Premise Health

Welcome to the Be Well Condition Management Program

What is Be Well Condition Management?

The Be Well Condition Management Program is designed to improve the health of persons with specific chronic conditions. This is an opt-in program in which you agree to participate. A primary care model is followed where you will remain with the same Condition Manager throughout the process.

The sessions will cover:

- Specifics of the condition,
- Possible complications,
- Modifiable risk factors,
- Guidance on self-care skills,
- Education on medications as needed,
- Related healthy eating and physical activity recommendations, and
- Ongoing preventive Condition needs.

The Condition Manager:

- Is specially trained in the management of chronic conditions.
- Will work with you on a 1:1 basis, following Evidence-Based Medicine Guidelines.
- Will schedule the ffrequency of visits determined by your condition and your availability.
- Will provide you with the knowledge, skills, and motivation to effectively manage your condition.
- Will help you to formulate stepwise goals to help you reach your healthcare goal.
- Will assist with identifying your challenges and strategies to address them.
- Keeps all conversations private and confidential.;
- Is punctual and responsive; and
- Will be your guide along the way in the journey to better health.

The Participant:

- Will strive to communicate openly with the Condition Manager.
- Will be punctual, responsive, and prepared for sessions.
- Will be open and honest about information that is relevant to his/her condition.
- Will ask questions to make certain that he/she understands explanations and instructions that are given.
- Will strive to make the changes and follow the suggestions offered: you may be encouraged to make some changes to your lifestyle, daily routines, medication adherence, eating habits, and physical activity to improve your health.
- Will contact the Condition Manager 24 hours in advance if an appointment needs to be rescheduled.
- Will notify the Condition Manager if he/she decides to unenroll.
- Will participate in 2 virtual Be Well Condition Management phone visits yearly; and
- If active in the Be Well Condition Management Program for Diabetes, participant will ensure that 2 HbA1C test results are submitted to the Condition Manager yearly.

<u>Other information:</u>

How will my health care provider be included?

- If you use the Shaw Family Health Center as your primary Care practice, your Condition Manager will work with your provider to establish a coordinated plan of care. If you would like to maintain your relationship with your community provider, we will work with them upon your consent. Condition Management does not change the treatment plan of your provider but rather complements the plan, providing you with information and understanding of your condition to be as healthy as possible.

Will my employer have access to my information?

- No: this program, as with the Health Center, is provided by Premise Health. Your employer contracts with Premise Health to provide the services confidentially. No personal information or identifiable data about you will be shared with your employer. The Notice of Privacy Practices that you received upon registering at the Health Center applies. You will be asked to sign an Authorization for Use and Disclosure of Protected Health Information to authorize specific disclosure of your protected health information.

Are there additional benefits when I enroll in this program?

- You have free, unlimited access to your Be Well Team
- Flexibility in appointments
- Some of your medication and supplies are free just for participating and being compliant with the program.
- Assurance that your health can improve, and you will have a better quality of life.

To remain compliant and to continue to offer zero-cost medications, participants in the Be Well program for must participate in 2 virtual Be Well Condition Management visits yearly. Members with diabetes must supply a diabetes diagnosis and an A1C of 6.5 or greater at the time of diagnosis. Prediabetes does <u>not</u> qualify.

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Instructions for Enrollment

Is your primary care provider at the Shaw Family Health Center? If so,

1. Complete the Enrollment Information in its entirety. Do not forget to sign and date this form agreeing to the program requirements.
2. Complete the Incentive Program Employee Notice and Authorization Form if you are an associate of Shaw Industries.

If your primary care provider is in the community (not at the Shaw Family Health Center),

1. Complete the Enrollment Information in its entirety. Do not forget to sign and date this form agreeing to the program requirements.
2. Complete the Incentive Program Employee Notice and Authorization Form if you are an associate of Shaw Industries.
3. Complete the Request for Information Form granting us permission to request your most recent records from your Primary Care provider.

Submit all forms by faxing all documents to 706.609.3397 or email to shawreferral@premisehealth.com. You will be contacted to schedule an appointment.

Questions: Contact the Shaw Family Health Center at 706-609-9960.

Enrollment Information:

Patient: ______________________________ DOB: ___/___/___

Name of Primary Care Provider: ____________________________________

Phone: ____

Please check the condition(s) you are enrolling for:

Asthma COPD

High Blood Pressure (Hypertension)

High Lipid Levels (Dyslipidemia)

Diabetes

For Members Enrolling for Diabetes: please provide the HbA1c at Diagnosis: ___________________

By completing and signing this form, I am requesting to participate in the Be Well Condition Management Program offered through the Shaw Medical Plan. I understand my participation is voluntary and I will only be able to qualify for the free medication and supplies associated with this program if I remain compliant with the information requested and my participation.

Signature of Participant ____________________________________ Date ______________________

Contact Number ____

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Incentive Program Employee Notice and Authorization

Your employer has contracted with Premise Health Employer Solutions, LLC, along with its professional affiliates ("Premise Health") to provide certain health and/or wellness services in connection with your employer's voluntary incentive program.

