General Office Policies
Primary Care Membership

Please read each paragraph and sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies.

RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA): I have been given the opportunity to read a copy of the Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practices for my records.

CONTACT PERMISSION: In the event that Glow Health Medical Clinic needs to contact me (patient) regarding an appointment, test result, medication, medical instructions, or any other reason, it is permissible to (check all that apply)

- ○ OK to leave detailed message on voicemail.
- ○ OK to send detailed message via text.
- ○ OK to send detailed message via email.
- ○ OK to speak with spouse/significant other.
- ○ OK to speak with other family member.

CONSENT TO TELEPHONE/EMAIL COMMUNICATION: I understand that any phone or email communication will be part of my medical record. I also understand that email is not to be used for any emergent matters, and response will be given back generally within two to three business days.

CONSENT TO TREATMENT: I consent to the performance of examinations, diagnostic procedures, and treatment by Glow Health Medical Clinic. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees can be made or implied as to the outcome of treatment.

CONSENT TO REFER: I authorize the staff to release pertinent records to any physician they refer me to for further care. I understand that this office will not use or disclose my medical information without my written authorization.

CONSENT TO PHOTOGRAPH: I authorize Glow Health Medical Clinic to take photographs/videos of me to be used in my medical record, not to be released without my prior authorization.

Your Rights and Responsibilities

Your participation in the practice is voluntary. Neither the Practice nor Dr. Zamorano will seek reimbursement for the Membership Fee from any insurer, Medicare or other third -party payer for services provided that are included in the Membership Fee. You are solely financially responsible for payment of the Membership Fee and agree not to submit the Membership Fee to Medicare or your private insurance carrier. You and your insurer will continue to be responsible for non-office related medical expenses including but not limited to blood tests, x-rays, and other medical studies, other doctors fees, aesthetic medical fees, and hospital fees. We ask that you provide us timely and accurate information regarding your health, medication, procedures provided by other clinicians, or other changes regarding the status of your healthcare. Our practice offers many ways (phone, video visits, email) by which you may communicate with the Practice and/or the office. Should you have a medical emergency, you should call 911. If you feel a medical concern is urgent, please do not email rather call the office directly or go to the nearest urgent care or emergency room.

Glow Health
MEDICAL CLINIC

General Office Policies
Primary Care Membership

Membership Program and Fee - $225 per month (paid either bi-yearly** or yearly***, see below) **provides:**

- Improved Access to Care -Same day, next day appointments
- Complementary emails, phone/texts per month
- No Co-payment for office visits
- Follow-up on lab/imaging/referrals ordered during an office visit at no charge
- Additional office/video follow-up visits if needed at $150-$175 (normally $275 - insurance reimbursement can be requested for these visits)
- 10% off any aesthetic procedure including Microneedling, Cryotherapy, Chemical Peels, Fillers, etc.
- Botox $12 per unit!

**Credit card will be charged for the first 6 months ($1350)

***Alternatively, $2400 for 12 months (Save $300 annually)

***The first 6 months fees are non-refundable. Cancel after the initial 6 months with 30 day notice.

All major Credit Cards are accepted and will be kept on file. Please check with your human resources department or plan information regarding if you can use your FSA or HSA accounts to pay this membership fee.

Membership Renewal

Annually, the practice will send you a letter outlining any changes to the practice, the membership terms and the membership fee. If you wish to remain in the practice, your credit card will be charged automatically. If you do not wish to renew, please notify us in writing with 30 days notice.

Canceling your membership

We want every patient to be happy and satisfied with our services. Should you wish to cancel your membership, please do so in writing. This must be done with a 30 day notice.
The initial 6 months of membership is non-refundable.

Refunds

Refunds will be given for membership fees received for the current year on a prorated basis.

Changes to the Practice

We may make changes to the practice, including reducing or eliminating amenities. If we substantially reduce the practice without terminating it, we will notify you. If you cancel your membership within 30 days of notice of a substantial reduction in the practice, we will refund your membership fee for the remainder of the year on pro-rata basis at the rate of 1\12 of the annual membership fee per full month remaining.

Discontinuance

We may discontinue the practice at any time. If we discontinue the practice or if we discharge you from the practice, we will refund your membership fee for the remainder of the year on a pro rata basis.

Print Patient Name: _____ Date: _____

Signature: _____

02/2025