ID Number_____

SUBURBAN PRIMARY HEALTH CARE COUNCIL
ACCESS TO CARE PROGRAM

ENROLLEE ACKNOWLEDGMENT AND RELEASE

RIGHT OF APPEAL/GRIEVANCE PROCEDURE: I understand that I may appeal any decision regarding my eligibility for the Program within 14 days of such decision by submitting in writing a grievance to the Suburban Primary Health Care Council.

CIVIL RIGHTS: I understand that the Suburban Primary Health Care Council is an equal opportunity program open to all eligible persons regardless of age, race, sex, national origin, religion, disability, sexual orientation, or any other class of people protected by any federal, state or local law. If I believe I have been discriminated against I may submit, within 14 days of the event, a written grievance to the Council.

DUAL PARTICIPATION: I have been informed that eligibility for he Medicaid Program, the Medicare Program, or receiving benefits under private health insurance for physician office visits may result in my termination from the Suburban Primary Health Care Council's Access to Care Program ("Program"). I certify that as of this date I do not participate in the programs or receive the benefits described in the preceding sentence. I agree to inform promptly the Suburban Primary Health Care Council if I begin to participate in such programs or begin to receive such benefits.

NON-TRANSFERABLE: I understand that enrollment is limited to the person (s) named on this application form and is not transferable. Giving my temporary or permanent identification as a Council client to any other person to use will result in my termination from the Program.

LIMITATION OF SERVICES: I understand and acknowledge the following:

A. Services provided by physicians under this Program are limited to a specific set of routine basic health care services which exclude, among other services, the following: some procedures normally provided by primary care physicians, service provided in the emergency room of a hospital, ambulatory specialty care and inpatient services.
B. A Non-Refundable Annual Enrollment fee of $20.00 for one person, $40.00 for two people, or $50.00 for a family of three or more. Payment of the enrollment fee does not guarantee continued services for one year.
C. Physicians require payment by me of $5.00 per visit.
D. Pharmacies require payment by me of $15.00 per prescription for generic drugs, $30.00 per prescription for preferred brand name drugs and $40.00 per prescription for non-preferred brand name drugs. Prescriptions will be limited to a 30 day supply.
E. I must pay $5.00 for each lab and/or x-ray procedure.
F. Only certain physicians and pharmacies are participating in the Council Program and that for a variety of reasons certain physicians and pharmacies may leave the Program at any time.
G. That certain participating physicians may be unavailable because they do not have room for additional patients; (i) my physician may request that I be transferred to another physician and under certain circumstances the Council will grant such a request; (ii) if I or my physician request my transfer to another physician, it may take up to 60 days to provide me with a new physician; and (iii) my physician will not be available at all times and may refer me to another physician who is participating in the Program.
H. My participation in the Program will expire on the date of my Access to Care card unless I meet the eligibility standards for the Program at that time and renew my participation in the Program. The Council has no obligation to advise me further of the date on which my participation in the program will end or to initiate renewal of my participation. My participation in the Program my be terminated at any time that I am no longer eligible for the Program, as the Council may establish general standards for eligibility from time to time.
I. Changes in program expenses or funding may require modification or termination of the Program at any time; therefore, access to program services even during my enrollment period are not guaranteed.

HOLD HARMLESS: I acknowledge that neither physicians participating in the program, nor any physician, clinic or hospital to which I may be referred, are employees, agents or partners of the Council and that the Council is not responsible to me in any way for the amount or quality of medical health care services which I may receive from a participating physician. I agree to hold harmless and release the Suburban Primary Health Care Council and its Directors, officers, employees, and agents from any liability arising from its arranging or attempting to arrange medical services for me through any healthcare provider or its payment of medical services on my behalf.

RELEASE OF INFORMATION: I consent to the release of any and all medical, social, and financial information, as well as, the release of any and all information concerning eligibility for health insurance for myself and/or my dependents to the Suburban Primary Health Care Council, its agents, contractors, and service providers with whom it maintains a relationship. I authorize the Social Security Administration to release any information concerning my eligibility for Medicare and Social Security benefits. I understand that the release of any medical information about me by the Suburban Primary Health Care Council is limited by the authorization form, a copy of which is attached to this Enrollee Acknowledgment and Release. I understand that I cannot become an enrollee of the Program until I sign this form and the authorization form attached.

_____ _____
Client or Guardian Signature Date

_____ _____
Spouse Signature Date

ID Number_____

ACCESS TO CARE AUTHORIZATION FORM

I hereby authorize the Suburban Primary Health Care Council ('the Council') to use any medical information, which we refer to as "Protected Health Information," about me in the following two ways.

1. If I choose to see a contracted healthcare provider, then the Council may assist that contracted healthcare provider in making a referral to another healthcare provider to provide me with treatment. I understand that, for example, a contracted doctor who I choose to see may send Protected Health Information about me to the Council so that the Council can refer me to another healthcare provider for additional services that the doctor says I may need. I understand that the Council will not use Protected Health Information that it receives in this manner for any purpose other than to refer me to another healthcare provider for additional treatment; and

2. I understand that the contracted healthcare providers who I choose to see will send the bills for their services to the Council for payment. I further understand that these bills will contain Protected Health Information about me. By choosing to participate in the Access to Care Program, I authorize the Council to obtain Protected Health Information about me from contracted healthcare providers who I choose to see so that the Council can pay for my healthcare. I understand that the Council will not use Protected Health Information about me it receives for any other purpose than bill payment.

This authorization is valid from the date that I chose to become a member of the Access to Care Program, and ends on the date on which I stop being a member of the Access to Care Program. I understand that I have the right to revoke this Authorization in writing by notifying the Council that I have revoked this Authorization, but I also understand that if I revoke this Authorization, I will lose the benefits covered by, and will no longer be eligible for, the Access to Care Program.

I have had the opportunity to read this Authorization, and I understand what this Authorization means.

_____
Printed Client or Guardian Name

_____ _____
Client or Guardian Signature Date

_____
Printed Spouse Name

_____ _____
Spouse Signature Date