



Member Contract

- I acknowledge and understand that I am voluntarily becoming an Trivas Family Medicine, PLLC (“Trivas”) patient and that this agreement is non-transferable.
- I have reviewed the Trivas 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 for comprehensive health insurance coverage nor is it a contract of insurance and that it provides only the health care services specifically described in the Trivas Patient Services Guide.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of Trivas including but not limited to emergency room, hospital and specialty services and that Trivas will not bill insurance carriers for any services provided by Trivas.
- I acknowledge and understand that Trivas 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 at www.trivasfamilymedicine.com or upon request.
- I acknowledge and agree to pay my monthly care fee on or before its due date. If 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 Trivas. Monthly fees will continue to accrue until written termination notice is received. Any pre-paid monthly care fees will be prorated to the date Trivas has received my written termination and refunded to me within ten (10) business days.
- In addition, I acknowledge and understand that Trivas 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. Trivas will not terminate this Patient Agreement solely on the basis of health status.
- I acknowledge and understand that Trivas 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-Trivas providers; neither I nor my Trivas healthcare provider(s) will seek reimbursement from Medicare for the medical services I receive from Trivas.)
- I understand that I have the right to receive accurate and easily understood information about Trivas'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 Trivas 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 Trivas, professional interpreters may be provided at an additional cost to me.
- In the event of membership termination, I understand that I must notify the practice in writing (email is sufficient) in advance of the date of termination. 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 Trivas 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 Trivas services, I agree to notify Trivas immediately so my concerns may be addressed in a timely manner.

- I understand that I in turn am obligated to treat Trivas staff and other members with consideration and respect and avoid threatening or abusive language or behavior. Such behavior may be grounds for placement on probationary membership status or immediate termination of membership, at the sole determination of Trivas staff.
- I understand that I have the right to know all 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 Trivas provider(s) and to have my health care information protected. I understand that Trivas 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 Trivas and requesting such an amendment.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my physician 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 Trivas staff and to participate in the Trivas 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.
- 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 Trivas health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Trivas health care clinician(s) of any healthcare services I receive outside of Trivas (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 Trivas health care clinician(s) about protecting the health and safety of myself and others.