SEQUIM MEDICAL ASSOCIATES, PLLP

This Agreement describes the terms under which you may participate in the Sequim Medical Associates, PLLP, program.

1. The Program. The Program provides *enhanced services* as an adjunct to our health care services, including:

- Regular newsletters
- Unhurried atmosphere
- Health education forums

The physicians who will provide services to Program participants may change from time to time. I wish my primary care physician to be:

☐ Militza Ausmanas, M.D.
☐ Samantha F. Reiter, M.D.
☐ David M. Lewis, D.O.
☐ William N. Hobbs, M.D.

2. Monthly Fee. The Monthly Fees for the Program are as follows; please check the appropriate box for your desired status:

☐ Individual 65 years of age or over $100.00

List patient name: _____

☐ Individual 21-64 years of age $85.00

List patient name: _____

You cannot transfer your participation in the Program to any other individual. The monthly fee for your participation in the Program will be increased only after providing you at least 90 days prior written notice.

For your convenience, Sequim Medical Associates, PLLP, will arrange for automatic withdrawal from your bank account or automatic credit card billing of program fees. If you wish to authorize either of these methods please complete the payment authorization card.

The Monthly Fee covers the cost of the enhanced services which are not covered by your health insurance.

3. Health Care Services Excluded From Monthly Fee. The Monthly Fee does not cover the cost of any health care services covered by your health insurance. The Monthly Fee does not cover the cost of any health care services if you have no insurance coverage. You and/or your health insurance company will be financially responsible for all health care services received from Program physicians and staff. The Program will bill your health care insurance for those health care services furnished to you and covered by your insurance. Your insurance coverage is as follows:

Primary Insurance:	**Other Insurance:**
COMPANY	COMPANY
NAME OF INSURED	NAME OF INSURED
GROUP NUMBER	GROUP NUMBER
IDENTIFICATION NUMBER	IDENTIFICATION NUMBER

You will notify the Program as soon as possible of any changes in the information listed above. Nothing in this Agreement supersedes or modifies the terms or conditions of any agreements relating to your insurance.

4. Co-payments. You will be financially responsible for any co-payments, co-insurance or deductible amounts due under your insurance. Co-payments are due at the time of health care service as required by your insurer. Payment for the amount set forth in the statement is due within 30 days of the date of billing.

You will be billed on a monthly basis for any charges for co-payments (if they were not collected at the time of the health care service), co-insurance or deductibles for health care services already received.

5. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state of Washington, and if any provision is held to be invalid or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, unless the provisions held invalid or unenforceable shall substantially impair the benefits of the remaining portions of this Agreement.

6. Termination. **You may terminate this Agreement and your participation in the Program at any time upon 30 days prior written notice to the Program**. The Program may terminate this Agreement and your participation in the Program by providing 30 days prior written notice to you, if any of the following occur: you fail to pay the Monthly Fee or charges for health care services when due; you fail to abide by the terms and conditions of your insurance coverage; or you fail to abide by the policies of Sequim Medical Associates, PLLP, and the Program. In addition, Sequim Medical Associates, PLLP, may terminate this Agreement at any time on 60 days' prior written notice if the Program is discontinued.

7. E-mail Communications. If you wish to receive e-mail communications from your provider, please consider the following information about e-mail communications and sign the consent to electronic communications below:

I understand that e-mail is not a secure medium for sending or receiving potentially sensitive personal health care information. Although communications between patient and physician are subject to confidentiality requirements of Sequim Medical Associates, PLLP, and applicable law, Sequim Medical Associates, PLLP, cannot assure the confidentiality or protection of e-mail communications. E-mail sent to Sequim Medical Associates, PLLP, may be accessed by individuals who are not directly involved in my care (for example, Sequim Medical Associates, PLLP, employees performing system administrative functions). E-mail sent to me may be accessed by others (for example, by my employer if my e-mail address is provided by my employer or by my internet service provider).

I understand that e-mail is not a good medium for urgent or time-sensitive communications. Time-sensitive communications should be handled by direct telephone contact or in person. At the discretion of my physician, e-mail communications may become part of my permanent medical record. I understand the e-mail information described above and authorize Sequim Medical Associates, PLLP, to send electronic mail to me at the following address: _____. I understand that I can revoke this consent at any time.

The undersigned agree to the terms of this Agreement.

CLIENT

ACCEPTED: SEQUIM MEDICAL ASSOCIATES, PLLP

SIGNATURE _____ BY: _____

NAME _____ ITS: _____

DATE _____

PAYMENT OPTIONS

***** A 2.5% convenience fee will be added to credit card transactions*****

PLEASE SELECT ONE: ☐ AUTOMATIC WITHDRAWAL ☐ CREDIT CARD

A. AUTO WITHDRAWAL ACCOUNT: ☐ CHECKING ☐ SAVINGS

ACCOUNT NUMBER: _____

ROUTING NUMBER: _____

BANK NAME: _____

****PLEASE ATTACH A VOIDED CHECK OR SAVINGS DEPOSIT SLIP**

B. CREDIT CARD: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

CARD NUMBER: _____BILLING ZIP _____

NAME ON CARD: _____EXP: _____SECURITY #_____

PLEASE SELECT ONE: ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY

SIGNATURE: _____ DATE: _____