Reinier Van Coevorden, M.D.
RVC Medical
1301 4th Ave NW, suite 204
Issaquah, WA 98027

Concierge Practice Patient Agreement

You have decided to participate in concierge practice with Dr. Van Coevorden RVC Medical. This agreement describes the terms of your participation in the "***Concierge Program***."

1. Our Services.

The following enhanced services ("***Concierge Services***") are provided as an adjunct to the standard health care services provided through your current health insurance plan:

a. Same-day or next-day office visits including routine follow-ups and urgent care visits with Dr. Van Coevorden.
b. Secure messaging (via private network email* to Dr. Van Coevorden or any staff member) for timely answers to routine questions.
c. Dr. Van Coevorden's private cell phone number for after-hours urgent calls.
d. Online appointment scheduling requests through secure email/messaging.

*You are responsible for your own internet access, all necessary hardware and software for such access, and all associated costs.

Secured messaging will be available to Concierge Program participants on-line via private and secure username and password. Through secure messaging, you can request appointments online, you're your electronic health records, and message your doctor directly. SECURE MESSAGING IS NOT A GOOD MEDIUM FOR URGENT OR TIME SENSITIVE COMMUNICATIONS. TIME-SENSITIVE COMMUNICATIONS SHOULD BE HANDLED BY DIRECT TELEPHONE CONTACT OR IN PERSON. Secured messaging communication between you and Dr. Van Coevorden may become part of your permanent medical record.

After hours cell phone access to Dr. Van Coevorden is intended for the sole purpose of providing urgent advice for acute medical illness.

If Dr. Van Coevorden is not readily available for any reason (i.e. holiday, vacation, illness, etc.), another medical provider will be available to you to consult with for urgent matters by phoning the office of Dr. Van Coevorden.

2. Patient Information.

Please provide us with the following information about yourself and any other family members who will be Concierge Program participants.

Patient Name:_____ Last, First, Middle Initial Date of Birth:__/__/____ Gender: (circle) F / M Social Security Number:_____	Address:_____ City:_____ State:_____ Zip:_____

Home phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____

Emergency Contact Name: _____	Emergency Contact Phone: _____

How would you prefer we contact you? (circle one) Letter / Phone / Secure Messaging

Insurance – Primary:	_____ Carrier	_____ Subscriber ID#	_____ Group ID#
Insurance – Secondary:	_____ Carrier	_____ Subscriber ID#	_____ Group ID#
Responsible Party (if different than Patient):_____			
Address:_____			
Phone:_____			

If additional family members or dependent children are participating in the Concierge Program, please provide the following:

Name:_____ Last, First, Middle Initial	Relationship:_____ Spouse/Dependent/Other	Date of Birth: ____/___/____ Mo./Day/Year
Name:_____ Last, First, Middle Initial	Relationship:_____ Spouse/Dependent/Other	Date of Birth: ____/___/____ Mo./Day/Year
Name:_____ Last, First, Middle Initial	Relationship:_____ Spouse/Dependent/Other	Date of Birth: ____/___/____ Mo./Day/Year
Name:_____ Last, First, Middle Initial	Relationship:_____ Spouse/Dependent/Other	Date of Birth: ____/___/____ Mo./Day/Year

Name:_____ Last, First, Middle Initial	Relationship:_____ Spouse/Dependent/Other	Date of Birth: ____/___/____ Mo./Day/Year

3. Payment Information.

Your payment for participating in the Concierge Program is only applied to charges associated with the Concierge Services set forth above. The monthly fee does not apply to charges associated with any other healthcare services outside of the Concierge Services, including but not limited to charges for exams and office visits ("***Healthcare Services***"). All charges for Healthcare Services will be billed to your health insurance company and you will be responsible for any coinsurance, copayment, deductible and/or amount due.

The following monthly fees will be charged for the Concierge Services, payment for which is due by the first day of each month:

a. $120 per individual adult patient;
b. $200 for 2 or more family members (same household); and
c. $275 for immediate and extended family (up to 2 other extended family members outside immediate household).

Please initial below to indicate which payment method you prefer.

____ Please charge the $120* fee to my credit card monthly for me
____ Please charge the $200* fee to my credit card for me and my family monthly
____ Please charge the $275* fee to my credit card for me and extended family monthly
____ Please find enclosed the annual payment of $1440* for me
____ Please find enclosed the annual payment of $2400* for me and my family
____ Please find enclosed the annual payment of $3,300* for me and my extended family
____ Please find enclosed the semi-annual payment of $720* for me
____ Please find enclosed the semi-annual payment of $1200* for me and my family
____ Please find enclosed the semi-annual payment of $1650* for me and my extended family

*Your initial payment is due at the time of registration, but will be prorated if registration is after the first day of the month of registration. You will be given at least 90-days advance written notice for any changes in the monthly fee for participation in the Concierge Program or changes in the Concierge Services.

Please provide your credit/debit card information:

Card type: □ Visa □ MasterCard □ American Express □ Other _____
Card number: _____
Name on Card: _____
Expires: _____ Security Code:_____

Cardholder's billing address:
Address: _____
City: _____
State/Zip: _____

Authorization for recurring Credit/Debit Card Transactions

I authorize Dr. Van Coevorden to charge my credit/debit card for my fee and the fees for any family members included on my account. I understand that my participation in the Concierge Program under this Agreement is continuous and that recurring charges are authorized and will continue until I provide written notice to discontinue such charges as provided above.

4. Health Insurance and Medicare

The Concierge Services covered by the monthly fee are not intended to replace your existing individual health insurance plan or benefits. By signing this Agreement you are agreeing that you will be financially responsible for the cost of all Healthcare Services provided by Dr. Van Coevorden that are not covered and paid by your individual health insurance plan, unless they are identified as a Concierge Service in Section 1 above. Dr. Van Coevorden will continue to bill your individual health insurance plan provider for all services covered under your individual health insurance plan.

5. Governing Law

This Agreement is governed and construed according to the laws of the State of Washington, and if any provision is held to be invalid or unenforceable, the remaining provisions will nevertheless continue in full force and effect.

6. Termination; No Assignment

Dr. Van Coevorden may cancel your participation in the Concierge Program at any time by providing at least 30-days advance written notice to you at your address provided in this Agreement. Likewise, you may cancel your participation in the Concierge Program at any time by providing at least a 30-days written notice to Dr. Van Coevorden. You will be responsible for all fees up through the date of cancelation and any advanced payments made for future Concierge Services covered beyond the 30 day notice period will be refunded. Participation in the Concierge Program is personal to you and may not be assigned.

Please Carefully Read the Following Statement Before Signing
By signing this Agreement I am agreeing to participate in the Concierge Program as outlined above. I authorize treatment for myself and for my dependents, if applicable. I agree to pay all fees associated with participation in the Concierge Program as specified above. If I am signing as an agent or as responsible party for a patient, I understand and agrees I am obligated to pay for the fees associated with the Concierge Program participant(s) identified in this Agreement.

PATIENT:

_____
Signature
Printed Name: _____
Date: _____

RESPONSIBLE PARTY:

_____
Signature
Printed Name: _____
Date: _____