



Medical Privacy

National Standards to Protect the Privacy of Personal Health Information

BUSINESS ASSOCIATE CONTRACT PROVISIONS

This Business Associate Agreement is entered into by and between Evexia Diagnostics (the “Business Associate”) and _____ (“Clinician”) (each a “Party” and collectively the “Parties”). WHEREAS, Clinician agrees to comply with the Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. §§ 160.101-160.312; 164.102-164.534) (“Privacy Regulations”) as promulgated by the U.S. Department of Health and Human Services (“HHS”) pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) with respect to its dealings with Business Associate; and, WHEREAS, the Clinician has engaged the Business Associate to perform “Services” as defined below; and, WHEREAS, in the performance of the Services, the Business Associate must use and/or disclose Protected Health Information (“PHI”), as that term is defined in Section 164.501 of the Privacy Regulations, received from or transmitted to the Clinician; and, WHEREAS, the Parties are committed to complying with the Privacy Regulations with respect to dealings between Clinician and Business Associate; NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained, the Parties enter into this Business Associate Agreement (“Agreement”).

Section 1

SERVICES PROVIDED

Business Associate provides laboratory testing services, laboratory interpretation services for the Clinician. In the course of providing the Services, the use and disclosure of PHI between the Parties may be necessary. Clinician acknowledges that Business Associate does not provide a definitive diagnosis or treatment and that it is Clinician’s responsibility to attend to any abnormal value results. In the event of “Critical” lab results as defined by laboratory, Business Associate will notify Clinician as soon as it is aware of such results. Business Associate assumes no further responsibility in this instance and Clinician is ultimately responsible for patient’s care.

Section 2

Obligations and Activities of Business Associate

- a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
- b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.



- c. Business Associate agrees to report to Clinician any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
- d. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Clinician agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- e. Business Associate agrees to provide access, at the request of Clinician, and in the time and manner, to Protected Health Information in a Designated Record Set, to Clinician or, as directed by Clinician to an Individual in order to meet the requirements under 45 CFR § 164.524.
- f. Business Associate agrees to make internal practices, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Clinician available to the Clinician, within five (5) business days by fax or mail for purposes of the U.S. Department of Health & Human Services Secretary determining Clinician's compliance with the Privacy Rule.
- g. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Clinician to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

Section 3

Permitted Uses and Disclosures by Business Associate General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information on behalf of, or to provide services to, Clinician for the following purposes, if such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Clinician or the minimum necessary policies and procedures of the Clinician, including but not limited to:

- Disclosure of PHI as compelled for legal reasons;
- To any laboratory contracted by Business Associate;
- Internal licensed physicians utilized by Business Associate.

Section 4

Specific Use and Disclosure Provisions



- a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law.
- c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Clinician as permitted by 45 CFR § 164.504(e)(2)(i)(B).
- d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

Section 5

Obligations of Clinician

Provisions for Clinician to Inform Business Associate of Privacy Practices and Restrictions

- a. Clinician shall notify Business Associate of any limitation(s) in its notice of privacy practices of Clinician in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
- b. Clinician shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
- c. Clinician shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Clinician has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

Section 6

Permissible Requests by Clinician

Clinician shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Clinician.



Section 7

Term and Termination

a. Term. The Term of this Agreement shall be effective as of date signed below, and shall terminate when all of the Protected Health Information provided by Clinician to Business Associate, or created or received by Business Associate on behalf of Clinician, is destroyed or returned to Clinician, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b. Termination for Cause. Upon Clinician's knowledge of a material breach by Business Associate, Clinician shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Agreement if Business Associate does not cure the breach or end the violation within the time specified by Clinician;
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
3. If neither termination nor cure are feasible, Clinician shall report the violation to the Secretary of State.

c. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Clinician, or created or received by Business Associate on behalf of Clinician. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Clinician notification of the conditions that make return or destruction infeasible. If return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Section 8

Miscellaneous

EVEXIA DIAGNOSTICS™

- a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 with respect to its dealings with Business Associate.
- c. Survival. The respective rights and obligations of Business Associate under the “Effect of Termination” Section 8-C of this Agreement shall survive the termination of this Agreement.
- d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Clinician to comply with the Privacy Rule with respect to its dealings with Business Associate.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be duly executed effective as of the signing of this agreement.

