Essential Health Access, P.A.

Member Agreement & Disclosure

Terms

- I acknowledge that I am voluntarily becoming an Essential Health Access, P.A. (EHA) patient and that this agreement is non-transferable.
- I have reviewed the EHA Membership Menu and I have had the opportunity to ask questions and receive answers regarding this content.
- I acknowledge that this **agreement does not provide comprehensive health insurance coverage** nor is it a contract of insurance. This agreement provides only the **health care services specifically described** in the EHA Membership Menu.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of EHA including but not limited to emergency room, hospital and specialty services.
- I acknowledge and understand that EHA 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 for my review at any time upon request.
- I acknowledge and agree to pay my monthly membership fee on or before the first day of the corresponding month. In the event that I am unable to pay my fee(s) on time, I understand that I will be charged a $25 late fee (if my membership fee is not paid within the first five (5) business days of the month) and that my service agreement may be terminated.
- I acknowledge and understand that I may terminate the Member Agreement at any time and for any reason by providing ninety (90) day written notice to EHA. I understand that my current monthly membership fee entitles me to receive EHA member services until the end of the month in which my last payment is received. Should I elect to re-enroll at a later date, I understand there will be a $150.00 re-enrollment fee assessed.
- In the event that EHA is unable to provide services promised, for any reason, there will be a prorated reimbursement of any fees paid in advance for that month.
- In addition, EHA may terminate this *Member Agreement* (with cause) by providing me written notice. With cause reasons for termination include but are not limited to fraudulence, abusive or violent behavior, lying, repeated episodes of non-compliance with treatment recommendations, non-payment for services received, or a failure of the patient-physician relationship. Any pre-paid monthly membership fees will be prorated to the date of termination and refunded to me within ten (10) business days. EHA will not terminate this *Member Agreement* on the basis of health status.
- I acknowledge and understand that EHA may add or discontinue services or may increase 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) day notice of such fee schedule changes.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the Private Contract with Medicare Beneficiary for review and signature before my first appointment. (Private Contract with Medicare Beneficiary does not prevent me from receiving current or future Medicare benefits from non-EHA providers; neither I nor my EHA health care provider(s) will seek reimbursement from Medicare for the medical services I receive from EHA.)

Rights & Responsibilities

- I understand that I have the right to receive accurate and easily understood information about EHA's health care services, health care professionals and health care facilities if I speak a language different from my clinician, have a physical or mental disability or do not understand something,
- I understand that EHA will make its best effort to provide assistance so I can make informed health care decisions. If I require interpreter services beyond what can be provided by EHA, professional interpreters may be provided at additional cost to me.
- I understand that if I receive services in any month before my monthly fee is paid, I am responsible for payment of that month's membership fee. My monthly payment entitles me to receive EHA services until the end of the corresponding month.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my EHA health care clinician(s).
- I also understand that I am responsible for communicating clearly and respectfully to my clinician. Should I become dissatisfied with my care or EHA services, I agree to notify EHA 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 health care 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 EHA provider(s) and to have my health care information protected. I understand that EHA 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 and may request that my health care provider(s) amend my record if I feel it is inaccurate or incomplete by contacting EHA.
- In order to receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to my EHA health care clinician(s) so they may help me achieve my health goals.
- I also agree to inform EHA health care clinician(s) of any health care services I receive outside of EHA (such as emergency room, specialist or hospital services).
- I understand that I am responsible for not exposing myself or others to disease or danger. I understand that I can receive information from my EHA health care clinician(s) about protecting the health and safety of myself and others.

By my signature below, I agree to become an Essential Health Access, P.A. Member and I agree to the terms outlined in this Member Agreement.

Signature: _____ Date: _____

Print Name:_____ Signature By: Patient____ Parent____ Legal Guardian____