Project Success Ministries Inc.
HELPING THOSE IN NEED

HIPAA - MEDICAL INFORMATION RELEASE

Federal privacy guidelines under HIPAA require a medical release of information on file for each patient.

This authorizes Project Success Ministries to release medical information to designated family members or caregivers.

It also allows release of medical and financial information to pharmacies, hospitals, emergency medical personnel, and referral specialists for treatment, payment, or health care operations.

Your signature allows us to share your health information, after proper identification, to those you have identified and if indicated at specified locations for such things as appointment and medicine pickup reminders.

Your signature also acknowledges that you are aware of the posted Notice of Privacy Practices in our waiting room and understand copies are available if you would like to have one.

Complete Section A OR Section B:

Section A:

List the name, date of birth, and telephone number of each of the authorized individuals below.

I, _____, *(Patient name)* give my authorization to the following individual(s) listed below to discuss my medical care with the staff or volunteers at Project Success Ministries on my behalf.

Name	Date of Birth	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any health information you do not wish to be released or any other specifics regarding release of information:

_____
_____
_____
_____
_____

Section B:

I_____, *(Patient name)* do not give my authorization to discuss my medical care with anyone other than myself.

A signed copy of this document will be provided to you and will be placed in your medical record. You can update the information on this document at any time to maintain accuracy.

Patient Signature: _____ Date: _____

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ALABAMA CHARITABLE IMMUNITY LEGISLATION

The Volunteer Service Act

&

Volunteer Medical Professional Act

Project Success Ministries is covered by the following State Laws:

- The Volunteer Service Act - AL Code Section 6-5-336
- Volunteer Medical Professional Act - AL Code Section 6-5-663

These state laws give limited immunity against lawsuits to all volunteers serving at Project Success Ministries.

You can ask for a copy to further educate yourself on the charitable immunity laws of Alabama. The information is also posted on the PSM website at wwwprojectsuccessministries.com.

Your signature below indicates you have been made aware of the existence of these laws.

Patient Signature: _____ Date: _____

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PATIENT'S RIGHTS AND RESPONSIBILITES

1. Patients are responsible for giving truthful personal, financial, and medical information. A patient who does not re-screen at the appropriate time cannot receive treatment until they have been re-screened for eligibility.
2. Patients will be responsible for keeping the clinic informed of any change in address, telephone numbers, income, or insurance status. To receive treatment at the clinic you cannot have any type of insurance, which includes Medicare, Medicaid, commercial insurance, or VA benefits.
3. Patients have the right to expect that their treatment and medical records will be kept confidential unless a proper release has been given. Please see the posted HIPAA "Notice of Privacy Practices."
4. Patients have the right to expect that their primary care will be provided by the clinic. When a patient goes to another facility without a Project Success Ministries referral, they are responsible for charges incurred.
5. Project Success Ministries does not perform examinations or complete paperwork for disability determination claims.
6. Patients are responsible for maintaining an appropriate and courteous attitude with clinic staff and volunteers. This responsibility extends to the offices of specialists who see PSM patients on a referral basis. Abusive behavior and/or inappropriate language will result in dismissal from the clinic.
7. Patients are not to bring anyone to the clinic who is under the influence of alcohol/illegal substances.
8. **Patient** initials _____Patients are subject to random drug testing or testing ordered by his or her provider. Refusal by a patient to submit to drug testing or discovery of legal or illegal drug abuse by a patient may result in dismissal from the clinic.
9. **Patient Initials** _____ For Medication Refill Requests, patients must give the clinic 7-10 days to complete a refill. Medications may not be refilled or replaced if patients are out of screening or if it is too soon to be refilled (based on last fill date). Exceptions will be diabetic, high blood pressure, seizure, asthma, or antibiotic medications.
10. **Patient Initials**_____ Patient non-compliance (not following physician instructions, not getting lab work done, not getting x-rays done, etc.) may result in dismissal from the clinic.
11. **Patient** initials _____Patients must adhere to the following **No-Show Policy:**
    a. A No-Show appointment is any appointment where a patient either does not show up (or login/answer for a telehealth appointment) or cancels on the day of the appointment.
    b. The No-Show policy applies to all types of appointments in the clinic: medical, counseling, diabetes education, physical therapy, case management, etc., whether in-person or through telehealth.
    c. Patients are responsible for being on time for their appointments.
    d. After 3 No-Show appointments at the clinic, a patient will receive a warning letter.
    e. After a 4th No-Show appointment at the clinic, a patient will receive a termination letter.
    f. After 1 No-Show appointment at an outside specialist referral, a patient will receive a termination letter.
    g. If a patient cancels an elective surgical procedure with less than 48 hours' notice for an outpatient procedure or less than 72 hours for a total joint procedure, the patient will receive a termination letter.
12. **Patient Initials** _____ Any patient who receives a termination letter will be dismissed from the clinic for one year.

