supplies.
- I understand and agree to pay my monthly membership fee in advance on the day each month that corresponds to my registration date. For example, if I register on June 15, 2010, the membership fee billing date will be the 15th of each month. In the event payment is not received, Charis Family Clinic will notify me through my given contact information. Failure to respond and deliver payment by the end of the month may result in immediate termination of membership.
- I understand that I am free to terminate this member agreement and my membership at any time by providing written notice to Charis Family Clinic, 23601 Highway 99, Suite A, Edmonds, WA 98026. Monthly fees will continue to accrue until written termination notice is received. Any pre-paid fees will be prorated to the date of termination and refunded to me within ten (10) business days.

Rights and Responsibilities

- I agree to disclose all information relating to my health condition and to actively collaborate with my health care provider(s) to understand my treatment options and develop the best course of action.
- **I understand that Charis Family Clinic will not bill any insurance carrier, Medicare or Medicaid for services covered under this agreement.**
- I understand that is it my responsibility to ensure that Charis Family Clinic has correct contact information (e.g., mailing address, phone, credit/debit card information) for my account.
- I understand that Charis Family Clinic will maintain the privacy of my health information in accordance with state and federal regulations regarding confidentiality of member records. This provision shall survive the termination of this agreement.
- I understand that Charis Family Clinic will not terminate this member agreement solely on the basis of health status. **Charis Family Clinic may decline to accept a member if the practice has reached its maximum capacity, or if the member's medical condition is such that the provider is unable to provide the appropriate level and type of health care services in the direct practice.**
- I understand that so long as Charis Family Clinic provides the member notice and opportunity to obtain care from another provider, the practice may discontinue care of members if the member has performed an act that constitutes fraud; the member repeatedly fails to comply with the recommended treatment plan; the member is abusive and presents an emotional or physical danger to the staff or other members of the direct practice; the member does not pay for services rendered; or Charis Family Clinic discontinues the "Charis Care" model of direct practice.
- I understand that I am responsible for all bills associated with services provided outside the direct agreement for primary care services. **We strongly encourage everyone to obtain conventional private individual, catastrophic or comprehensive health insurance.**
- I understand that Charis Family Clinic may terminate this member agreement and my membership by giving me written notice. In such a case, any pre-paid monthly care fees will be prorated to the date of termination and refunded to me within ten (10) business days. I understand that once my accounts with Charis Family Clinic are in good standing, I may re-enroll in the Charis Care program subject to the same terms of my original enrollment (i.e, payment of first month's membership fee and payment of set up fee).
- I understand that Charis Family Clinic may add or discontinue services included in the fee or increase my fee schedule at any time (but no more than once annually), and that I will be given at least sixty (60) days notice of such fee schedule changes.
- I understand that if I am dissatisfied for any reason I may contact Deonne Brown Benedict at Charis Family Clinic at drdeonne@charisclinic.com or 206-714-4476. 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 (TDD 360-586-6241) or by email at cad@oic.wa.gov.
- I understand that if I have an existing account with Charis Family Clinic, that account must be current before I am eligible for membership in Charis Care.

I agree to become a Charis Care member and I agree to the terms of this Member Agreement.

Signature _____ **Date**_____

Printed Name _____

Signature by: Member Parent Legal Guardian

Credit / Debit Card Information

Name on Credit/Debit Card:

Card Number:

Card Billing Address:

Card Billing Zipcode:

Expiration Date:

Card Type: Visa Mastercard (Please Circle)

Card Security (back of card):

Printed Name_____
Signature_____ Date: _____

Staff: Shred this page immediately after entry into secure system