Return Form to:

Reese Family Practice
Teleios Primary Healthcare Clinic
P.O. Box 40386
Eugene, OR 97404
Phone: 541-255-3905 Fax: 541-636-4339

Teleios Primary Healthcare Clinic

Membership Based Healthcare

Enrollment Form

Primary Member:

First Name:____________________Middle Initial:_______Last Name:________________________
Mailing Address:____
City:______________State:_______Zip:______________SSN:____________________________
Date of Birth:_____________ ☐ M ☐ F Home Phone: ______________Cell Phone:___________
Email Address:____
Billing Address: ☐ Same as Above ☐ Other:____
Emergency Contact: Name:______________________________Phone:_______________________
Relationship to Patient:____
Do you have additional members to enroll? ☐ Yes ☐ No (If yes, complete below.)

Additional Member:

First Name:____________________Middle Initial:______Last Name:________________________
Mailing Address ☐ Same as Above ☐ Other:____
Date of Birth:_____________ ☐ M ☐ F SSN:_________________________________
Home Phone: _________________Cell Phone:____________________
Relationship to Primary Member: ☐ Spouse ☐ Domestic Partner ☐ Child

Additional Member:

First Name:____________________Middle Initial:______Last Name:________________________
Mailing Address ☐ Same as Above ☐ Other:____
Date of Birth:_____________ ☐ M ☐ F SSN:_________________________________
Home Phone: _________________Cell Phone:____________________
Relationship to Primary Member: ☐ Spouse ☐ Domestic Partner ☐ Child

Additional Member:

First Name:____________________Middle Initial:______Last Name:________________________
Mailing Address ☐ Same as Above ☐ Other:____
Date of Birth:_____________ ☐ M ☐ F SSN:_________________________________
Home Phone: _________________Cell Phone:____________________
Relationship to Primary Member: ☐ Spouse ☐ Domestic Partner ☐ Child

Rev. 08/07/2017

Patient Agreement & Disclosure Statement:

Terms - I acknowledge and understand the following:

- I am voluntarily becoming a Reese Family Practice (RFP) Teleios Primary Healthcare Clinic (a retainer medical practice) patient and understand that this agreement is non-transferable.
- I have received the Membership Handbook, which describes the types of service provided by my RFP healthcare provider, the services not provided by my healthcare provider, as well as the general policies of RFP. I have had the opportunity to ask questions and receive answers regarding the content.
- **This agreement does not provide health insurance coverage nor is it a contract of insurance – it provides only the healthcare services specifically described** in the RFP Member Handbook.
- RFP encourages patients to obtain and maintain insurance for healthcare services not provided by Reese Family Practice.
- If I'm Medicare eligible I understand that any charges incurred for services at Reese Family Practice Teleios Primary Healthcare Clinc, including the office visit fee, may not be submitted to Medicare for payment Reese Family Practice or by the Medicare eligible patient.
- I am responsible for any charges incurred for healthcare services performed outside of RFP, including but not limited, to emergency room, hospital, and specialist care services.
- RFP will not bill my insurance carrier for any services provided by RFP as part of this Patient Agreement.
- The Teleios Primary Healthcare Clinic will be available to me for treatment on the first day of the calendar month following completion of the enrollment process. This process includes submitting a completed enrollment form, as well as payment of the first month's membership fees for all enrolled members.
- I am responsible for a $20.00 office visit fee when I use the Teleios Primary Healthcare Clinic.
- I will pay my monthly membership fee on the due date. In the event that I am unable to pay my fees on time, I understand that I will be charged an administrative fee and that my membership may be terminated.
- I am free to cancel this Patient Agreement at any time for any reason by providing written notice to RFP. **Monthly fees will continue to accrue until written cancellation notice is received.** If my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.
- I will be given at least sixty (60) days notice of any fee schedule changes.
- As a patient of RFP, my medical treatment is under the supervision of a medical doctor. I consent to any diagnostic imaging and/or laboratory procedures, medical treatments, or other services rendered under the general and/or special instruction of the provider.
- My medical record may contain information specific to drug/alcohol abuse and/or addiction, and/or mental health conditions, and/or HIV testing, and/or HIV positive diagnosis. Such diagnosis and treatment information may not be released without my specific consent. I may also withdraw my consent at any time. RFP will maintain the privacy of my health information as provided in the RFP Notice of Privacy Practices.
- There are federal/state and other agencies required to review, and on occasion copy, parts of my medical record for the purpose of assuring an acceptable standard of medical care. I consent to review of my medical record for these purposes alone.
- I have received a Notice of Privacy Practices, Patient Rights & Responsibilities, and information regarding the Opt-Out Statement in my member handbook.
- Reese Family Practice reserves the right to terminate this service with 60 days notice to its membership at any time.
- Failure to pay will result in my account being referred to a collection agency, which may affect your credit. Referral to a collection agency, no naming Reese Family Practice in bankruptcy filing, and you will be charged a processing fee and any applicable legal fees.

