ACHIEVE Concierge

Exceeding your wellness expectations

Name_____Address_____

City, State, Zip_____ Phone _____

Email Address: _____

This Agreement describes the terms under which you may participate in the Achieve Concierge practice.
The Achieve Concierge program provides premier service amenities including:

- Same day or next day appointments with your private provider
- Timely Appointments and extended appointment time
- Personalized Concierge Coordinator

1. **Annual Fee.**

	New	**Existing**
Individual	$2,800	$2,500
Couple	$5,000	$4,500
College Students	$1,800	$1,500
Children 18 under	$2,500, each additional child $1,200	$2,500 each additional child $1,200

2. **Insurance.**
   Primary Insurance: _____ ID _____
   Secondary Insurance: _____ ID _____
   Insurance will be billed for all services including office visits, phone consultations and skype sessions.

3. **Co-Payments/Co-Insurance/Deductibles.**
   You will be financially responsible for any co-payments, co-insurance, or deductible amounts due under your
   insurance.

   Mastercard Visa Discover American Express

   Card Number _____ Expiration Date _____ CVC _____

   I certify that I have read the foregoing, received a copy of thereof, and accept its terms.

   _____ _____
   Patient or patient's agent, representative or responsible party Date

CONSENT FOR TREATMENT

I hereby authorize and request Achieve Medical Center, Professional Corporation, to carry out psychiatric and psychological examination, evaluation, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that these are subject to my agreement. I fully understand that while the course of my treatment is designed to be helpful, Achieve Medical Center, Professional Corporation, can make no guarantees whatsoever about the outcome of my treatment. I also understand that the psych pharmacotherapeutic process can initiate and bring up uncomfortable feelings and reactions including, but not limited to anxiety, sadness, anger and physical side effects. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be jointly worked on between my therapist and me.

Patient/Guardian Signature: _____Date _____

GENERAL CONSENT TO TREATMENT IN CASE OF DEPENDENT/CHILD/MINOR

I am the legal guardian and/or representative of the patient and on the patient's behalf legally authorize Achieve Medical Center, Professional Corporation, to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Signature of Guardian/Legal Representative: _____ Date _____

Relationship to Patient: _____

PATIENT ARBITRATION AGREEMENT The contract below is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather that a suit in court. I believe the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts. By signing this agreement, you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings. Of course, my goal is to provide medical care in such a way as to avoid any such disputes. I know that most problems begin with communication. Therefore, if you have any questions about your care, please ask me.

By signing this agreement, the patient agrees with the provider that any dispute between you and Achieve Medical Center and any dispute relating to medical services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whomever made (including, to the full extent permitted by applicable law, third parties who are not signatories to this agreement) shall be resolved by binding arbitration. Any award of the arbitrator(s) may be entered as a judgment in any court having jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective and the remainder of the agreement shall remain effective. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

This agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. This provision for arbitration may be revoked by written notice delivered to the physician within 30 days of signature.

If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

Patient/Responsible Party Initials: _____

The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the physician, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

Patient Name _____

Signature of Patient or Responsible Party (if Patient is a Minor) Date _____

HIPPA NOTICE OF PRIVACY PRACTICES

A federal law, known as the "HIPAA Privacy Rule" requires that we tell you how we may use and give out personal health information about you to others. This summary will tell you what out Privacy Notice contains.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION

We may use and share personal health information that is protected (PHI) to you or your personal representative. We may use and share this information:

For healthcare treatment that doctors, nurses and other clinicians give you For certain business activities called "health care operations" and For payment.

Some examples of how we may use and share PHI about you without your written permission including sharing information:

To report abuse, neglect, or domestic violence

To prevent a serious threat to your other's health or safety

To prevent public health problems

To agencies that audit, investigate and inspect health programs for the public's health For lawsuits and other legal proceedings For research To the Government for specialized purposes, such as military or national security; and For worker's compensation.

YOUR RIGHTS You have the following rights as described in our Notice:

The right to ask us if we will put more limits on the way we use and share PHI about you

The right to share confidential communications from us

The right to see and get a copy of PHI about you

The right to ask us for a report that describes how and with whom we share PHI about you.

If you have any questions regarding your rights or privacy, please inquire with our office or reference http://www.hhs.gov/ocr/privacy. I hereby acknowledge that I have read a copy of this HIPAA Notice of Privacy Practices. I further acknowledge that I may obtain a copy if requested.

PATIENT (PRINT): _____

SIGNATURE: _____ DATE:_____

FOR PATIENTS UNDER THE AGE OF 18: RESPONSIBLE PARTY (PRINT):

_____

RELATIONSHIP TO PATIENT: _____

SIGNATURE:_____DATE:_____