



Patient Membership Agreement

This agreement is between Dr. Erin Kershisnik and or Dr. Samantha Ritchie ("Physician"), whose principal place of business is Vantage Physicians, 3703 Ensign Road Suite 10A, Olympia, WA 98506 and patient _____ ("Patient").

In exchange for the Membership Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

Initial each line that applies to you:

_____ 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 Vantage Physicians. Further, I have had the opportunity to ask questions and receive answers regarding its content. (*Available in office*)

_____ I acknowledge and understand that all services provided by my Vantage 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 will be enrolling as a member at a rate of \$_____ per month. My membership fees will be paid on an annual/ quarterly / monthly basis. (*pls circle*)

_____ 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 my membership fees will be held in an escrow account and will not be dispersed to Vantage Physicians until the 1st day of the month following the month enrolled.

_____ I acknowledge and understand that I am free to terminate my relationship with Vantage Physicians at any time with written notice of no less than 30 (thirty) days.

_____ I acknowledge and understand that Vantage Physicians 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.

_____ For CHPW, Molina, and Group Health Patients (except Group Health Options): Some insurance plans will not allow Vantage Physician doctors to make referrals because we are not on their list of providers. This applies to insurance plans such as Community Health Plan of Washington (CHPW) or Molina. It also applies to Group Health (except Group Health Options). In other words, if you have one of these insurance plans and need a referral to a specialist, to physical therapy, for massage or medical equipment, etc., you will need to see another primary care provider who is part of your insurance plan in order to get that referral.

_____ For DSHS Patients (including CHPW, Molina, and other Healthy Options Plans or GAU/categorically needy state sponsored plans): When our patients with DSHS insurance are hospitalized and we are their primary doctor in the hospital, DSHS does not pay the hospital for the patient's stay. If you are hospitalized, we will continue to visit you and keep careful track of what goes on in the hospital, but we will need to have you admitted under the hospitalist program at Providence St. Peter Hospital. The hospitalists will bill DSHS for your daily visits.

_____ For Medicare Eligible Patients: I acknowledge and understand that I have received a copy of the Medicare Beneficiary Addendum Agreement for review and signature before signing this agreement.

_____ For Non-Primary Members: I acknowledge and understand that my membership is under the primary membership of _____ at a reduced rate. I acknowledge and understand that should the primary membership be terminated by either the Patient or Vantage Physicians and I choose to remain a member, my enrollment rate and fees may increase within the policies and limitations expressed in the Patient Handbook.

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| Patient Signature | Office Staff Witness |
| Printed Name | Date |