Service Agreement with Dr. Dennis Galvon

The Program provides enhanced health care services, including:

- Same day appointments
- Forms completed
- Emails to / from Doctor
- Access to the Doctor after hours
- Extended visits for lifestyle coaching

Retainer Fees for the Program are as follows;

☐ **Individual 21 years of age or over** **$75.00 per month = $900 / year**

List patient name: _____

☐ **2nd Individual in same household** **$50.00 per month = $600 / year**

List patient name: _____

☐ **Family** **$125.00 per month = $1500 / year**

(No additional charge for children under 21 years of age, as long as at least one adult over 21 is in the Program.)

List patient names: _____

_____

_____

You may change your status as an individual or family at any time on 30 days notice. You cannot transfer your participation in the Program to any other individual. The monthly fee for your participation in the Program may be increased only after providing you at least 90 days prior written notice.

Health Care Services Excluded From Retainer Fee The retainer fee covers the cost of enhanced services not covered by your health insurance. It does not cover the cost of any health care services covered by your health insurance nor does it cover the cost of any health care services if you have no insurance coverage. You and/or your health insurance company will be financially responsible for all health care services received from Dr. Galvon. The office will bill your health care insurance for those services furnished and covered by your insurance.

Primary Insurance:	Other Insurance:
COMPANY	COMPANY
NAME OF INSURED	NAME OF INSURED
GROUP NUMBER	GROUP NUMBER
IDENTIFICATION NUMBER	IDENTIFICATION NUMBER
INSURANCE COMPANY PHONE NUMBER	INSURANCE COMPANY PHONE NUMBER

Please notify the office of any changes in the information listed above, as soon as possible. Nothing in this Agreement supersedes or modifies the terms or conditions of any agreements relating to your insurance.

Co-payments. You will be financially responsible for any co-payments, co-insurance or deductible amounts due under your insurance. Co-payments are due at the time of office visit as required by your insurer. Payment for the amount set forth in the statement is due within 30 days of the date of billing.

Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state of Washington, and if any provision is held to be invalid or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, unless the provisions held invalid or unenforceable shall substantially impair the benefits of the remaining portions of this Agreement.

Termination. You may terminate this Agreement and your participation in the Program at any time upon 30 days prior written notice to the Program. The Program may terminate this Agreement and your participation in the Program by providing 30 days prior written notice to you, if any of the following occur: you fail to pay the Monthly Fee or charges for health care services when due; you fail to abide by the terms and conditions of your insurance coverage; or you fail to abide by the policies of Dr Dennis Galvon and the Program. In addition, Dr Dennis Galvon may terminate this Agreement at any time on 60 days prior written notice if the Program is discontinued. At termination, the Monthly Fee will be prorated based on the number of days you have participated in the Program.

E-mail Communications. If you wish to receive e-mail communications from your provider, please consider the following information about e-mail communications and sign the consent to electronic communications below:

I understand that e-mail is not a secure medium for sending or receiving potentially sensitive personal health care information. Dr. Galvon cannot assure the confidentiality or protection of e-mail communications. E-mail sent to Dr. Dennis Galvon may be accessed by individuals who are not directly involved in my care (for example, employees performing system administrative functions).

I understand that e-mail is not a good medium for urgent communications. Time-sensitive communications should be handled by direct telephone contact or in person. E-mail communications may become part of my permanent medical record. I understand the e-mail information described above and authorize Dr Dennis Galvon to send electronic mail to me at:

e-mail address: _____@_____

I understand that I can revoke this consent at any time.

The undersigned agree to the terms of this Agreement.

PATIENT

SIGNATURE _____

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE NUMBER (WITH AREA CODE) _____

DATE _____

ACCEPTED: Dr Dennis Galvon

BY: _____

ITS: _____

Payment - *Frequency and Options*

1. □ **ANNUAL** **= $900 individual or $1500 couple / family**

2. □ **SEMI-ANNUALLY** **= $450 individual or $750 couple / family**

3. □ **QUARTERLY** **= $225 individual or $375 couple / family**

   Please provide one of the following for your payment.

   i. **Credit Card:** **□ VISA** **□ MASTERCARD**

   Card Number: _____

   Expiration: _____ **Zip Code: _____**

   ii. **Check / Cash enclosed _____**

4. □ **MONTHLY** **= $75 individual or $125 couple / family**

   Please provide one of the following for your payment.

   i. **Credit Card:** **□ VISA** **□ MASTERCARD**

   Card Number: _____

   Expiration: _____ **Zip Code: _____**

   Please note: all monthly payments are due by the 10th of the month. We will process your card payment before the 10th of each month.

   ii. **Automatic "Bill Payer" or automatic check. We accept automatic payments made directly from your bank account each month. You will set this up from your account. See your bank for details.**

SIGNATURE: _____DATE: _____

Dr Dennis Galvon 4423 Point Fosdick, Suite #212, Gig Harbor, WA 98335 Tel: 253-851-8545