Vitality Family Health

New Member Registration Form

Member Information

Primary Member

Last name: First name: DOB: [ ] Male [ ] Female

Home address: City: State: Zip:

Phone (cell): Phone (other): Email address:

Employer:

Please check one of the following, so we know which membership tier you will be at (Maintenance vs. Restorative):
[ ] I am not on any prescription medications (Maintenance).
[ ] I am on prescription medications and will transfer care so Vitality Family Health is the prescribing physician's office (Restorative).
[ ] I am on prescription medications, but I will get them prescribed at another physician's office (Maintenance).
[ ] I am not on prescription medications, but I would like to be at the Restorative tier to have access to unlimited visits.

Additional Members

If your spouse or partner is to become a member, please use the first slot, so we may get their contact information as well. If not, it is okay to use first slot for children. For any children 18 years of age or older, please provide their contact information in the designated slots.

1. Name: DOB: [ ] M [ ] F Relationship:

Phone (cell): Phone (other): Email:

Employer:

Please check one of the following, so we know which membership tier you will be at (Maintenance vs. Restorative):
[ ] I am not on any prescription medications (Maintenance).
[ ] I am on prescription medications and will transfer care so Vitality Family Health is the prescribing physician's office (Restorative).
[ ] I am on prescription medications, but I will get them prescribed at another physician's office (Maintenance).
[ ] I am not on prescription medications, but I would like to be at the Restorative tier to have access to unlimited visits.

2. Name: DOB: [ ] M [ ] F Relationship:

If 18+ years: Phone: Email:

3. Name: DOB: [ ] M [ ] F Relationship:

If 18+ years: Phone: Email:

4. Name: DOB: [ ] M [ ] F Relationship:

If 18+ years: Phone: Email:

5. Name: DOB: [ ] M [ ] F Relationship:

If 18+ years: Phone: Email:

Emergency Contact

Name: Relationship to member(s): Phone #:

Enrollment & Billing Information

Date I would like my membership with Vitality Family Health to begin:

One-time registration fee: $100 (per family, not per person)

BILLING: Credit Card or Debit Card – charged on the 1st day of enrollment and every month there after

Name on card: CC #:

Card type: [ ] Visa [ ] MasterCard [ ] Discover [ ] American Express [ ] Expiration:

Card billing address: [ ] Same as home [ ] Other:

I wish to pay my membership in full for the year in order to receive a 10% discount. [ ] Yes [ ] No, I wish to be charged monthly.

*We at Vitality will NOT bill insurance, but you may choose to let the lab companies bill your insurance for your lab work. We do not guarantee coverage when using insurance for labs since we are out of network for all insurance companies and it will be reliant on your particular plan. When using insurance for labs, all bills are final, and we will not resubmit a claim. Vitality Family Health is not responsible for any bills you may receive if you choose to use your insurance for labs. We do, however, offer wholesale cash prices for all labs and vaccinations. For vaccinations and labs, you may request a superbill to submit to insurance for credit and potential reimbursement. We cannot guarantee insurance reimbursement when you submit a superbill. Superbills will not be provided for any other services.

By initialing, I understand that I will pay for my labs and/or vaccines at the time of service. If I choose to have a lab company bill my insurance for lab work, I understand that I am responsible for any and all bills received. _____

Authorization

Your membership fee covers the Direct Primary Care services for your package (maintenance or restorative). At times, however, your care may require third-party services that are not covered by your monthly subscription fee. To streamline your appointment check-out please note that by providing the above billing information you authorize Vitality Family Health to automatically charge your credit card or draw from your bank account for any of these additional items at the time of service. In all cases, these additional items are charged at or near our cost and will be discussed with you in advance.

- By signing below, I hereby authorize Vitality Family Health to contact me using the information I have provided above.
- By signing below, I hereby authorize Vitality Family Health to initiate charges to my credit card, debit card, or bank account for my periodic membership fee (or pay in full for year to receive 10% discount) and any incidental fees that I incur or have incurred on my account since my last billing date. 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 with Vitality Family Health is continuous and that, by signing below, I authorize recurring credit/debit charges (If I chose to pay in full for the year to receive a 10% discount, I authorize Vitality Family Health to charge the one-time membership fee).
- If I paid in full for the year to receive the 10% discount and since the membership is continuous, I would like to:
  [ ] Charge my credit card in full after the first year is up (and for every year thereafter), so I may continue to receive the 10% discount unless I submit my Membership Service Termination Form 30 days before the next billing cycle.
  [ ] Begin charging my credit card once per month after the first year of my contract unless I submit my Membership Service Termination Form 30 days before the next billing cycle.
- I understand that a $25 fee will be charged to me for a declined credit card or debit card transaction that is not honored.

