Advocate Health Care, PLLC

Renée Woods, MD

Membership Agreement

This Agreement is between Advocate Healthcare, PLLC, a Washington professional limited liability company, located at 4702 Summitview Ave Suite 102, Yakima, WA 98908 (AHC), and you (Member). Renée Woods, MD is acting as an agent of AHC and shall be referred to as the "Practitioner."

The Agreement is entered into based upon the following:

- The Practitioner and/or other duly authorized membership of AHC have determined the Member is a candidate for membership at AHC.

- The Practitioner, who specializes in Functional Medicine, delivers care on behalf of AHC at the address set forth above.

- AHC, through its Practitioner and its staff, agrees to provider Member with a collection of services as part of its consultation membership (Membership) as set forth in Appendix 1 of this Agreement.

- Therefore, in consideration of the mutual agreements between the parties and for other good and valuable consideration, the parties hereto agree as follows:

Terms

This agreement shall commence on the date signed by the parties below and shall continue for a period as indicated by the membership type selected and set forth in Appendix 1 (12 to 18 months), automatically renewed.

Fees

In exchange for the Membership described herein, Member agrees to pay AHC the amount as set forth in Appendix 1, based on the level of membership that is mutually agreed upon.

*Initials*_____

Patient / Member Cooperation

By signing this Agreement, the Member acknowledges AHC and the Practitioner are using a systematic yet customized functional medicine approach to the Member's assessment, evaluation and treatment. A functional medicine approach is a participatory one that requires active participation and cooperation by the Member to achieve the best outcomes. This includes attendance at one-on-one visits and group programs, following mutually agreed upon lifestyle behavioral modifications, and compliance with nutraceutical and prescription recommendations.

No Guarantee of Results

The Member understands that AHC and the Practitioner cannot guarantee results. Rather, AHC provides a model that is based on a systematic approach that will allow members to take control of their health to achieve the desired results. AHC provides practitioners and mentors who have been trained in functional medicine and health coaching to help Members reach their own health goals by implementing positive, sustainable lifestyle changes. If the Member is under the care of another practitioner, the Member should discuss any dietary changes or potential dietary supplement use with his/her primary care physician if he/she desires, and should not discontinue any prescription medications without first consulting his or her prescribing physician.

Member recognizes this Agreement is not a guarantee of results and deals solely with the services to be rendered and the fees to be paid for the care as provided. The Member's payment obligation is not contingent upon the outcome of care.

Non-Participation in Insurance

Member acknowledges that neither AHC, nor the Practitioner participate in any health insurance or HMO plans or panels. Neither AHC nor the Practitioner make any representations whatsoever that any fees paid under this Agreement are covered by your health insurance or other third-party payment plans applicable to the Member. The Member shall retain full and complete responsibility for any such determination and payment of any fees. If the Member is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Member will notify Practitioner or the Practitioner's staff immediately.

Termination

The Member may discontinue care and terminate this Agreement at any time by written notice to that effect delivered to AHC. Such "notice of termination" shall discharge AHC from all further obligations and/or duty to render care to the Member. AHC reserves the right to terminate this Agreement at any time.

Should termination occur prior to the applicable membership commitment and terms, termination fees may apply, which can be found in Appendix 1.

*Initials*_____

Communications

You acknowledge that communications with the Physician using email, fax, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. As such, you (Member) expressly waive the Practitioner's obligation to guarantee confidentiality with respect to correspondence using such means of communication. You (Member) acknowledge that all such communications may become a part of your medical records.

Assumption of Risk

The Member acknowledges that the Member takes full responsibility for the Member's life and well-being, and all decisions made during and after this program.

The Member expressly assumes the risks of the Membership, including the risks of trying new foods or supplements, and the risks inherent in making lifestyle changes.

Confidentiality

The Practitioner will keep the Member's information private and will not share the Member's information to any third party unless required by law.

Complete Agreement

This Agreement, along with the Member Registration, Consent to Treat Form, Billing Authorization, Cancellation & No Show Policy, and Lab Review Policy contains the complete agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement. This Agreement will not be changed or modified in any way unless agreed to by both parties in writing.

