Team Lead Care (TLC)
PROGRAM AGREEMENT

PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____

Phone: ( ) - _____ **Member ID#:** _____

Address: Street Number: _____ Apt Number: _____ Street name _____

City: _____ Zip Code: _____

Email Address: _____

Doctor's Name: _____ **Doctor's Phone**: ( ) -

MEMBER REQUIREMENTS

- ☑ Keep your scheduled appointment with your care manager to discuss opportunities that can help your health.
- ☑ Obtain the required examinations and laboratory evaluations for your condition(s).
- ☑ Provide any information requested by your care manager
- ☑ Work to the best of your ability toward improving your lifestyle (i.e., regular exercise and better nutrition).
- ☑ Take all of your medications as instructed by your doctor and get medications refilled on time.
- ☑ Interact with your wellness team to customize your care goals—be an active participant!

CANCELLATION POLICY and MISSED APPOINTMENTS WITH CARE MANAGER

- ☑ **Three (3) missed appointments** with your care manager without prior notification—24 hours before—will result in program cancellation and termination of your program benefits. Member must reschedule first missed appointment within 30 days. If this meeting is not rescheduled, the member will then have 15 additional days to reschedule their appointment. If member fails to reschedule a second time they will be dismissed from the program.
- ☑ Failure to comply with member requirements will result in cancellation and termination of your program benefits.
- ☑ Once program cancellation and termination of your program benefits have occurred, you must wait **six (6) months** before you are eligible for renewed participation.

UNDERSTANDING AND SIGNATURE

I want to take control of my overall well-being. I understand that I can make a difference in my health and the way I feel. I am committed to lowering my risk for health-related complications by agreeing to follow the requirements of the TLC Program. I understand that not following them may result in my cancellation from the program and termination of my program benefits.

Signature _____ ***Date*** _____

BEACON HEALTH SYSTEM

Authorization for Disclosure of Protected Health Information [1]

I, _____, authorize the disclosure of my protected health information [1] (PHI) to Beacon
[please print full name]
Health System (dba Team Lead Care Program), as described below.

I understand that this authorization is voluntary and represents my personal intentions and that federal law allows Beacon Health System to release my PHI as part of the payment of claims or as part of its daily operations to the extent minimally necessary. [2] I also understand that Beacon Health System may need to disclose my PHI to others outside of the Beacon organization for the purpose of providing services related to my specific plan. As a result, I authorize Beacon Health System to disclose my PHI as provided by law and in accordance with the standards established in HIPAA.

I also authorize the following person(s) and/or organization(s) to DISCLOSE AND/OR RECEIVE my PHI. I understand that subsequent receipt by such person(s) and/or organization(s) may not be protected under federal law and state health information privacy laws if the person(s) and/or organization(s) that I authorize to receive my PHI is(are) not subject to such laws.

Name:	_____	Name:	_____
Address:	_____	Address:	_____
	_____		_____
	_____		_____

[Authorization to disclose psychotherapy notes must be separate.]

I certify that I have had the opportunity to read and consider the contents of this authorization. This authorization is in effect until revoked.

Signature of Patient
[or person legally authorized to consent to disclosure] _____

Date Signed: _____

Relationship to Patient
[for person legally authorize to consent disclosure]: _____

[1] Protected health information (PHI), as defined under 45 CFR § 501, means any information – whether oral or recorded in any form or medium – that may reasonably be used to identify the individual and that relates to: a) the past, present, or future physical or mental condition of an individual; (b) the provision of health care to an individual; or (c) the past, present, or future payment for the provision of health care to an individual.

[2] As described under the Health Insurance Portability and Accountability Act of 1996 or HIPAA [45 CFR 164] and Health Information Technology for Economic and Clinical Health or HITECH [Public Law 111-5] which apply privacy and security rules to health plans, healthcare providers, healthcare clearinghouses, and business associates of covered entities.

BEACON HEALTH SYSTEM