SILOAM HEALTH
MELROSE

CONSENT TO TREAT, MEDICAL RECORDS RELEASE, PDAP, NPP, & SILOAM HEALTH MELROSE PATIENT POLICIES AGREEMENT

Patient Name:	Date of Birth: / /

To provide the best care for you, Siloam Health needs your consent to treat you, authorization to acquire your medical records from your previous physician, and permission to disclose your medical information when necessary.

We may use and share your medical information as we:

- Treat you
- Run our organization
- Do research
- Refer you to a medical specialist outside our office
- Comply with the law
- Help with public health and safety issues

By signing this form:

1. You consent to medical treatment, pharmaceutical, pastoral services, social work services, and behavioral health care services provided by Siloam Health.
2. You give Siloam permission to obtain your previous medical records.
3. You authorize release of your medical records, including all test results and pertinent information acquired during your treatment, to other physicians and healthcare providers involved future treatments.
4. You agree to allow your Siloam health care provider to discuss your care with other providers at Siloam.
5. You give permission for Siloam Health to share your immunization records with the Health Department and TennIIS registry.
6. You have the right to cancel this authorization at any time by written request to Siloam. Canceling this authorization will not affect actions taken before this cancellation.
7. A copy of this authorization is acceptable with the same effectiveness as an original.
8. Signing this authorization is a voluntary act. Your treatment, payment, enrollment in a health plan, or eligibility for benefits will not be affected by your authorization of this disclosure.

If you are enrolled in Patient Drug Assistance Program at Siloam Health Melrose, by signing this:

1. You give permission to release your personal and medical information in order to request medications on your behalf from the Patient Drug Assistance Program (PDAP) of pharmaceutical companies. Information will be shared only to the extent necessary to process the application for the medication(s).
2. You give permission to **sign your name** on applications for the Patient Drug Assistance Program (PDAP) of pharmaceutical companies in order to request medications on your behalf.

Consent to leave messages: Does Siloam have your consent to leave lab results or other medical information on your answering machine or in your voice mail? YES_____ NO_____

Consent to text: Does Siloam have your consent to send appointment reminders to your cell phone via SMS text messaging? YES_____ NO_____

Please list your Emergency Contacts and your authorized persons with whom we can release your medical information and medications.

Name	Phone Number	Relationship	Emergency Contact?	Release of Info/med?
1.			YES / NO	YES / NO
2.			YES / NO	YES / NO

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

X_____ _____/_____/_____

Signature of patient (Parent or guardian, if patient is under 18) **(Today's Date)**

Identify the relationship if signed by anyone other than patient (parent, legal guardian, caseworker, etc.)

This consent and authorization apply to all health care information and will remain active for **one year** after it has been signed. You may cancel this authorization at any time, by writing to **Siloam Health**.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPAA)

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information ("PHI"). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in my treatment directly and indirectly
- Obtain payment from third-party payers (though Siloam's current practice is to not bill insurance plans)
- Conduct normal health care operations such as quality assessments and physicians' certifications

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Proof of Income Policy at Siloam Health Melrose

Siloam is not a free clinic. Generous financial donations fund us to offer sliding fee scale based on your income. Therefore, PROOF OF INCOME (POI) is required for all patients. Siloam patients MUST provide POI annually and bi-annually if your POI is paychecks.

Missed Appointment (No-Show) Policy at Siloam Health Melrose

You will be charged $10 if you do not show up for your scheduled appointment or call to reschedule 24 hours before your appointment. If you repeatedly missed appointment, there will be penalties along with the possibility of transitioning you out of Siloam depends on the level of missed appointments.

Insurance Screening Policy at Siloam Health Melrose

Siloam Health exists to provide care for those who have nowhere else to go. In order to fulfill this mission, we screen every patient for active insurance coverage one time annually. We will make you aware when the screening will take place, and if you do have active insurance coverage, we will help you find a new healthcare provider that files to your insurance company.

Required Payment Plan for High Balance at Siloam Health Melrose

Our goal for Siloam patients is that they are prepared to thrive in the current healthcare system. One way to prepare our patients is to allow them how to take responsibility for their medical expenses. We require patients with over $100 balances to participate in a payment plan that will best fit their financial situation.

I, or my authorized representative, understand my privacy rights and agree to observe the policies of Siloam Health.

X_____ _____/_____/_____

Signature of patient (Parent or guardian, if patient is under 18) **(Today's Date)**

Identify the relationship if signed by anyone other than patient (parent, legal guardian, caseworker, etc.)
This signed agreement will remain active for one year after it has been signed.