Severability

If any provision of this Agreement or the application thereof to any Member, Practitioner, Person or circumstance shall be invalid, illegal or unenforceable to any extent, the remainder of this Agreement and the application thereof shall not be affected and shall be enforceable to the fullest extent permitted by law.

Waivers

With the above acknowledgments made and understood, I, the Member, hereby agree to expressly assume and accept any and all risks of injury, regardless of severity, or death with regard to the Membership, AHC and the Practitioner. I agree to be solely responsible for my own safety and to take every precaution to provide for my own safety and well-being while participating in a Membership program or treatment or any work with AHC or Practitioner.

*Initials*_____

In consideration of AHC's and Practitioner's agreement to allow me to participate in any Membership program or treatment, to the fullest extent as allowed by law, I do here now, for myself, my heirs and assigns, forever release and discharge and hereby hold harmless AHC and the Practitioner and their respective agents, owners, members, heirs, assigns, contractors, and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in this or any consultation, treatment or program with AHC or Practitioner, advice or work with AHC and Practitioner, or the preparation for any such work including but not limited to any injuries resulting there from except those caused by the gross negligence of AHC or the Practitioner.

THIS WAIVER AND RELEASE OF LIABILITY INCLUDES, WITHOUT LIMITATION, INJURIES WHICH MAY OCCUR AS A RESULT OF (1) EQUIPMENT BELONGING TO AHC, PRACTITIONER OR TO MYSELF THAT MAY MALFUNCTION OR BREAK; (2) ANY SLIP, FALL, DROPPING OF EQUIPMENT; (3) AND/OR NEGLIGENT INSTRUCTION OR SUPERVISION.

In the event any claim is deemed to be unwaivable by law or the determination of a court or arbiter, the limit of may damages shall be the amount paid for any services or $500.00, whichever is greater. In addition, I hereby waive the right to any consequential damages and any action I bring shall be against AHC only, and not the Practitioner and recovery limited to the assets of AHC and not any owner, shareholder, partner, employee or manager.

I ACKNOWLEDGE THAT I HAVE THOROUGHLY READ THIS FORM IN ITS ENTIRETY AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY AND A LIMIT OF ANY DAMAGES. BY SIGNING THIS DOCUMENT OR ACCEPTING IT ELECTRONICALLY, I AM WAIVING ANY RIGHT I OR MY SUCCESSORS MIGHT HAVE TO BRING A LEGAL ACTION OR ASSERT A CLAIM AGAINST PRACTITIONER FOR YOUR NEGLIGENCE OR THAT OF YOUR EMPLOYEES, AGENTS, OR CONTRACTORS.

Name: _____

Signature: _____

Date: _____

Advocate Health Care, PLLC

Renée Woods, MD

Cancellation & No-Show Policy

Each time an appointment is missed without providing proper notice, another patient is prevented from receiving care.

Therefore, AHC Health Care reserves the right to count the missed appointment as part of the membership package or charge a fee of for all missed appointments ("no shows") and appointments which (absent a compelling reason) are not cancelled within 24 hours or one business day – whichever is greater.

Current members will have the missed appointment counted as an appointment toward their allowed appointments during membership, or will be charged the established patient rate below.

Established patients (those who have been seen by Dr. Woods within the last 3 years) will be charged a cancellation fee of $250.

PLEASE NOTE: For appointments on Mondays, we require notice by 8 am on the Thursday prior to the appointment. In this case the cancellation policy is "one business day."

Any fees incurred will be billed to the patient and must be paid prior to your next appointment.

Multiple no-shows in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our members and patients. **By signing below, you acknowledge that you have received this notice and understand this policy.**

As a courtesy we try to do reminder calls or texts, but this is not an obligation. Please take responsibility to keep record of your appointments. The responsibility of keeping the appointment is a commitment the patient makes when the appointment is made. If you are ever unsure of your appointments scheduled date or time, please call the office to verify.

