Consent Form

The purpose of this form is to obtain your informed consent for the medical services provided by RPM Care Coordination, PC, RPM Care Coordination, P.C., and RPM Care Coordination, P.A. ("Group") which may do business as Circadia Health. Care may be provided by Group staff including the medical doctor, nurse or other staff person. Care may include, but is not limited to, obtaining a medical history, performing a physical examination, recommending clinical observation, and providing treatment as needed. Treatment may include an order for remote patient monitoring ("RPM") as well as providing RPM services.

If RPM is ordered, Group will remotely monitor your respiratory rate and other vital signs and bio signals recorded during your stay to look for any subtle or significant abnormalities. Any clinical indications which are of concern to Group during your inpatient stay will trigger an alert to your on-site clinical team who are then also provided recommended follow up steps individualized for each patient.

The services provided by Group can be an important part of your care during your inpatient stay. Early detection and intervention may assist with avoiding serious clinical events such as respiratory failure, complicated cardio-pulmonary conditions, and emergencies like falls and injuries. Early detection and intervention may also avoid unnecessary hospitalizations.

As with any other medical treatment, medicine is not an exact science and diagnosis and treatment may involve risk of injury or even death. RPM services do not include and Group does not provide active patient monitoring. Group's RPM services are for retrospective analysis only and Group does NOT provide alarms for timely response in life-threatening situations.

WARNING!

IN THE EVENT OF AN EMERGENCY, CALL 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM. THIS IS NOT AN EMERGENCY SERVICE.

RPM services may include use of The Circadia C100 System (the "System") which Group will place within a detectable range of your bed and use to monitor your respiratory rate through radar technology. The System is indicated for both contactless spot checking and continuous measurement of respiratory rate data as part of a vital signs assessment. The System records, transmits, and displays respiratory rate from multiple connected devices for retrospective analysis only. The System is intended to be used under the care of clinicians and medically qualified personnel. The System is indicated for use in adult patients during no-motion conditions, for patients in health care facilities. It is available for sale only upon the order of a physician or licensed health care provider. The System is not indicated for active patient monitoring, as it does not provide alarms for timely response in life-threatening situations. The System is not intended to monitor vital signs. This System is not an apnea monitor.

[ ] I hereby acknowledge that I am aware of all potential risks associated with RPM treatment, including use of the System. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment by Group.

[ ] I have made the medical doctor and medical staff aware of all my known health conditions, allergies, and medications I am taking, including herbal medications/supplements.

[ ] I consent to treatment by Group. I understand I have the right to withdraw this consent at any time.

[ ] My signature below verifies that I have read all of the information contained in this Consent Form and that I have asked questions about anything I have not understood up to this point.

SIGNATURE

_____

PATIENT/LEGAL REPRESENTATIVE NAME DATE

_____ _____

[ ] VERBAL [ ] IN-PERSON

SERVICES AGREEMENT

This Services Agreement (the "Agreement") is between of RPM Care Coordination, PC, RPM Care Coordination, P.C., and RPM Care Coordination, P.A. ("Company") which may do business as "Circadia Health" and me, the Client identified below ("I," "me" or "Client") as of the date identified below. This Agreement sets forth the contractual rights and obligations of the parties with respect to the services (the "Services") provided by Company described below. This Agreement applies to my use of Company's technology platform for virtual telehealth services (the "Platform") (including any content therein) and the Services, including any new versions, updates, supplements, and support services Company makes available. By utilizing the Services, I accept the terms of this Agreement. If I do not accept them, I may not use the Platform or access the Services.