Print Name

Clinician Signature

Date



Evexia Diagnostics
Michelle Holmes, Director of Corporate Compliance

Please Make a Copy of this Legal Document for Your Records



**LABORATORY SERVICES AGREEMENT
QUEST DIAGNOSTICS AND DOCTOR'S CHOICE**

CLINICAL SECURE FAX FORM

Dear Ordering Clinician:

Pursuant to the terms of your arrangement with Doctor's Choice, you have directed Quest Diagnostics to release all laboratory test results to Doctor's Choice, which is acting on your behalf as your "Business Associate" as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Other than critical results, which will be transmitted to your office by facsimile, Doctor's Choice will receive all the results from all of the tests that you order. By executing this document, you authorize such a disclosure of test results to Doctor's Choice, and you represent and warrant that if required, you have obtained any appropriate consent forms or authorizations required by your patients for whom you have ordered laboratory testing. If you agree to the guidelines as explained in this communication, we will be able to begin transmitting once you have completed this form and returned it to us.

Because we are transferring confidential patient medical information to your office in the facsimile transmissions, we ask that you verify that your receiving fax machine is in a secure location. We also require you to verify your fax number. If your fax machine prints on paper that may fade over time, you should make a copy of the faxed report to ensure longevity of the test report. Please provide the information requested below and fax this form to Quest Diagnostics at the number listed at the bottom of this letter.

Return of this letter by you constitutes your representation that the facsimile machine identified below for receiving the electronic transmission of your patients' test results is in a non-public and confidential area. You agree to advise Quest Diagnostics prior to changing your facsimile number. As the Client, you are solely responsible for transmissions of your patients' test results to fax numbers that were changed without prior notice to Quest Diagnostics. The signer of this document represents that he/she has the authority to sign this document on behalf of the Client, and acknowledges that Client is responsible for maintaining the security and confidentiality of the reports sent to the Telephone Number listed below.

Fax Format-Fax number entered in our database for faxing of critical reports.

Please complete information below. Account number(s) will be assigned by Quest Diagnostics once the paperwork has been returned.

Account Name: _____

Address where Fax is located: _____

Secure Fax Phone Number: _____

Effective Date: _____

Authorized Contact: _____ Contact Phone #: _____

Physician (Authorized) Signature: _____ Date: _____

Please PRINT Physicians' Name: _____ License #: _____

Please fax this letter back to FAX #: 888-952-2723



DOCTOR'S CHOICE™
Professional Laboratory & Diagnostic Services



TERMS OF SERVICE

Evexia Diagnostics requires payment through Visa, MasterCard, Discover or American Express credit cards. A valid credit card must be on file at all times. Please fill out the following credit card authorization agreement, read the terms below and sign.

NAME: _____ DEGREE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: _____

PHONE: _____ FAX: _____

REFERRED BY: _____

CIRCLE TYPE OF CARD: VISA MASTERCARD DISCOVER AMEX

CC# _____

EXP. DATE: _____ Security Code: _____

BILLING ADDRESS FOR CREDIT CARD IF DIFFERENT THAN ABOVE

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I _____ am an authorized signer on the above listed credit card and authorize Evexia Diagnostics to create an Evexia Diagnostics membership account(s) and keep my credit card and signature on-file and charge this credit card for every test or service ordered through the Evexia Diagnostics account(s) to which this credit card has been appropriately linked. Credit card billing takes place at the time of service or when laboratory results are finalized and transmitted. There is a \$300.00 membership fee to join. This includes a \$250 enrollment fee and an annual membership fee of \$50 for the first year. The annual membership renewal fee is \$50 per year, per Evexia Diagnostics account, and payable every 12 months. The annual membership renewal fee will be automatically charged to the credit card on-file, unless I notify Evexia Diagnostics in advance and in writing, using the appropriate Termination Form, of my intent to terminate my membership. I understand that I am financially responsible for all services ordered and laboratory tests performed through my Evexia Diagnostics account(s). I agree to follow all disclosed membership rules and guidelines as well as abide by all state and federal laws as a requirement for maintaining my active membership status with Evexia Diagnostics. I also agree to return or destroy all unused laboratory requisition forms, which are the property of Evexia Diagnostics, to Evexia Diagnostics if I decide to terminate my membership. I am submitting a copy of the active professional license(s) for the designated, healthcare provider(s) that will be utilizing my Evexia Diagnostics account(s), which is a requirement for membership. Please note that ordering labs for patients located in states other than those states for which a current license has been submitted to Evexia Diagnostics may result in automatic termination of my Evexia Diagnostics membership. I further assert that I understand that Evexia Diagnostics is ONLY a professional service, and that Evexia Diagnostics is NOT responsible for the medical care provided to any patient. It is the responsibility of the healthcare provider to obtain the proper patient authorizations, and Evexia Diagnostics will be held harmless in the event that the proper patient authorizations were not obtained.

Clinician Signature

Date