Name: _____

Signature: _____

Date: _____

Lab Review Policy

Dr. Woods' practice at AHC Health Care is highly oriented towards knowing the patient, both as a person and in terms of the person's story. The labs we order help tell a part of each person's story.

The interpretation that Dr. Woods offers from the lab results will often include information that is at the cutting edge of medical understanding. It may not be the usual interpretation a patient might receive if they were to review those labs with another physician or search for online.

One example is that of elevated cholesterol. When most doctors see elevated cholesterol, they are going to recommend a medication intended to drive the cholesterol level down. Dr. Woods, however, will investigate *why* it is elevated, address the root cause, and see the problem resolve as the root cause resolves.

Therefore, **it is our policy to not release lab results prior to an appointment with Dr. Woods**.

We will prepare a copy of the labs prior to that appointment and will release them to you after that appointment with Dr. Woods, but not before.

We feel that by allowing Dr. Woods to be given the opportunity to give you the first interpretation of the lab she has ordered, it allows for the first impression, which is usually the greatest impression.

Should a patient insist on obtaining lab results prior to an appointment with Dr. Woods (even if because of extenuating circumstances), a no-show fee will be charged to the patient as indicated by the above Cancellation and No Show Policy, regardless of whether an appointment was scheduled or not, and the patient will immediately be dismissed from the practice.

We hope you will see the logic in this policy and understand we do this with the patients' best interests at heart.

By signing below, you are agreeing to our Lab Review Policy as stated above.

Name: _____

Signature: _____

Date: _____

Advocate Health Care, PLLC

Renée Woods, MD

Billing Authorization

Your monthly membership fee includes the services described in the membership flyer made available to you via our front desk or our website at the time and date of your signature below.

At times your care may require other services or products not included in your monthly membership fee.

To streamline your appointment check-out, please note that by providing your billing information, *you authorize Advocate Health Care to automatically charge your card or draw on your bank account for any incidental items that we discuss during your appointment.*

By signing below, I hereby authorize Advocate Health Care (AHC) to contact me using the information I have provided in the Member Registration Form.

By signing below, I hereby authorize AHC to initiate charges to my credit card, debit card, bank account, or other payment method for my recurring membership fee and any incidental fees that I incur or have incurred on my account since my last billing date.

This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until AHC has received written notification from me of its termination in such time and in such manner as to afford AHC and my financial institution a reasonable opportunity to act on it.

I understand that my participation in AHC is continuous and that by signing below, I authorize recurring charges via the payment method circled below and/or any future changes to that payment method.

I understand that a $25 fee will be charged to me for declined credit, debit card or automatic funds transfer transactions that are not honored.

I understand that there is a minimum commitment, and that if I terminate membership prior to the minimum commitment date, early termination fees may apply.

Name: _____ Date of Birth: _____

Signature: _____

Date: _____

Method of Payment on File (circle one): Credit Card Debit Card Bank Account

Membership Level (circle one): Access Impact

Appendix 1

Membership Options, Fees and Early Termination Fees

Membership Type	Monthly Fee	Minimum Commitment	Cost per Appointment	Early Termination Fee?*
Per Session	$0	None	$495	Not Applicable
Access	$99	12 months	$250	Yes
Impact	$349	12 months	$0	Yes

*Early termination fees are assessed due to the limited availability of memberships and appointments. Early termination fees are calculated by applying the difference between the amount paid in monthly memberships minus the total for the minimum commitment term.

> For example, Patient John Doe has an Access membership that started in January, is paid once per month and wishes to cancel membership in July. Since John Doe has paid 7 months of membership, the early termination fee would be the difference between 12 months of Access membership and the 7 months he has already paid. 12 month commitment minus 7 months paid equals 5 months termination fee at $99/month = $495.

Details for each level of membership may be found in the current flyer or on our website https://advocatehealth.care/membership/

*Initials*_____

Thank you for completing this form at each visit.

