Service Agreement with Dr. Dennis Galvon

The Program provides enhanced health care services, including:

* Emergent Same Day Appointments
* Access to the Doctor After Hours
* Forms Completed
* Extended Visits for Lifestyle Coaching
* Emails to/from the Doctor

Retainer Fees for the Program are as follows:

☐ **Individual** **$90.00 per month OR $1000 per year**

List patient name: _____

☐ **Couple** **$150 per month OR $1700 per year**

List patient name: _____

(This plan also includes children under eighteen (18) living in the home.)

☐ **Family** **$175.00 per month OR $2000 per year**

(Up to five (5) adult (over 18) family members on the same policy, regardless of home address.)

List patient names: _____

_____

_____

☐ **Homebound (in own home or residential care facility)** **$125 per month OR $1400 per year**

You may change your Plan from an Individual to a Family Plan at any time with 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 90 days' prior written notice.

Healthcare 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 healthcare services covered by your health insurance, nor does it cover the cost of any healthcare services if you have no insurance coverage. You and/or your health insurance company will be financially responsible for all healthcare services received from Dr. Galvon. The office will bill your health 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 NAME_____
IDENTIFICATION NUMBER_____	IDENTIFICATION 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.

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

Governing Law: The Program 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 Program.

Termination: You may terminate this agreement and your participation in the Program at any time with 30 days' prior written notice. The office 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: failure to pay the Monthly Fee or any charges for healthcare services when due; failure to abide by the terms and conditions of your health insurance coverage; or failure to abide by the policies of Dr. Galvon and the Program. In addition, Dr. Galvon may terminate this agreement with 60 days' prior written notice if the Program is discontinued.

E-mail Communication: If you wish to receive e-mail communications from Dr. Galvon, 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 healthcare information. Dr. Galvon cannot assure the confidentiality or protection of e-mail communications. E-mail sent to Dr. 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. Galvon to send electronic mail to me at:

e-mail address:
_____@_____

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

The undersigned agrees 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- *Plan and Frequency Options*

(Please circle your choice.)

	Individual	Couple	Family	Homebound
Monthly	**$90**	**$150**	**$175**	**$125**
Quarterly	**$270**	**$450**	**$525**	**$375**
Bi-Annually	**$500***	**$850***	**$1000***	**$700***
Annually	**$1000***	**$1700***	**$2000***	**$1400***

***Price reflects discount.**

Please provide one of the following for your payment:

i. Credit Card: ☐ VISA ☐ MASTERCARD

Name on Card: _____

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.

iii. Check/Cash enclosed: _____

SIGNATURE:_____ DATE:_____