Member Signature:

By my (our) signature(s) below, I (we) have requested to become a RFP Teleios Primary Healthcare Clinic patient and I (we) agree to the terms outlined in this Patient Agreement & Disclosure Statement. (If the member is a minor or legally incompetent to sign for his/her own medical care, the parent or legal guardian may sign in his/her place for any of the above terms).

Primary Member Signature:_____

Printed Name:_____

Date:_____ Signature by: ○ Patient ○ Parent ○ Legal Guardian

Additional Members Must Also Sign Below:

Additional Member Signature:_____

Printed Name:_____

Date:_____ Signature by: ○ Patient ○ Parent ○ Legal Guardian

Additional Member Signature:_____

Printed Name:_____

Date:_____ Signature by: ○ Patient ○ Parent ○ Legal Guardian

Additional Member Signature:_____

Printed Name:_____

Date:_____ Signature by: ○ Patient ○ Parent ○ Legal Guardian

Payment Information:

The RFP Teleios Primary Healthcare Clinic will be available to you for appointments and treatment on the first day of the calendar month following completion of the enrollment process. This process includes submitting a completed enrollment form and payment of the first month's $65.00 membership fee for each enrolled member when there are up to three members in a household. For households of four or more members, the membership fee is $50.00 per month for each enrolled member. In addition, each office visit will cost $20. There is no fee to enroll; however, if a member cancels his or her membership and then reenrolls, there is a $99 charge to re-enroll. We will accept cash, check, or a credit/debit card for the initial membership fee. The ongoing monthly membership fee will be processed through automatic funds transfer (AFT) from a checking/savings account or through a credit/debit card transaction.

Payment of Membership Fees: Please select one of the following payment options for the first month membership fee(s). Credit Card payments will have a $2.00 charge added for its usage fee.

☐ Cash Enclosed ☐ Check Enclosed ☐ Bill my Credit/Debit Card (as listed below)
Credit Card/Debit Card O Visa O MasterCard O Discover Card

Card Number:_____ Expiration Date:_____3 Digit Code: _____

Name on Card:_____

Card Billing Address:_____City:_____State:_____Zip:_____

Recurring Monthly Transactions: The ongoing monthly membership fee will be charged to your account on the first business day of the month by the option selected below. Credit Card payments will have a $2.00 charge added for its usage fee. The best day of the month to bill me: □ 1st □ 15th

1) ☐ Credit Card/Debit Card O Visa O MasterCard O Discover Card

Card Number:_____ Expiration Date:_____3 digit code_____

Name on Card:_____

Card Billing Address:_____City: _____State:_____Zip:_____

2) ☐ Automatic Funds Transfer (**please attach a voided check to this form**)

Bank Name:_____Branch:_____

Address:_____City:_____State:_____Zip:_____

Bank Routing Number:_____Account Number:_____

Type: O Checking O Savings Name on Account:_____

Incidental Fees:

Your monthly membership and office visit fee covers general services, diagnostic testing, as set forth in the RFP Teleios Primary Healthcare Clinic Member Handbook. At times, however, your care may require durable medical supplies, medications, or third-party services that are not covered. **You will be responsible for these charges at the time of service.** In all cases, incidental items are charged at or near our cost and will be fully discussed with you in advance. You may pay for incidental items at the time of service using cash, check, or credit card.

Please initial here:

Authorization for Recurring Transaction:

- By signing below, I hereby authorize Reese Family Practice to initiate charges to my credit/debit card or by Automatic Funds Transfer (AFT) withdrawal as indicated above for my monthly membership fee.
- This authorization to initiate monthly charges to my credit/debit card or monthly AFT withdrawals will continue until Reese Family Practice has received written notification from me of my wish to cancel membership in such time and in such manner as to afford Reese Family Practice and my financial institution a reasonable opportunity to act on it.
- I understand that the transaction amount is the total of my membership fee plus the membership fee for all individuals on my account. I understand that Reese Family Practice needs to receive written notice at least seven (7) days before the first of the month in order to alter or cancel my scheduled payment; or if I have a credit/debit card number and/or expiration date change.
- I understand and authorize that a $25.00 fee may be charged to me for declined credit or debit card transactions that are not honored or for insufficient funds.

Primary Member Signature:_____ Date:_____

Printed Name:_____

Please tell us how you heard about this program:

- ☐ Radio (which station? _____)
- ☐ T.V. (which station? _____)
- ☐ Employer _____
- ☐ Friend or Family
- ☐ Website
- ☐ Other

For Clinic Use Only
Membership Effective Date:_____