Name: **DOB:** **Date:**

Please provide updated information if there have been any changes since your last visit.			
Street Address:			
City, State, Zip:			
Home Phone:		Work Phone:	
Marital Status:		Spouse/Partner Name:	
Occupation:		Education:	
Insurance:			

What brings you to the office today?			
☐	Annual Exam or Routine Care	☐	New Patient Visit
☐	Pelvic Floor Rehabilitation	☐	Review Lab Results
☐	Problem/Concern/Other (Please describe briefly):		

Gynecologic History			
Date of Last Menstrual Period:		Every _____ Days	Lasting _____ Days
Date of Last Pap Smear:		Normal Results?	☐ Yes ☐ No
Date of Last Mammogram:		Normal Results?	☐ Yes ☐ No
Current Method of Contraception:			

Please describe any changes to your medications and medication allergies since your last visit.	
Medication Update:	
Allergy Update:	

Please inform us of any changes to your family history since your last visit.

☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ High Blood Pressure ☐ Cancer: Breast, Ovarian, Colon ☐ Drinking Problem

Please mark any symptoms you are having today:

General
☐ Weight Loss or Gain
☐ Fevers
☐ Trouble Sleeping
☐ Chronic Fatigue
☐ Excessive Bleeding
☐ Easy Bruising
☐ Abnormal Thirst

Eyes
☐ Itchy, Red Eyes
☐ Vision Problems

Ears
☐ Ear Pain
☐ Ringing in Ears
☐ Hearing Loss

Nose
☐ Sinus Problems
☐ Nose Bleeds

Mouth
☐ Sore Throat
☐ Mouth Sores

Lungs
☐ Coughing Up Blood
☐ Shortness of Breath
☐ Chronic Cough
☐ Blood Clot in the Lungs
☐ Painful Breathing
☐ Wheezing

Cardiovascular
☐ Chest Pain
☐ Irregular Heart Burn
☐ Ankle/Hand Swelling

Gastrointestinal
☐ Frequent Diarrhea
☐ Constipation
☐ Bloody Stools
☐ Nausea/Vomiting
☐ Hemorrhoids

Urinary
☐ Incomplete Urination
☐ Loss of Urine
☐ Painful Urination
☐ Bloody Urine

Musculoskeletal
☐ Muscle Weakness
☐ Joint Pains
☐ Joint Swelling
☐ Clot in Leg Vein

Neurological
☐ Frequent/Severe Headaches
☐ Dizziness
☐ Seizures
☐ Numbness
☐ Trouble Walking
☐ Fainting Spells

Skin
☐ Acne
☐ Dry Skin
☐ Unwanted Hair Growth
☐ Unusual Lump or Growth

Emotional
☐ Excessive Worry
☐ Depression
☐ Frequent Crying
☐ Serious Thoughts of Harming Yourself or Others

Menstrual Problems
☐ Cramps/Pain
☐ Heavy Bleeding
☐ Too Frequent Periods
☐ Bleeding Between Periods
☐ Missed a Period
☐ Other Period Issue

Pre Menstrual Issues
☐ Bloating, Swelling
☐ Mood Changes
☐ Breast Changes
☐ Headaches
☐ Acne
☐ Other PMS Issue

Menopause Issues
☐ Hot Flashes
☐ Night Sweats

Breast Problems
☐ Breast Pain
☐ Breast Lump
☐ Nipple Discharge
☐ Other Breast Issue

Other Gynecological Issues
☐ Vaginal Discharge
☐ Itching, Irritation
☐ Vulvar Pain
☐ Vulvar Lump, Growth
☐ Vulvar Sores

Sexual Problems
☐ Painful Intercourse
☐ Bleeding After Intercourse
☐ Decreased Desire
☐ Orgasm Problems
☐ Dryness
☐ Possible Exposure to STD
☐ Other Sexual Issue

Would you like to discuss any of the following?
☐ Contraception
☐ Menopause Issues
☐ Pregnancy Issues
☐ Self Breast Exam
☐ Sexuality Issues
☐ STD's
☐ Other

Signature: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name _____ **Date** _____

Provider _____ **Patient ID #** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** _____ **Somewhat difficult** _____ **Very difficult** _____ **Extremely difficult** _____

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