

# DIAB Medical Group Colon Cancer Screening Program Agreement

This Agreement (the “Agreement”) is made as of the date set forth on the check box effected by CLIENT when signing up for the Services referenced herein, and is between DIAB Medical Group (“DIAB”) (DBA Tembihealth) and Client.

“Client” is a patient who signs up for services from DIAB and whose information is entered into the member client form.

“Providers” are Physicians, Nurse Practitioners, and Physician Assistants who provide medical services to patients on behalf of DIAB.

“Services” means the Colon Cancer Screening Program provided by DIAB to Clients, through telemedicine or otherwise.

## **The Parties and Their Roles**

The purpose of this Agreement is to set forth the terms on which DIAB provides the Services and the Client receives the Services. DIAB will not accept patients other than those who agree to the terms of this Agreement.

DIAB will provide Services to the Client at a level of professionalism and expertise consistent with that generally provided by primary and urgent care practitioners.

**Telehealth:** Client must request Services provided via telehealth through the dedicated site provided by the members program. DIAB providers do not prescribe medication or recommend any labs that are not consistent with the Colon Cancer Screening program. Client is responsible for Client’s data fees associated with the provision of Services.

**Cologuard Recommendations:** If indicated by the screening process, the provider will recommend Cologuard screening services. DIAB Medical Group

will submit the order request and provide Exact Science DBA Cologuard with the clients demographic information. Cologuard will then send the client the appropriate testing kit. It is the clients responsibility to complete the test and if the client fails to perform the test, DIAB is not responsible for any medical liabilities that could arise from non compliance. DIAB is not responsible for the cost that could arise from ordering Cologuard. DIAB providers will review Cologuard false positives and false negatives with the client and educate the client that a Colonoscopy is the choice of treatment for Colon Cancer Screening.

**Cologuard Screening Results:** DIAB will instruct the client to follow up with their respective Primary Care Physician if a test is positive. If the client does not have a primary care provider, the client will be instructed to follow up with their respective insurance or program. DIAB is not liable for any medical liabilities that could arise from the client's failure to follow up with either DIAB or Primary Care Physician for a positive result. A negative result also does not exclude the possibility of having Colon Cancer. DIAB highly encourages the client to follow up with their Primary Care Physician for a colonoscopy.

**Screening Recommendations:** It is the responsibility of the client to follow up with their Primary Care Physician for any recommendations made by DIAB providers. DIAB is not liable for any medical liabilities that could arise from the client's failure to follow DIAB recommendations.

**Labs:** DIAB may provide a lab order if appropriate. Laboratory results will be forwarded to Client's primary care physician. If a Client wishes to review his or her lab results with a Provider, Client is required to purchase another visit for such purpose. It is the Client's responsibility to visit his or her primary care physician for any abnormal laboratory values.

**Scheduled Visits:** Client agrees to schedule the initial screening visit with a DIAB provider and to schedule a follow up visit if a Cologuard screening is performed. Scheduled visits take approximately 10-20 minutes and are performed over video. If the client has difficulty in performing a video consultation, then a phone consultation will be performed.

**Termination of Agreement:** If Client violates any of the terms herein, this Agreement will immediately terminate and Providers may no longer provide the Services to Client. Upon termination of this Agreement,

**PA/NP:** Physician Assistant and Nurse Practitioners are highly qualified trained professionals that work under the supervision of a physician. These clinicians are qualified to interpret labs as well as treat and diagnose most conditions. They may prescribe medication within the scope of the supervising physician's practice and DIAB policies.

Colon Cancer Screening Program is available Mon-Friday 9am-5pm PST and is depending on schedule availability.

DIAB reserves the right to refuse to provide the Services to any Client via telehealth if telehealth would be inappropriate for Client's stated condition or symptoms.

### **DIAB Administrative Responsibilities**

DIAB will assist Client in creating an account, any website issues, telehealth troubleshooting and any customer service issues that might arise during a visit. DIAB will be available to assist Client during scheduled visits.

