

**HIRSCH HOLISTIC FAMILY MEDICINE**

3525 Ensign Rd NE, Suite N, Olympia, WA 98506

PH: 360-464-9965 Fax: 888-897-8320

**PATIENT INFORMATION FORM**

Patient Name:		Birthdate:	Age:	<input type="checkbox"/> M <input type="checkbox"/> F
Address:			Height:	Weight:
Email:		City:		State: Zip:
Home Phone:		Work Phone:		Cell Phone:
Social Security#			Employer:	
Occupation:			Referred by:	
<b>PROVIDERS SEEN IN THE PAST TWO YEARS:</b>				
<input type="checkbox"/> I acknowledge/authorize HHFM to contact the providers listed, to receive copies of medical records, which may include laboratory, imaging, treatment notes or other sensitive medical history.  <input type="checkbox"/> I understand I have the right to revoke this authorization at any time. I understand that authorizing the disclosure of this health information is voluntary.  _____ Patient Initials	Name:		Phone:	
	Name:		Phone:	
	Name:		Phone:	
	Name:		Phone:	
	Name:		Phone:	
<b>PAYMENT OPTION (CHOOSE ONE):</b>				
<input type="checkbox"/> Insurance Program <input type="checkbox"/> Membership Program <input type="checkbox"/> Cash Pay <i>(If you selected Insurance or Membership Programs, please complete the appropriate agreement form.)</i>				
<b>INSURANCE INFORMATION (INSURANCE PROGRAM PARTICIPANTS ONLY):</b>				
Primary		Member ID/Subscriber #:		Group #:
Subscriber's name:		Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Subscriber DOB:
2 <sup>nd</sup> Insurance Name:		2 <sup>nd</sup> Member ID/Subscriber #:		2 <sup>nd</sup> Group #:
2 <sup>nd</sup> Subscriber's name:		2 <sup>nd</sup> Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		2 <sup>nd</sup> Subscriber DOB:
In Case of Emergency Notify:			Phone:	Relationship:
By assigning my signature, I affirm that the above is true. I hereby authorize the staff of Hirsch Holistic Family Medicine to consult, examine, perform, and treat the patient's problem(s). I understand that I am financially responsible for all charges incurred by me or my dependent.				
Patient's Signature (Parent/Guardian)			Dated:	

## INSURANCE PROGRAM AGREEMENT

This agreement is between Hirsch Holistic Family Medicine ("Physician"), whose principal place of business is 3525 Ensign Road NE, Suite N, Olympia, WA 98506 and patient(s) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ ("Patient(s)"), who resides at \_\_\_\_\_.

For all the services not covered by insurance reimbursement (Fee for Non-Covered Services– FNCS), the Patient(s) agrees to make payments to Physician at the rate of \$20 per month (\$40 per month for families). Patient(s) also agrees, understands and expressly acknowledges the following:

Initial:

	I have read the information about e-mail procedures and privacy and have received answers to all of my questions about using e-mail to communicate with Hirsch Holistic Family Medicine (HHFM).
	I have read the Practice Policies, Fees and Email Policies of Hirsch Holistic Family Medicine and have received answers to all of my questions regarding the contents therein. I understand that non-payment of the aforementioned fees is grounds for dismissal from the practice.
	I have read the Privacy Practice for Protected Health Information policy of Hirsch Holistic Family Medicine and have had all of my questions answered regarding its contents.
	I have received and reviewed the Patient Handbook, which outlines the general policies and customs of Hirsch Holistic Family Medicine. Further, I have had the opportunity to ask questions and receive answers regarding its content.
	I acknowledge and understand that all services provided by my Hirsch Holistic Family Medicine Physician and their staff will be within the community standards of medicine.
	I understand that I am responsible for my FNCS at a rate of <b>\$20 / \$40 per month (circle one)</b> . My FNCS will be paid on an annual/ quarterly / monthly basis. <b>NOTE: 5% discount for annual payment.</b>
	I acknowledge and understand that quarterly and monthly schedules require an automatic payment authorization and have completed the necessary paperwork.
	I acknowledge and understand that any and all FNCS refunds due will be processed within the policies and limitations expressed in the Patient Handbook.
	I understand that the Fee for Non-Covered Services pays for the availability of services that are not covered by my health insurance plan.
	I understand that I or my dependents are free to see a different doctor for medical care who does not charge this Fee for Non-Covered Services.
	I understand that this Fee for Non-Covered Services may be changed at any time with at least 3 months of advanced notice.
	I understand that I or my dependents may leave Hirsch Holistic Family Medicine at any time and for any reason. If I decide to leave this practice, I am entitled to a prorated refund of the Fee for Non-Covered Services only if all covered family members also leave the practice.
	I understand that HHFM is filing insurance on my behalf and that I am responsible for any patient portion as indicated by the contract with my insurance company and for any uncovered benefits.
	I authorize HHFM to keep my signature on file and to charge my credit card for any delinquent balances for which I am responsible after mailing of billing statement and non-payment for 30 days.
	I give consent to treatment by Evan H. Hirsch, MD, and any practitioners listed under HHFM.

