

# Ithaca Health Alliance Provider Membership Application

Upon payment of an Ithaca Health Alliance membership donation, We/I hereby agree to all terms of Ithaca Health Alliance membership.

We/I understand that grants and loans made to members out of the Ithaca Health Fund are done in a discretionary manner by the IHA Board of Directors, in accordance with strict guidelines approved by the membership. We/I understand that to apply for a grant or loan We/I need to provide prompt documentation of health services received. We/I understand that terms of this agreement may be changed by the elected IHA Board of Directors. We/I have reviewed the HIPAA Statement below. We/I understand that the Ithaca Health Alliance does not operate under the supervision of the New York State Insurance Department. We hold Ithaca Health Alliance harmless for the effects of any treatment facilitated through its programs. We/I understand that Ithaca Health Alliance General Membership is available to residents of New York State only, and affirm that the NYS address provided below is our/my residence for a majority of the calendar year.

I am a professional health service provider, and wish to be a Provider Member of the Ithaca Health Alliance. I agree to offer the discount I specify below to IHA members, and to accept Ithaca HOURS for the listed % of services rendered. I understand that I am eligible for IHA grants and loans through the Health Fund program only if I reside in New York State, and join for \$50/yr. or more.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Health Modality/Service Offered: \_\_\_\_\_

Discount offered to Ithaca Health Alliance Members: \_\_\_\_\_

% Ithaca HOURS accepted for services rendered: \_\_\_\_\_

*Significant Other and/or Children:*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Number in Household: \_\_\_\_\_ Annual household income: \_\_\_\_\_

Insurance Provider, if any: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Email Address(es): \_\_\_\_\_

<b>Provider Membership Donation Info:</b> \$50 - 100/year for individual \$75/year for a spouse/partner \$50/year per child 10% discount for 2-year membership 100% payable in Ithaca HOURS (provider) 25% payable in Ithaca HOURS (family)	Provider:	\$
	Spouse/Partner:	\$
	Child:	\$
	2-year member	\$
	Total enclosed:	\$

Visa/MasterCard: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Verification #: \_\_\_\_\_

Signed: \_\_\_\_\_

Please print and sign this form, include a check payable to "Ithaca Health Alliance", and any Ithaca HOURS.

Mail to: Ithaca Health Alliance, PO Box 362, Ithaca, NY 14851

<http://www.ithacahealth.org>

[office@ithacahealth.org](mailto:office@ithacahealth.org)

(607) 330-1253

**Ithaca Health Alliance Provider Member Directory Information**

Please provide, briefly, information to be included in the directory of IHA Provider Members available on the IHA website, and available to members:

Health Modality/Service Offered: \_\_\_\_\_

Name, as you wish to be listed: \_\_\_\_\_

Contact information to be listed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **HIPAA NOTICE OF PRIVACY PRACTICES**

Please review this notice carefully. It is our HIPAA Notice of Privacy Practices, summarized for your convenience. A copy of the complete Privacy notice is available for your review upon request.

### Summary of HIPAA Notice of Privacy Practices

#### **A. Our Commitment to Your Privacy**

Your Individually Identifiable Health Information, further known as “IIHI” is defined as all health information that identifies you. We are required by law to maintain confidentiality of this health information and to provide you with this notice of our legal duties and the privacy practices of Ithaca Health Alliance. We will provide this information:

- \* How we may use and disclose your IIHI
- \* Your privacy rights in your IIHI
- \* Our obligations concerning the use and disclosure of your IIHI

#### **B. Questions about this Notice to:**

Privacy Officer, Ithaca Health Alliance, PO Box 362, Ithaca NY 14851  
E-mail [privacyofficer@ithacahealth.org](mailto:privacyofficer@ithacahealth.org)

#### **C. We may Use and Disclose your IIHI in the following ways:**

1. Treatment
2. Payment
3. Health Care Operations
4. Appointment Reminders
5. Treatment Options
6. Health-Related Benefits and Services
7. Release of Information to Family/Caregivers
8. Disclosure Required by Law

#### **D. Use and Disclosure of your IIHI in Certain Special Circumstances**

1. Public Health Risks
2. Health Oversight Activities
3. Lawsuits and Similar Proceedings
4. Law Enforcement
5. Deceased Patients
6. Organ and Tissue Donation
7. Research
8. Serious Threats to Health or Safety
9. Military
10. National Security
11. Inmates
12. Workers' Compensation

#### **E. Your Rights Regarding Your IIHI**

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

#### **Policy of the Ithaca Health Alliance:**

The Ithaca Health Alliance Board of Directors formally opposes the automatic disclosure of Individually Identifiable Health Information without a member's notification, consent and advice of counsel. It is the intent of the Ithaca Health Alliance to Guard your privacy rights through this notification process if called upon to respond to the use and disclosure of your IIHI in special circumstances as stated in HIPAA law.

Effective date of this notice: 14 April, 2003