Doc Bee Well

Patient Rights and Responsibilities

- I agree to disclose all information relating to my health condition and to actively collaborate with my health care provider to understand my treatment options and develop the best course of action.

- I understand that my enrollment in Doc Bee Well is a commitment to my ongoing health and wellness. I agree to commit to those plans for my medical care which have been agreed upon by me and my provider.

- I understand that I will be forthright with regard to my prescription medication and my use of them.

- I understand that Doc Bee Well does not contract with Labor and Industries (worker's comp) nor do its providers complete evaluations for a commercial driver's license, nor manage injuries related to motor vehicle accident or injury.

- I understand that Doc Bee Well does not provide management of chronic/long term narcotic or benzodiazepine prescription use.

- I understand that it is my responsibility to inform Doc Bee Well of any changes to my credit/debit card or bank account information used by Doc Bee Well.

- I understand that it is my responsibility to ensure that Doc Bee Well has correct contact information (e.g. mailing address, phone) for my account.

- I agree to arrive on time for my appointment. If I do not arrive on time, my provider may not be able to spend as much time with me as I may need. In addition, I agree to call Doc Bee Well at least 24 hours before an appointment if I need to cancel, so that other patients can use my visit time. I understand that same-day cancellations are subject to a $15 cancellation fee. These fees do not apply to patients in the Honeybee or Worker Bee membership.

- I understand that I have the right to receive accurate and easily understood information about Doc Bee Well health care services, health care professionals, and health care facilities.

- I understand that I have the right to speak in confidence with my Doc Bee Well provider and to have my health care information protected. I understand that Doc Bee Well will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider amend my record if I feel it is inaccurate or incomplete by contacting my Doc Bee Well provider.

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- I understand that the monthly fee is intended to cover Doc Bee Well provider's availability to provide services as well as the individual services provided, and that the monthly fee is due each month under the Member Agreement, even if I do not communicate with Doc Bee Well providers or see them during a particular month.

- I understand that I am responsible for all bills associated with services provided outside the direct agreement for primary care services, whether provided by Doc Bee Well or another organization or individual.

- In the event I wish to cancel my membership, I understand that I must notify Doc Bee Well in writing of my intent to cancel. Notice by email or text is sufficient. If my account is overdue, I am responsible for resolving the outstanding balance within 90 days or be subject to collections reporting.
- I understand that if I am dissatisfied for any reason, I may contact the Clinic's Administrator to address any complaints at the address provided below. I agree to first bring issues to Doc Bee Well's attention. I understand that I may address any unresolved complaints to the attention of the Office of the Insurance Commissioner for the State of Washington by calling the Consumer Advocacy department at: (800) 562-6900 or by e-mail at cad@oic.wa.gov.

Doc Bee Well Clinic's Administrator
1201 Pacific Ave, Suite 600,
Tacoma, WA 98402
Email: admin@docbeewell.com

Office of the Insurance Commissioner for the State of Washington
(800) 562-6900
Email: cad@oic.wa.gov

Washington State Department of Health Systems Quality Assurance Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
1-800-633-6828 (toll-free)
Fax: 360-236-2626
Email: HSQAComplaintIntake@doh.wa.gov

Washington Medical Commission

WMC Complaint Intake PO BOX 47866
Olympia, WA 98504
Email: to Medical.complaints@wmc.wa.gov

Doc Bee Well

I have read and understand the information provided above regarding Patient Rights and Responsibilities, have discussed it with my health care provider, counsel and/or legal guardian, and I hereby give informed consent to Doc Bee Well Patient Rights and Responsibilities.

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Signature of patient (or guardian/conservator)

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Printed name

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Date

Doc Bee Well