Qliance
Primary Care Specialists

PATIENT REGISTRATION

PATIENT INFORMATION

Last name:	**First name:**	**MI:**	**DOB:**	**O Male**	**O Female**
Home address:		City:	State:	ZIP:	
Billing address: ☐ *Same as home.*		City:	State:	ZIP:	
Phone #1: ( ) O Home O Work O Cell		Phone #2: ( ) O Home O Work O Cell			
Email address:					
Emergency contact:		Phone: ( )	Relationship:		
Known allergies:		Current Medications:			

MEMBERSHIP

Membership Start Date: **Qliance Service Level:** O Level 1 O Level 2

Preferred clinician and clinic location: O Downtown Seattle O Kent Station O Mercer Island

Do you take medications regularly for pain, anxiety, sleep or ADD? O Yes O No

Please Note: *If you are taking a controlled substance regularly for any of these conditions, please see our controlled substance policy on the Qliance website or request a copy from Member Services to make sure that Qliance is right for you.*

How did you hear about Qliance? O Personal Referral: O TV/Radio:

O Internet: O Print Publication: O Other:

Do you have medical insurance? O Yes O No *If yes, please bring your ID card to your first visit so that we may expedite referrals and outside lab testing.*

BILLING

Billing Frequency: O Monthly O Quarterly O Semi-Annually O Annually

- **OPTION A: Credit Card or Debit Card**

Name on card:

Card type: O Visa O MasterCard O American Express	Card number:	Expiration:

Card billing address: ☐ *Same as home.*

☐ *Yes, please add me to the billing account of an existing Qliance patient associated with the above credit card:*

- **OPTION B: Automatic Funds Transfer**

Name on account:

Bank name:	Account type: O Checking O Savings
Account number:	Bank routing number: *(please attach a voided check to this form)*

AUTHORIZATION

Your monthly care fee covers the services described in the Qliance Patient Services Guide. At times, however, your care may require durable medical supplies or third-party services that are not covered by your monthly care fee. To streamline your appointment check-out, please note that by providing the above billing information you authorize Qliance to automatically charge your card or draw on your bank account for any incidental items at the time of service. In all cases, incidental items are charged at or near our cost and will be discussed with you in advance.

- By signing below, I hereby authorize Qliance to contact me using the information I have provided above. By signing below, I hereby authorize Qliance to initiate charges to my credit card, debit card or bank account for my periodic membership fee 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 individuals on my account.
- This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until Qliance has received written notification from me of its termination in such time and in such manner as to afford Qliance and my financial institution a reasonable opportunity to act on it.
- I understand that my participation in Qliance is continuous and that, by signing below, I authorize recurring credit/debit card charges.
- I understand and that a $25 fee will be charged to me for declined credit or debit card transactions that are not honored.

ACCOUNT HOLDER SIGNATURE: **DATE:**

OFFICE USE ONLY

Patient Number:	**Billing Number:**	**Registration Fee: $**	Date:

PATIENT AGREEMENT & DISCLOSURE STATEMENT

TERMS

- I acknowledge and understand that I am voluntarily becoming a Qliance Medical Group of Washington PC ("Qliance") patient and that this agreement is non-transferable.
- I have reviewed the *Qliance Patient Services* guide and I have had the opportunity to ask questions and receive answers regarding its content.
- 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 health care services specifically described** in the *Qliance Patient Services Guide.*
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of Qliance including but not limited to emergency room, hospital and specialty services and that Qliance will not bill insurance carriers for any services provided by Qliance.
- I acknowledge and understand that Qliance must maintain the privacy of my health information as per the terms of the ***Patient Privacy Policy***. I understand and acknowledge that this policy is available for my review at any time at www.Qliance.com or upon request.
- I acknowledge and agree to pay my monthly care fee on or before its due date. 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 and that my service agreement may be terminated.
- I acknowledge and understand that I may terminate this *Patient Agreement* at any time and for any or for no reason by providing written notice to Qliance. **Monthly fees will continue to accrue until written termination notice is received.** Any pre-paid monthly care fees will be prorated to the date Qliance has received my written termination and refunded to me within ten (10) business days.
- In addition, I acknowledge and understand that Qliance may terminate this *Patient Agreement* by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and refunded to me within ten (10) business days. Qliance will not terminate this *Patient Agreement* solely on the basis of health status.
- I acknowledge and understand that Qliance 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) days notice of such fee schedule changes.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the *Medicare Opt-out Agreement* for review and signature before my first appointment. *(The Opt-out Agreement does not prevent me from receiving current or future Medicare benefits from non-Qliance providers; neither I nor my Qliance health care provider(s) will seek reimbursement from Medicare for the medical services I receive from Qliance.)*

RIGHTS & RESPONSIBILITIES

- I understand that I have the right to choose my personal health care clinician and to change my clinician at any time, for any reason. I understand that all reasonable efforts will be made to accommodate my request, but only if my new clinician's patient panel is open to new patients.
- I understand that I have the right to receive accurate and easily understood information about Qliance'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 Qliance 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 Qliance, professional interpreters may be provided at an additional cost to me.
- In the event of membership termination, I understand that I must complete a **written Service Cancellation Form**. Any differences in payment between my billing date and the date of cancellation will be refunded to me via the payment method I have chosen for my monthly care fee. I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Qliance health care clinician (s). I also understand that I am responsible for communicating clearly and respectfully with my clinician. Should I become dissatisfied with my care or Qliance services, I agree to notify Qliance 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 Qliance clinician(s) and to have my health care information protected. 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 clinician(s) amend my record if I feel it is inaccurate or incomplete.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care clinician(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities. I agree to first bring any complaints to the attention of Qliance staff and to participate in the Qliance complaint and grievance process. Unresolved complaints may be brought to the attention of the Office of the Insurance Commissioner for the State of Washington by calling the Consumer Advocacy department at: (800) 562-6900 (TDD 360-586-6241) or by email at cad@oic.wa.gov.
- 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 Qliance health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Qliance health care clinician(s) of any health care services I receive outside of Qliance (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 Qliance health care clinician(s) about protecting the health and safety of myself and others.

By my signature below, I agree to become a Qliance Medical Group patient and I agree to the terms outlined in this Patient Agreement.

SIGNATURE: **DATE:**

PRINT NAME: **SIGNATURE BY:** O Patient O Parent O Legal Guardian