\_\_\_\_\_  
Patient - Print

\_\_\_\_\_  
Patient - Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
HHFM Staff – Signature

\_\_\_\_\_  
Date

## MEMBERSHIP PROGRAM AGREEMENT

This agreement is between Hirsch Holistic Family Medicine ("Physician"), whose principal place of business is 3525 Ensign Road NE, Suite N, Olympia, WA 98506 and patient(s) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ ("Patient(s)"), who resides at \_\_\_\_\_.

In exchange for the **Membership Program Services**, the Patient agrees to make payments to Physician at a rate of \$\_\_\_\_\_ per month. Patient also agrees, understands and expressly acknowledges the following:

Initial:

	I have read the information about e-mail procedures and privacy and have received answers to all of my questions about using e-mail to communicate with Hirsch Holistic Family Medicine (HHFM).
	I have read the Practice Policies, Fees and Email Policies of Hirsch Holistic Family Medicine and have received answers to all of my questions regarding the contents therein. I understand that non-payment of the aforementioned fees is grounds for dismissal from the practice.
	I have read the Privacy Practice for Protected Health Information policy of Hirsch Holistic Family Medicine and have had all of my questions answered regarding its contents.
	I have received and reviewed the Patient Handbook, which outlines the covered and non-covered services of this membership as well as the general policies and customs of Hirsch Holistic Family Medicine. Further, I have had the opportunity to ask questions and receive answers regarding its content. I understand that this agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described.
	I acknowledge and understand that all services provided by my Hirsch Holistic Family Medicine Physician and their staff will be within the community standards of medicine.
	I acknowledge and understand that my membership does not entitle me to any and all medical services or treatments available unless medically indicated or necessary.
	I acknowledge and understand that quarterly and monthly schedules require an automatic payment authorization and have completed the necessary paperwork.
	I acknowledge and understand that I am free to terminate my relationship with Hirsch Holistic Family Medicine at any time with written notice of no less than 30 (thirty) days.
	I acknowledge and understand that Hirsch Holistic Family Medicine may terminate its relationship with me on 30 days written notice within the policies and limitations expressed in the Patient Handbook.
	I acknowledge and understand that any and all membership fee refunds due will be processed within the policies and limitations expressed in the Patient Handbook.
	I acknowledge and understand that this membership is non-transferable.
	I acknowledge and understand that I will not receive any compensation from my insurance company for services provided by the practice.
	I acknowledge that I WILL NOT submit to my insurance company for reimbursement any information detailing services from the practice and that I WILL NOT receive an invoice for services rendered by the practice for purposes of submission to my insurance. I understand that this is unlawful in this type of practice.
	I give consent to treatment by Evan H. Hirsch, MD, and any practitioners listed under HHFM.

\_\_\_\_\_  
Patient - Print

\_\_\_\_\_  
Patient - Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
HHFM Staff – Signature

\_\_\_\_\_  
Date

## CREDIT CARD AUTHORIZATION

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The following conditions apply to the recurring payments program:

1. If any payment is refused by a bank or credit card issuer you may no longer be eligible for recurring payments and may be discharged from Hirsch Holistic Family Medicine.
2. All future installment payments will be processed via recurring payments as required by the Hirsch Holistic Family Medicine Patient Handbook.
3. You may discontinue the recurring credit card plan anytime by providing Hirsch Holistic Family Medicine with 30 days written notice. Please be aware that Hirsch Holistic Family Medicine financial policy requires recurring Visa, MasterCard for all monthly and quarterly payments.

The undersigned authorizes Hirsch Holistic Family Medicine to debit my Visa or MasterCard for future payments AND for any outstanding balances due on my Hirsch Holistic Family Medicine *Insurance / Membership (circle one)*.

Please charge my card \$ \_\_\_\_\_ per month/quarter/year (circle one) for program services noted above.

I agree to make all future payments under this recurring charge authorization according to my credit card statement. I understand that my Hirsch Holistic Family Medicine membership will be subject to cancellation if my credit card is declined or if I contest any recurring charge made under this recurring payments authorization. **ALL RECURRING CHARGES WILL SHOW ON YOUR CREDIT CARD STATEMENT AS HIRSCH HOLISTIC FAMILY MEDICINE.**

Patient Name

Card Holder's name  
(as it appears on the card)

Credit Card Number

Visa  Mastercard

3 Digit Number from Back of Card

Expiration Date

Credit Card  
Billing Address

Street Address

City

State

Zip

Signature

Date

Please email me my transaction receipt to:

@