Client may request any results from the screening by emailing [concierge@ihealthrive.com](mailto:concierge@ihealthrive.com)

Client agrees that in the event Client does not receive a response from a Provider by phone or video within 10 minutes of Client's scheduled visit, Client will contact customer support to check on Provider's status. Neither DIAB nor the Provider will be liable to the Client for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to the Client.

There is a fee of \$15.00 for a copy of your complete medical record.

### **Additional Provisions**

At the discretion of the Provider, email and chat communications may be made a part of the Client's permanent medical record. Client understands and

agrees that email/chat is not an appropriate method of communication for emergencies, other time-sensitive issues, or inquiries regarding sensitive information.

In the event of an emergency, or a situation in which Client reasonably expects to develop into an emergency, Client agrees to call 911 or to visit the nearest emergency room.

DIAB Medical Group does not provide telehealth services for patients physically located in Puerto Rico.

DIAB may unilaterally amend this Agreement to the extent required by federal state, or local law or regulation (“Applicable Law”) without notice to Client. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by DIAB. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

Client may not assign this Agreement.

## **HIPAA NOTICE OF PRIVACY PRACTICES**

**This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. DIAB and Providers (“We”) must follow the privacy practices described below. This Notice will take effect on January 17, 2012 and will remain in effect until amended or replaced by us.

It is our right to change our privacy practices provided the law permits a change. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request.

We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting our Privacy Officer can be found at the end of this Notice.

## **TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION**

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your health care information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so..

**Payment:** We may use and disclosure health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclosure health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are

incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclosure your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management.

Reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclosure your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities** We will disclose healthcare information to report problems with products, reactions to medications, products recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information

is required for lawful intelligence, counterintelligence or any other national security activities, we may disclose it to authorized federal officials.

## **TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION**

**Appointment Reminders:** We may use or disclosure health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

## **YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine or copy your health information, you will need to submit your request in writing to our Privacy Officer at the address listed at the end of this notice. **Copies of each current file will be \$15.00, if only specific pages are needed the charge will be \$.50 per page requested.**

**Amendment:** You have the right to amend your health care information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclose information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years. Information prior to that date would not have to be released. (*Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.*)

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information.

We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.)

Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

## **CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

I, Client, hereby authorize **DIAB** To use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, DIAB can refuse to treat me.

I have been informed that DIAB has prepared a notice ("HIPAA Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying DIAB, in writing, but if I revoke my consent, such revocation will not affect any actions that took before receiving my revocation.

I understand that DIAB has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that DIAB restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations.

By using the Tembi website, I agree to receive telehealth services. Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data



communications. During my visit, my Tembi provider and I will be able to see and speak with each other from remote locations. I understand and agree that: I will not be in the same location or room as my medical provider. My Tembi provider is licensed in the state in which I am receiving services. I will report my location accurately during registration. Potential benefits of telehealth (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to a provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location. Potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold Tembi responsible for lost information due to technological failures. I further understand that my Tembi Provider's advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my Tembi provider relies on information provided by me before and during our telehealth encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability. I may discuss these risks and benefits with my Tembi provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to future treatment by Tembi. I understand that the level of care provided by my Tembi provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to the nearest medical center, hospital emergency department or other appropriate health care provider. I have the right to receive face-to-face medical services at any time by traveling to a medical center that is convenient to me. In case of an emergency, I will dial 911 or go directly to the

nearest hospital emergency room. I consent to, understand and agree that: I have the right to discuss the risks and benefits of all procedures and courses of treatment proposed by my health care provider(s), together with any available alternatives. Tembi will provide care consistent with the prevailing standards of medical practice but makes no assurances or guarantees as to the results of treatment.

I have the right to review and receive copies of my medical records, including all information obtained during a telehealth interaction, subject to Tembi's standard policies regarding request and receipt of medical records and applicable law. The laws of the state in which I am located will apply to my receipt of telehealth services.

By clicking on the box I agree to the terms and services listed above.