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

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

BILLING: Credit Card or Debit Card – charged on the 1st day of enrollment (prorated) and the first day of every month thereafter.

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 have 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

Date of Enrollment:	**Prorated Amount (Until 1st of Following Month):**	
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: ___________________________

HIPAA Notice

Name: ______________________ Date of Birth: ______________

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Responsibilities Under HIPAA

In the course of providing health care we generate, collect and share health-related information pertaining to our patients. Traditionally that information was kept confidential by ethical traditions and a patchwork of regulations that vary by state. We have certain responsibilities regarding that information due to Congressional enactment of HIPAA, the Health Insurance Portability and Accountability Act. Under HIPAA, all information in your medical record along with associated billing and payments plus other related demographic data which can be traced back to you as an individual is considered PHI (Protected health Information). This Notice explains how we use and disclose medical information about you and inform you of your rights to access and control that information.

Protected Health Information Uses and Disclosures

The following are examples of the types of uses and disclosures of your PHI that might occur. Some are more likely to happen than others, some may never happen. These examples are neither exhaustive nor an indication of what we intend to do. They are simply examples of the types of uses and disclosures that could be made by our medical practice without your permission as allowed by HIPAA.

- Medical Treatment
- Payment
- Health Care Operations
- Appointment and Patient Reminders
- Emergency Situations
- Research, Death, and Organ Donation
- Required by Law
- To Avert Serious Threat to Health or Safety
- Workers Compensation
- Oversight of Health and Public Policy
- Investigative, Government and Security Activities
- Lawsuits and Disputes
- Law Enforcement and Criminal Activity

Changes to this Notice - We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, top-center, the date of the last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

Complaints - If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Compliance Officer who will direct you on how to file an official complaint. All complaints must be submitted in writing, and all complaints shall be investigated without repercussion to you. You will not be penalized for filing a complaint.

Disclosures and Uses of PHI with your Written Permission - We will not disclose your PHI for any purpose not previously referenced in this notice without first obtaining your written authorization. When we need your permission, you may grant it by signing an authorization form. You may later revoke it in writing, except to the extent an action, use or disclosure was already performed as a result of your prior authorization.

Business Associates - Companies who provide services to our Practice who may have access to our patient's PHI will be required to sign a Business Associate Agreement protecting the Practice from PHI disclosures without authorization. An example of a business associate would be a medical transcription service.

Your Rights As Our Patient

Access to Your Health Information - You have the right to inspect and obtain copies of your PHI that may be used to make decisions related to our care for you, generally within 30 days. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your PHI, you must submit your request in writing to our Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying and mailing.

We may deny your request to access and disclose in certain very limited circumstances, such as when disclosure would reasonably endanger you or another person. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend - If you feel that the medical information we have about you in your records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing to the Compliance Officer, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If we believe that the PHI is already accurate and complete, we will deny your request. We will likely deny requests for amendment to any PHI that was not created by us (unless you provide reasonable evidence that the person or entity that created the information is no longer available to make the amendment). We cannot grant requests to amend PHI, which is not kept by the practice or which is not part of the PHI that you are permitted to inspect.

As part of your access right, you have the right to authorize and later revoke in writing the use or disclosure of your PHI to anyone for any purpose with limited exceptions. (See above section entitled Disclosures and Uses of PHI with Your Permission.)

Right to an Accounting of Disclosures - You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back. We will notify you of any cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions - You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received. Your request must be made in writing and (1) state what information is to be limited (2) to whom the restriction applies and (3) if the restriction applies to use, disclosure or both.

We are not required to agree to these additional restrictions, but if we do, we will comply with your request except in cases of emergency or when we are otherwise required to disclose the information by law.

Right to Request Confidential Communications - You have the right to request that we communicate with you about medical matters in a certain way or at a certain time. For example, you can ask that we only contact you at work or by mail, that we not leave voicemail messages, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of this Notice - You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

THE NAME OF OUR COMPLIANCE OFFICER CAN BE OBTAINED FROM THE RECEPTIONIST AT OUR OFFICE.

Signature: ______________________________ Date: ______________

Print name: ______________________________