SWEDISH

SWEDISH FAMILY MEDICINE – BALLARD

Patient Agreement

Terms

- ☐ I understand that I am voluntarily becoming a Swedish Family Medicine — Ballard patient.
- ☐ I have read the *Swedish Family Medicine — Ballard Home Guide to Patient Services* and understand what services are provided in the clinic.
- ☐ I understand that this agreement does not provide health insurance coverage. It provides only the health care services specifically described in the *Guide to Patient Services*.
- ☐ I understand that I am responsible for charges for health-care services outside of Swedish Family Medicine — Ballard. This includes but is not limited to specialty care, hospital and emergency services, medications, imaging and lab tests.

Rights and Responsibilities

- ☐ I understand that I have the right to choose my Swedish Family Medicine — Ballard provider.
- ☐ I understand that I have the right to considerate, respectful and nondiscriminatory care from my Swedish Family Medicine — Ballard providers. I understand I am responsible for communicating clearly and respectfully.
- ☐ I agree to call the clinic at least 24 hours before an appointment if I need to cancel so that other patients can use my visit time.
- ☐ I agree to arrive on time for my appointment. If I do not arrive on time, my provider may not be able to spend as much time with me as I may need.
- ☐ In order to receive the best possible care, I agree to be actively involved in my health-care decisions. I will let my Swedish Family Medicine — Ballard providers know about any health-care services I receive outside of Swedish Family Medicine — Ballard so that my provider can better serve my needs.

Patient Signature

By my signature below, I agree to the terms outlined in this Patient Agreement.

Patient Name _____

Date of Birth _____

Signature _____

Date _____

Consent for Minors

By my signature below, I agree to have _____ become a Swedish Family Medicine — Ballard patient and I agree to the terms outlined in this Patient Agreement.

Patient Name _____

Date of Birth _____

Name of Parent or Guardian _____

Signature of Parent or Guardian _____

Date _____

(continued)

For Patients Paying by Monthly Debit or Credit Card Withdrawal

- ☐ I understand that if I have health insurance, Swedish Family Medicine — Ballard will not bill my insurance or receive payment for services provided by Swedish Family Medicine — Ballard.
- ☐ I understand that I am responsible for informing the clinic of any changes to my credit or debit care information. If my card is declined, I will be charged for any services received.
- ☐ I understand that charges will be made to the card on file the first day of each month as long as I remain a patient. The first payment will be charged the first day of the first month after the patient's first visit.
- ☐ I understand that if this Patient Agreement is ended, the last automatic withdrawal from my credit or debit card for services will be on the first of the month following the end of the Agreement.
- ☐ I understand that Swedish Family Medicine — Ballard is not a drop-in clinic; my enrollment is a commitment to my ongoing health and wellness. Therefore, I agree to a minimum enrollment period of 6 months. If I end my enrollment during this period, I will be charged a $200 early termination fee.
- ☐ Swedish Family Medicine — Ballard reserves the right to increase enrollment fees at any time. You will be informed 30 days prior to any fee increase.
- ☐ You will be informed of any enrollment fees that may be due at the patient's initial appointment.

Authorization for Recurring Credit/Debit Transactions

To be Completed by Cardholder:

- ☐ I authorize Swedish Family Medicine — Ballard to charge my credit/debit card for the above named patient's monthly clinic fee. When my financial institution honors the transaction, this shall constitute my receipt for payment.
- ☐ I understand that the transaction amount is the total of my fee plus the fees of any family members included on my account.
- ☐ I understand that participation in Swedish Family Medicine — Ballard is continuous and that recurring credit/debit card charges will continue monthly until I provide Swedish Family Medicine — Ballard with written notice to discontinue such transactions.

Debit or Credit Card Information

To be Completed by Cardholder:

For security purposes, please show your card to the receptionist prior to the patient's appointment.

Card Holder Name_____

Billing Address_____

Phone Number_____

Signature _____

Date _____