Patient Enrollment Form

Basic Information

Last Name: ______________________________ First Name: _______________________________

Date of Birth: ____________________________ Sex: □ Male □ Female

Home Address: ____

City: _____________________________________ State: _________________ ZIP: ____________

Phone: (_____)_____-_____________ Email address:_________________________

□ I do not have Medicaid coverage, Medicare, or other insurance coverage.

□ I have insurance AND my deductible* is more than $3000/individual. (Please fill out insurance information below ↓.)

Members in Household

Last Name: _______________________ First Name: _______________________ Middle Initial:___

Date of Birth: ____________________________ Sex: □ Male □ Female

Alternate Phone *(If different from above)*: (_____)_____-_____________

Last Name: _______________________ _______________________ Middle Initial:___

Date of Birth: ____________________________ Sex: □ Male □ Female

Alternate Phone *(If different from above)*: (_____)_____-_____________

Last Name: _______________________ _______________________ Middle Initial:___

Date of Birth: ____________________________ Sex: □ Male □ Female

Alternate Phone *(If different from above)*: (_____)_____-_____________

Last Name: _______________________ _______________________ Middle Initial:___

Date of Birth: ____________________________ Sex: □ Male □ Female

Alternate Phone *(If different from above)*: (_____)_____-_____________

RNFNP
Real Nurturing Family Practice

I certify that all the information provided by me on this form is true and correct.

Print Name: ____

____	____________________
Authorization Signature	Date

Membership & Billing Information

Desired Start Date: ___________	Bill me using my *(choose one only)*: ☐ Credit Card or Debit Card ☐ Bank Account

Credit Card or Debit Card Information	Bank Account Information
______________________________	____
Card type: ☐ MasterCard ☐ Visa *(Other card types not accepted.)*	____ Account Holder's Name
Cardholder's name:_________________	Bank name: ___________________________________
Card number: ______________________	Account number: ______________________________
Expiration Date: Month: __________ Year: ______	Routing number:_______________________________
Billing Address (if different from above): ______________________________ ______________________________	

Routing number Account number

Authorization Statement: I authorize Real Nurturing Family Practice to charge my credit card, debit card, or bank account on occurring basis for my Direct Prime Care Membership until I have canceled my membership in writing. If my credit card company or bank declines charges, then my membership is canceled immediately until I make another payment.

Authorization Signature: ________________________________	Date:____________________

Required For Enrollment *(one form per adult)*:

Patient Rights & Responsibilities

Member Rights
1. You have the right to respectful and fair service from Real Nurturing Family Practice providers and staff. This care should be considerate of your cultural and personal beliefs. If you feel you have not been treated with respect, please talk to the clinic manager. 2. You have the right to be provided information concerning your health status, condition, and/or treatment options. 3. You have the right to refuse treatment and be informed about the potential consequences of the refusal. 4. You have the right to be informed, up front, about how much a recommended test or procedure will cost. 5. You have the right to an interpreter if you do not speak or understand English. 6. You have the right to cancel your membership. To cancel, you must fill out and turn in the Membership Cancellation Form and membership will be cancelled within 30 days of notice. 7. You have the right to seek and maintain insurance coverage for services not provided by your membership. 8. If you have a serious dispute with the Real Nurturing Prime Care program, you have the right to file a consumer complaint.

Member Responsibilities

1. Communicate respectfully to Real Nurturing Family Practice providers and staff.
2. Provide complete and accurate information about past and current health status, any medications, any allergies, and any services received outside of the Direct Prime Care program (such as hospitalizations or visits to the emergency room).
3. Come to appointments on time or call ahead if you cannot come to the appointment.
4. Tell RNFP staff about changes in address, phone number, and health insurance information.
5. Provide current credit card, debit card, or bank account information to pay membership fees.
6. Following the treatment plan recommended by your provider.

Terms of Agreement

1. This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described in the Included Services List. RNFP may make changes to the Included Services List from time to time. If any changes are made, RNFP will inform you in writing.
2. RNFP will not bill an insurance carrier for services covered under your membership.
3. RNFP may change membership fees. If changes are made, RNFP will give you 60 days' notice in writing.
4. RNFP may terminate membership or the Direct Primary Care program at any time. You will be notified in writing, with 30 days' notice, of any such decisions.

Financial Policy
1. RNFP will charge your credit card/debit card or deduct membership fees from your bank account on a regular basis. You are financially responsible for any procedure, test, or service provided that is not listed in the Included Services List. 2. RNFP may make changes to the Included Services List from time to time. If any changes are made, RNFP will inform you in writing. 3. If charges are sent to collections due to non-payment, your membership may be subject to review and cancellation.
Your Signature:____
1. I have read, understand, and agree to the Rights, Responsibilities, Terms of Agreement, and Financial Policy for the Prime Care program. 2. I have had an opportunity to ask RNFP staff any questions I have. 3. I agree to join the Prime Care program at Real Nurturing Family Practice.
Print Name: ____
Signature: ___________________________________ Date: ______________

Mail to: Real Nurturing Family Practice
10730 Barker Cypress Rd.
Set C #234 Cypress, Tx 77433

Phone: (713) 714-6343

Fax to: (832) 831-8335

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