Protection of Your Health Information: Premise Health agrees to abide by all applicable laws and regulations governing the privacy and security of your personal health information. Premise Health will abide by HIPAA and maintain the privacy and security of your Protected Health Information ("PHI") in accordance with its Notice of Privacy Practices ("Notice"), which Premise Health has provided to you. This Notice is also available at Health Center and on the Premise Health website. You may also request a copy of this Notice from Premise Health at any time.

By participating in the Incentive Program, it may include PHI from the following types of visits: biometric screening, health risk assessment ("HRA"), yearly physicals and flu vaccination, wellness coaching, classes or visits for disease management and wellness lifestyle improvements, ergonomic exams, musculoskeletal exams, clinical pharmacy evaluation and support, and external lab results, member portal activation that also qualify for my employer incentive participation requirements.

Authorization: I understand that my participation in the incentive program is strictly voluntary, but in order to determine my eligibility for health and/or wellness incentives, the administrator(s) of the health and wellness program must receive a record of my participation. By signing below, I authorize Premise Health to disclose information regarding my participation in the program with the administrator(s) of the program. If the incentive program includes by design a review of my results (e.g., measurement, test or blood specimen results) so that I can be provided recommendations in furtherance of my health, I authorize Premise Health to disclose my results to my employer, Premise Client or any third party who has contracted with my employer to review and analyze those results in connection with the program.

I understand that this information may be disclosed through electronic means. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Effective Date: This consent and authorization will expire five (5) years from the date of signature.

Right to Revoke Authorization to Release PHI: I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to the Health Center, or to Premise Health, Compliance Department, 5500 Maryland Way, Suite 120, Brentwood, TN 37027. I understand that my revocation of this authorization does not affect any actions taken prior to receipt of my revocation. I further understand that my revocation of this authorization may impact my ability to participate in the incentive program and/or receive the incentives.

Signature and Copy: I have read and understand this form in its entirety and voluntarily authorize the uses and disclosures of the information described above. I acknowledge that the person executing this form is the person participating in or receiving services, or such participant's legal representative who is authorized to act on such person's behalf to sign this form. I further acknowledge I am at least 18 years old. I understand that I have the right to receive a copy of this authorization upon request.

Participant

First Name:______________________________ Last Name:_________________________ Date of Birth:______________

Participant or Legal Representative Signature:____ Date:_____________________

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
(Not valid for research, marketing, or psychotherapy notes' requests)

Section 1- Patient Information:

Last Name:________________________________First Name:________________________________Middle: ________________________

Other Name Used:____Date of Birth: ____

Address:____City:__________________________State:_____Zip: __________

Home Phone:_____________________________Cell Phone ____________________Work Phone: ___________________________________

Section 2 – Record Request
I hereby request access to the protected health information in my medical record
FROM date **(required)**__________________**TO** date **(required)**________________maintained or created by the following
Clinic &/or Provider Name: **(required)** ____
Check all that apply (required)

- ☐ Most Recent Progress/Office Visit Notes
- ☐ Pathology/Lab Reports
- ☐ X-Ray Reports/Films
- ☐ Pharmacy
- ☐ Occupational Health
- ☐ Workers Compensation
- ☐ MVA
- ☐ Discharge Summaries
- ☐ Immunization Records
- ☐ HIV/AIDS Treatment
- ☐ Drug & Alcohol Treatment
- ☐ Sexually Transmitted Diseases Treatment
- ☐ Mental Health Services
- ☐ Other ________________________ ________________________
- ☐ Entire Health Record
- ☐ Billing Records

Section 3 –Recipient Information – Check One (required)
To Patient: ☐ My Premise Health Portal ☐ Email: __________________________________ ☐ Pick up ☐ Mail (provide address below)
To 3rd Party: ☐ Email: __________________________________ ☐ Fax: ________________________ ☐ Mail (provide address below)
Emails will come from either an **@premisehealth or @medicopy** with directions on how to securely access your records. Please look for these messages in your Inbox/Junk/SPAM folders.

Records To (required if releasing by Email / Fax / Mail):		
Name:		
Address:		
City:	State:	Zip:

If **Purpose of Request** is other than Patient's Request **(required)**: ☐ Legal ☐ Insurance ☐ Continuing Care ☐ Other: ____________________

I understand:

- I may revoke this Authorization at any time by providing my written revocation to: Premise Health Privacy Officer, 5500 Maryland Way, Suite 120, Brentwood, TN 37027. The revocation will not apply to information that has already been released in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be three (3) years from date of signature. Otherwise, this authorization will expire on (Date): ______________ or a defined event:_______________________.
- The information in patient's health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- After the above information is disclosed, it may be re-disclosed by the person or agency that received it, and the information may not be protected by federal privacy laws or regulations.
- Authorizing the use or disclosure of the information identified above is voluntary. This form is not required in order for a patient to receive health care treatment, payment, enrollment or eligibility from benefits.
- I have a right to receive a signed copy of this authorization form.

____ ____

Signature of Patient, Parent or Authorized Representative Relationship to Patient
(required) - Electronic Signature Not Permissible -

____ ____

Print Name of Patient, Parent or Authorized Representative **Date (required)**

*For Internal Office Use Only*____*v. 02/2024*

Secondary Approver Signature________________________________ Date ____________________________