I understand my patient rights and responsibilities as a patient of Project Success Ministries.

Patient Signature: _____ Date:_____

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MEDICAL BILLING POLICY

Project Success Ministries does not pay medical bills.

Your letter will list the amount of coverage you are to receive from Care Affiliate along with any applicable copay. If you are referred to ARMS for lab tests or imaging or to a provider who practices under ARMS, you will be expected to pay your copay as outlined in your ARMS/PSM letter.

There are many free services that PSM can provide but be aware that some providers may bill you for their services. The time to ask about billing is at the time of your procedure or visit is being scheduled.

Project Success Ministries may refer you to other physicians or dentists and ask for 100% charity write-off, a discount, or some type of payment plan for your procedure or visit. The amount of discount or benefit given is at the discretion of the physician or office taking the referral. If you cannot afford an applicable charge, please alert PSM prior to your appointment.

YOU MAY OR MAY NOT RECEIVE A BILL FOR OTHER CHARGES SUCH AS ANESTHESIA OR RADIOLOGY BECAUSE THEY ARE PROVIDED THROUGH OUTSIDE CONTRACTS AT ARMS and UAB. BILLING MAY DEPEND ON SEVERITY OF NEED.

If you get a bill that you do not understand:

- Call the provider who sent the bill and ask them if you can receive a discount since you are PSM Affiliate Care and Project Success Ministries patient.
- If their office does not give a discount, you are responsible for the entire bill.
- If they have forgotten to give you a discount, they should correct your bill at the time of your call. You will then owe the corrected balance.

Please do not tell any providers or hospitals that Project Success Ministries will be responsible for your medical bills.

I understand the medical billing policy of Project Success Ministries.

Patient Signature: _____ Date: _____

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Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

_ Release to: Project Success Ministries
1524 Huffman Road
Center Point, AL 35215
PH: (866) 866-0007
FAX: (205) 407-4018

From: _____
_____
_____

Ph: _____
FAX: _____

_ Release from: Project Success Ministries
1524 Huffman Road
Center Point, AL 35215
PH: (866) 690-0007
FAX: (205) 407-4018

To: _____
_____
_____

Ph: _____
FAX: _____

Information Requested:

All health care information___

Immunization Record___

Other: _____

This authorization is valid for this certification period, not to exceed 12 months from the date of signing.

By signing this authorization, I authorize the use and disclosure of the protected health information requested. I further understand that the information may be re-disclosed by the recipient and may no longer be protected by the HIPAA privacy rule. I have the right to revoke this authorization, except to the extent that Project Success Ministries has acted with reliance upon this authorization.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

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LETTER OF SUPPORT

REQUIRED IF APPLICANT HAS NO INCOME, MUST BE NOTARIZED

APPLICANT

APPLICANT NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

APPLICANT SIGNATURE: _____ DATE: _____

PERSON PROVIDING SUPPORT *(CANNOT BE APPLICANT)*

NAME OF SUPPORTER OF ABOVE APPLICANT: _____

My signature below indicates that I provide or assist with food, lodging, transportation, and/or financial support for the above applicant.

SUPPORTER SIGNATURE: _____ DATE: _____

NOTARY PUBLIC

(The State of Alabama)

County of _____

I, _____ *(NAME OF NOTARY PUBLIC},* hereby certify that _____ *(NAME OF SUPPORTER)* whose name is signed to the foregoing conveyance, and who is known to me, acknowledged before me on this day that, being informed of the contents of the conveyance, he/she executed the same voluntarily on the day that bears the same date.

Given under my hand this_____ day of _____, 20_____

SEAL or STAMP BELOW

(Notary Public in and for said County in said State)