Primary Member's Signature: _____ **Date: _____**

Print Name: _____

Patient Agreement & Disclosure Statement

- I acknowledge and understand that I am voluntarily becoming a Vitality Family Health patient and that this agreement is non-transferable.
- 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 healthcare services specifically described on the Vitality Family Health website. The practice strongly encourages Members to maintain health insurance during the term of this membership agreement to cover services that are not provided by Vitality Family Health. Member should purchase health insurance to cover, at minimum, unpredictable and catastrophic expenses
- I acknowledge and understand that I am responsible for the monthly membership fee and any charges incurred for healthcare services performed outside of Vitality Family Health, including but not limited to emergency room, hospital and specialty services, imaging services or laboratory tests sent to third party labs. The payment for vaccinations or shots administered at Vitality Family Health 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 a superbill will be available upon request for potential reimbursement of vaccinations and lab work from my insurance company (NOT including Medicare, Medicaid and HMO plans). Vitality Family Health cannot guarantee reimbursement for any services.
- I acknowledge and understand that Vitality Family Health has opted out of participation in Medicare. This means that Medicare cannot be billed for any services performed by the Practice. I agree not to make any attempt to collect reimbursement from Medicare for any services provided by the Practice. Vitality Family Health also cannot be considered a Medicare Member's Primary Care Office and cannot prescribe any prescription medications for Medicare Members. Vitality Family Health will operate as a consultative wellness practice for all Medicare Members.
- I acknowledge and understand that Vitality Family Health 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 vitalityfamilyhealth.com or upon request.
- I acknowledge and agree to pay my monthly care fee on its due date. In the event that I am unable to pay the monthly Membership fee in full and on time or if a credit card is declined, I understand that I will be given one warning via phone and email. If the issue is not resolved within 7 days, a late fee of twenty-five dollars ($25.00) will be assessed for each week payment is not received. If the issue is not resolved by the start of the next monthly billing period, Vitality Family Health may, in its sole discretion, terminate a Membership Agreement for continued late fees or declinations of credit cards.
- I acknowledge and understand that my monthly membership fee may decrease or increase based on the Vitality Family Health's health-based fee schedule (e.g., Maintenance vs. Restorative). This decrease or increase would take effect the first month after spoken about with your healthcare provider(s).
- I acknowledge and understand that I will be with Vitality Family Health's membership practice for a minimum of one year in order to endure the full experience, and after the one-year mark, I may terminate this Patient Agreement at any time and for any or for no reason by providing a written Service Cancellation Form, which is available by Vitality Family Health. Monthly fees will continue to accrue until a written Service Cancellation Form is received at least 30 days before the next billing cycle.
- After one year of being a member, I understand that I may cancel my membership with at least 30 days notice by completing a written Service Cancellation Form, which is available from Vitality Family Health. If I cancel before completing my one-year contract, I understand that I will owe a cancellation fee equal to 50% of the remaining monthly fees of the one-year contract.
- In addition, I acknowledge and understand that Vitality Family Health 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 we reserve the right to send a member to collections for non-payment of fees. Vitality Family Health will not terminate this Patient Agreement solely on the basis of health status.
- I acknowledge and understand that I am eligible to receive medical services listed below, and I acknowledge and understand that there will be an additional fee outside of the monthly membership fee for any services indicated with a "**" after.

Primary Care Services	Specialty Services
○ Annual well checkups ○ Well woman exams ○ School & work physicals ○ Acute care visits ○ Lab work at wholesale pricing ** ○ Vaccinations (alternative schedules) at wholesale pricing ** ○ Dermabond for minor injuries ○ Suture & staple removal ○ Abscess drainage, wart removal, ear cleaning ○ Nebulizer treatments in office ○ Management of all chronic diseases ○ Visits lasting 30 to 90 minutes ○ Refills on medications ○ Electronic prescriptions directly to your pharmacy ○ 24/7 on call service ○ Pre-operative visits for any surgeries ○ Cancer Treatment Counseling & Support	○ HPA axis/adrenal testing ** ○ Up-to-date nutrition information ○ Food allergy and sensitivity testing ** ○ Regular classes on a variety of health & lifestyle topics ○ Micronutrient and oxidative stress testing ** ○ Advanced celiac and gluten testing ** ○ Extensive cardiac and diabetes lab testing ** ○ Neural antibody testing ** ○ Access to pharmaceutical grade supplements ** ○ Vaccine friendly ○ Medically supervised detoxification ** ○ Telemedicine for certain visits ○ Stool testing **

- I acknowledge and understand that Vitality Family Health may add or discontinue services or may increase or decrease 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.
- I understand that I have the right to receive accurate and easily understood information about Vitality Family Health's healthcare services, healthcare professionals and healthcare facilities. If I speak a language different from my provider(s), have a physical or mental disability or do not understand something, I understand that Vitality Family Health will make their best effort to provide assistance so I can make informed healthcare decisions.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Vitality Family Health provider(s). I also understand that I am responsible for communicating clearly and respectfully with my provider(s). Should I become dissatisfied with my care or Vitality Family Health's services, I agree to notify Vitality Family Health 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 healthcare 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 Vitality Family Health provider(s) and to have my healthcare information protected. I understand that Vitality Family Health 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 upon appropriate payment for these records and may request that my healthcare provider(s) amend my record if I feel it is inaccurate or incomplete by contacting Family Health.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my healthcare provider(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of healthcare services and facilities. I agree to first bring any complaints to the attention of Vitality Family Health's staff and to participate in the Vitality Family Health's complaint and grievance process.
- In order to receive the best possible care, I agree to be actively involved in my healthcare decisions and to disclose all relevant information to my Vitality Family Health healthcare provider(s) so that they can help me achieve my health goals. I also agree to inform my Vitality Family Health healthcare provider(s) of any healthcare services I receive outside of Vitality Family Health (such as emergency room, specialist, or hospital services).
- I understand that I am responsible for Vitality not exposing myself or others to disease or danger. I understand that I can receive information from my Vitality Family Health healthcare provider(s) about protecting the health and safety of myself and others.

By my signature below, I agree to become a Vitality Family Health patient, and I agree to the terms outlined in this patient agreement.

Primary Member's Signature: _____ **Date:** _____

TO BE COMPLETED AT OFFICE UPON REGISTERING

Name	Membership Type	Monthly Amount
Primary Member:	**[ ] Maintenance $150/mo** **[ ] Restorative $250/mo**	
	[ ] Maintenance $150/mo **[ ] Restorative $250/mo** **[ ] First Child $50/mo**	
	[ ] First Child $50/mo **[ ] Additional Child $25/mo**	
	[ ] Additional Child $25/mo	
	[ ] Additional Child $25/mo	
		TOTAL:

Notes:

Vitality Family Health Witness: _____ **Date:** _____