Patient Services: **PFAC Membership Application Form**

Hill Physicians Medical Group, Inc. ("Hill Physicians" or "Hill Physicians Medical Group") is committed to high quality care to ensure our patients ("Members") get and stay healthy. Patient advisors play an important role to help shape the patient experience. If you are interested in participating as a patient advisor on the Hill Physicians Patient Family Advisory Council (PFAC), please complete this application and we will be in touch shortly. **Please do not include any personal health or medical information in responses you provide in this application. Please PRINT all information clearly.**

Contact Information

Name (First, Middle Initial, Last) _____ Date of Birth ____/____/____

Mailing Address _____ City _____ State ____ Zip _____

Email _____ Preferred phone (_____) _____

Is this a cell number?* ☐ Yes ☐ No What is your contact preference? ☐ email ☐ phone

*By providing a cell phone number, I expressly consent to receive PFAC-related communications, including automated calls and text messages, at such cell phone number. I will let Hill Physicians know immediately if my cell phone number changes. I understand that message and data rates may apply to the receipt of calls and text messages.

References and Background

Please provide names of two people, other than relatives, whom we may contact for a reference.

Print Full Name _____ phone (_____) _____

Print Full Name _____ phone (_____) _____

Have you ever been convicted of a misdemeanor or a felony? ☐ Yes ☐ No

What is your relationship with Hill Physicians Medical Group?

☐ Hill Physicians Member ☐ I am a family member or a caregiver of a Hill Physicians Member*

Name of Member _____

*By checking this box, I certify that I have the identified Hill Physicians Member's express consent, or am otherwise legally authorized and empowered, to participate on the PFAC in the place of such Hill Physicians Member. I agree to provide written evidence of such consent or authority upon request.

Are you able to commit to a 1.5 hour meeting one afternoon or evening per month? ☐ Yes ☐ No

Which do you prefer? ☐ Afternoon ☐ Evening

Are you able to commit to a one year term? ☐ Yes ☐ No

Why would you like to be an advisor? _____

_____

Do you have any past volunteer or advisory group experience? ☐ Yes ☐ No

– Continued on back

References and Background (continued)

What is your comfort-level using a digital platform such as Webex for PFAC group meetings?

☐ Very comfortable ☐ Comfortable ☐ Not comfortable

Do you have challenges accessing a computer or using a telephone to participate in meetings?

☐ Yes ☐ No If yes, please explain _____

_____

Recall a time when you have been in a group setting and someone had a difference in opinion with you. How did you handle the situation? Check all that apply:

☐ Ask questions to the individual or group ☐ Listen to understand
☐ Describe why you feel the way you do ☐ Find common ground on what you two agree on
☐ Keep your opinion but allow the conversation to be carried forward by others

☐ Other: _____

Acknowledgment

By signing below, I certify that all statements in this application are complete and true. If I am selected for membership on the PFAC, I acknowledge and agree that any falsehood or omission of information in this application may result in my being excused from the Patient Family Advisory Council.

I understand, acknowledge and agree that if I am selected for membership on the PFAC:

- I will be required to attend an orientation and training on the vision and goals of Hill Physicians Medical Group and the PFAC.
- I will abide by any and all PFAC guidelines, rules, and bylaws, including the PFAC Charter, and any other rules or policies Hill Physicians may provide from time to time, will respect patient confidentiality, will hold all information and materials I obtain or have access to in connection with the PFAC and its proceedings, in whatever form, in strict confidence, and will uphold the standards of Hill Physicians Medical Group as expressed in the Hill Physicians Medical Group Code of Conduct or any similar document provided by Hill Physicians.
- I will not receive compensation of any kind for participating as a volunteer member of the PFAC.

We will contact you by phone or email if you are selected for an interview to learn more about your interests, and discuss the opportunity to become a member of the PFAC. In order to participate on the PFAC, you will be required to sign a Confidentially Agreement, sign and adhere to the PFAC Charter, comply with applicable HIPAA requirements, and adhere to the Hill Physicians Medical Group Code of Conduct and any other policies and rules of Hill Physicians as may be provided to you from time to time. If you are unable to fulfill these requirements you will not be able to serve on the PFAC.

I further understand and acknowledge that my participation on the PFAC is voluntary. I understand that any health care services that I or a family member or a Member for whom I am a caregiver, as applicable, receive through the Hill Physicians Medical Group, Inc. provider network are not, and will not be, conditioned upon my completing this application or my participation on the PFAC.

All information contained on this form is considered confidential and is intended for use only by Hill Physicians Medical Group and its affiliated companies.

Signature: _____ Date _____

Thank you for your interest in the Hill Physicians Medical Group Patient and Family Advisory Council. Please submit your application to **Patient.Experience@hpmg.com** or mail to: Hill Physicians Medical Group, Attn: Patient & Provider Experience, 2409 Camino Ramon, 4th floor, San Ramon, CA 94583.