Member Contact Information

The member's right to privacy and confidentiality shall extend to all records pertaining to the member's treatment except as otherwise provided by law. Summit Medical Compassion center believes that understanding and adhering to the federal HIPAA standards will ensure that we are meeting our privacy obligations to our members.

*Date: ______________________

*First Name: ___________________________*Last Name: __________________________________

Preferred first name (if different): ____

Current Address: ____

Apt/PO#:_______________ City:__________________________ Zip Code:_____________________

Phone #: _____________________________________

If we do call, may we leave a message? Yes No

*Emergency Contact: __________________________ *Relationship: __________________________

*Emergency Contact Phone #: ____

Preferred Rates Program Member Agreement

I, ______________________________________, am currently eligible for and/or receiving Rite Care, Food Supplement Benefits, Supplemental Security Income, Medicare, Social Security Disability Income; or, I am a military veteran or age 65 or over.I give Summit Medical Compassion Center the permission to verify my current eligibility with my Family Independence Specialist or case worker at DOH as Summit Medical Compassion Center deems necessary.
I have provided the original of the documents(s) selected below for Summit Medical Compassion Center to copy for their records. I understand that my records are kept confidential by Summit Medical Compassion Center to the extent possible under existing state statutes:

- ☐ Eligibility for Rite Care
- ☐ Eligibility for State of Rhode Island Food Supplement Benefits (EBT)
- ☐ Eligibility for Supplemental Security Income (SSI)
- ☐ Eligibility for Medicare
- ☐ Eligibility for Social Security Disability Income (SSDI)
- ☐ Proof of Military Service
- ☐ Proof of Being 65 Years or Older

I will notify Summit Medical Compassion Center and provide updated documentation if my eligibility for or status in the above-selected program(s) has been changed, renewed, or discontinued.
I understand that this Preferred Rates program may be altered or discontinued by Summit Medical Compassion Center at any time, with or without notice.

Member Signature ____ Date __________

Witness Signature ____ Date __________