Lacamas Medical Group, PC
Family Practice, Urgent Care & Occupational Medicine

Patient Enrollment

Basic Information		
Last Name:	First Name:	Middle Initial:
Date of Birth:		Sex: □ Male □ Female
Home Address:	City: State:	ZIP:
Phone: ( )	Email address:	

Insurance Coverage

□ I do not have Medicaid coverage, Medicare, or other insurance coverage.

□ I have insurance AND my deductible* is more than $3000/individual. (Please fill out insurance information below↓.)

Insurance Carrier Name:	ID #:
Subscriber Name (Person with insurance coverage):	Group #:
Subscriber Date of Birth:	Relation to patient: □ Self □ Spouse □ Child □ Other: _____

Enroll Additional Members in Household:

Additional Adult #2	Last Name:	First Name:	Middle Initial:
	Date of Birth:		Sex: □ Male □ Female
	Alternate Phone (If different from above): ( )		
Child #1	Last Name:	First Name:	Middle Initial:
	Date of Birth:		Sex: □ Male □ Female
	Alternate Phone (If different from above): ( )		
Child #2	Last Name:	First Name:	Middle Initial:
	Date of Birth:		Sex: □ Male □ Female
	Alternate Phone (If different from above): ( )		

To register more children, attach an additional Patient Enrollment form with their information.

I certify that all the information provided by me on this form is true and correct.	
Print Name:	
Authorization Signature:	Date:

Revised:01/03/2014

Complete other side

Let us know…

I found out about Direct Primary Care from (Check all that apply):

□ Friends & Family
□ Another doctor/clinic
□ Newspaper / Magazine Ad
□ Mailer
□ Internet Ad
□ Other: _____

Membership & Billing Information

Desired Start Date:

Bill me using my (choose one only): □ Credit Card or Debit Card □ Bank Account

Credit Card or Debit Card Information

Card type: □ MasterCard □ Visa
(Other card types not accepted.)

Cardholder's name:

Card number:

Expiration Date—Month: Year:

Billing Address (if different from above):

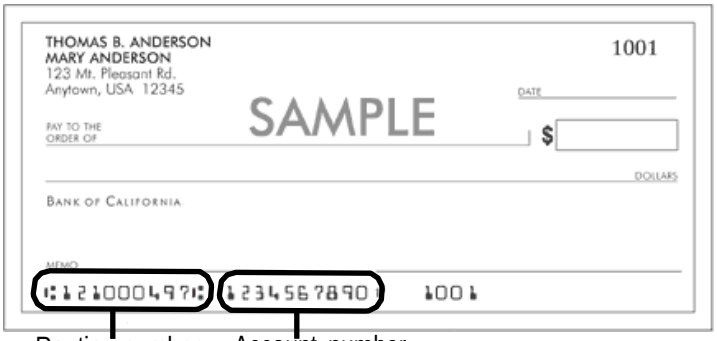
Bank Account Information

Account holder's name:

Bank name:

Account number:

Routing number:



Authorization Statement: I authorize Lacamas Medical Group to charge my credit card, debit card, or bank account on a recurring basis for my Direct Primary Care Membership until I have cancelled my membership in writing. If my credit card company or bank declines charges, then my membership is cancelled immediately until I make another payment.

Authorization Signature:

Date:

Questions? 360-838-2440

Please mail or FAX this form to:

Lacamas Medical Group, PC
3240 NE 3rd Ave
Camas WA, 98607
360-838-2450

Revised: 7/23/2013

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Required For Enrollment (one form per adult):

Patient Rights & Responsibilities

Member Rights

1. You have the right to respectful and fair service from Lacamas Medical Group (LMG) providers and staff. This care should be considerate of your cultural and personal beliefs. If you feel you have not been treated with respect, please talk to the clinic manager.
2. You have the right to be provided information concerning your health status, condition, and/or treatment options.
3. You have the right to refuse treatment and be informed about the potential consequences of the refusal.
4. You have the right to be informed, up front, about how much a recommended test or procedure will cost.
5. You have the right to an interpreter if you do not speak or understand English.
6. You have the right to cancel your membership. To cancel, you must fill out and turn in the Membership Cancellation Form.
7. You have the right to seek and maintain insurance coverage for services not provided by your membership.
8. If you have a serious dispute with the LMG Direct Primary Care program, you have the right to file a consumer complaint with the WA State Office of the Insurance Commissioner at PO Box 40256, Olympia, WA 98504-0256.

Member Responsibilities

1. Communicate respectfully to LMG providers and staff.
2. Provide complete and accurate information about past and current health status, any medications, any allergies, and any services received outside of the Direct Primary Care program (such as hospitalizations or visits to the emergency room).
3. Ask questions if you do not understand what the provider is saying about your medical status or treatment plan.
4. Come to appointments on time or call ahead if you cannot come to the appointment.
5. Tell LMG staff about changes in address, phone number, and health insurance information.
6. Provide current credit card, debit card, or bank account information to pay membership fees. If a charge is rejected by the bank, LMG will discontinue membership.
7. Following the treatment plan recommended by your provider.
8. Get x-ray and lab services from LMG Direct Primary Care location only.

Terms of Agreement

1. This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described in the Included Services List. LMG may make changes to the Included Services List from time to time. If any changes are made, LMG will inform you in writing.
2. LMG will not bill an insurance carrier for services covered under your membership.
3. LMG may change membership fees. If changes are made, LMG will give you 60 days' notice in writing.
4. LMG may terminate membership or the Direct Primary Care program at any time. You will be notified in writing, with 30 days' notice, of any such decisions.

Financial Policy

1. LMG will charge your credit card/debit card or deduct membership fees from your bank account on a regular basis. You are financially responsible for any procedure, test, or service provided that is not listed in the Included Services List.
2. LMG may make changes to the Included Services List from time to time. If any changes are made, LMG will inform you in
3. writing.
4. If charges are sent to collections due to non-payment, your DPC membership may be subject to review and cancellation.

Your Signature

1. I have read, understand, and agree to the Rights, Responsibilities, Terms of Agreement, and Financial Policy for the Direct Primary Care program.
2. I have had an opportunity to ask LMG staff any questions I have.
3. I agree to join the Direct Primary Care program at Lacamas Medical Group.

Print Name:	
Signature:	Date:

Mail to: Lacamas Medical Group, PC, 3240 NE 3rd Ave, Camas WA, 98607 **Phone**: 360-838-2440
Fax to: (360) 838-2450