TERMS AND CONDITIONS

1. **DISCLAIMER OF WARRANTIES:** I understand that the Platform and Services may not accurately process the data I provide about myself, and the reports provided through the Platform or the Services, if any, may not be accurate. Company is not obligated to update or modify, in any manner, this or any later version of the Platform or the Services. Furthermore, Company is not responsible to provide any support to me in connection with my use of the Platform or the Services. To the maximum extent permitted by applicable law, Company and its suppliers provide the Services, and any technical advice or support services related thereto, AS IS AND WITH ALL FAULTS, and hereby disclaim all warranties and conditions, either express, implied or statutory, including, but not limited to, any (if any) implied warranties or conditions of merchantability, of non-infringement, of fitness for a particular purpose, of lack of viruses, of accuracy or completeness of responses, of results, and of lack of negligence or lack of workmanlike effort, all with regard to the Platform and the Services and the provision of or failure to provide technical or other support services.

2. **LIMITATION OF LIABILITY:** In no event shall Company, its agents, representatives, employees, contractors, and all affiliated entities or personnel be liable for any direct, indirect, consequential, incidental, exemplary, punitive special damages or any damages whatsoever whether arising from breach of warranty, breach of contract, negligence or any other legal theory, whether in tort or contract, even if such party has been apprised of the likelihood of such damages occurring, including without limitation, damages from interruption of business, loss of income or opportunities, loss of use of the Services, loss of data, cost of recreating data or cost of capital. My sole and exclusive remedy for any harm under this Agreement shall be to cease using the Services. These limitations will apply notwithstanding any failure of essential purpose of any limited remedy. Because some jurisdictions do not allow limitations on how long an implied warranty lasts, or the exclusion or limitation of liability for consequential or incidental damages, the above limitation may not apply to certain users. I agree to defend, indemnify and hold harmless Company and its officers, directors, agents, representatives and employees from and against any claims that arise from or relate to my breach of this Agreement or any other term required as a condition of use of the Platform, as well as for claims against Company related to care provided.

3. **CONSENT TO COMPANY'S FOCUSED APPROACH:** In seeking the Services of Company, I acknowledge that Company delivers care virtually and is focused on the use of technology to provide remote patient monitoring services. In entering into this Agreement, I acknowledge that this is a distinctive and highly focused approach and is not intended to take the place of my primary care and specialist physicians. If I do not consult my doctors on information I receive from the Company, I may be foregoing standard of care or evidence-based recommendations that may have negative health consequences. It is my responsibility to arrange for appropriate medical consultations and care directly with other physicians whose specialties are distinct from Company's offerings. The potential risks associated with Company's approach include lack of sufficient testing, questionable efficacy of recommended strategies to constitute "evidence-based" medicine; or delay in my seeking other treatment based on

unvalidated or scientifically unsupported practices. At all times, I understand and agree **to maintain a primary care physician** at my own expense and such other specialists, that my primary care physician may recommend or are appropriate for my health needs. I agree to consult my primary care physician and not Company to provide or refer to emergent and urgent care if needed. I understand that Company makes no representations, claims, or guarantees that my medical problems or conditions will be cured, solved, or helped by the Services.

4. **CONSENT TO TELEHEALTH:** I acknowledge that, as reflected in Company's Telehealth Authorization and Consent, Company provides telehealth services, meaning that Company services are provided virtually to me after my creation of an account, provision of information, payment, review of data, and consultation, all of which are prerequisites to Company determination that I am a good candidate for Company Services. Company reserves the right to decline or terminate service at any point for any reason. Using Company's Platform or visiting Company website and making payment do not establish a provider-patient relationship or duty. Please note that the content on Company website and that Company provides is for information purposes only and does not constitute professional medical advice. **I acknowledge that my failure to seek in-person care or care from a primary care physician may result in delay or failure to identify a medical condition that needs further investigation or immediate treatment that I need**. I understand that although Company uses reasonable efforts to safeguard my privacy and the confidentiality of all health information, Company cannot make any guarantees. I understand that Company will provide detailed information to help me and my doctor make an informed decision about how to manage my health. I understand that medicines, supplements, or treatments that Company may recommend, including over-the-counter medicines and supplements, can cause serious side effects and adverse events that include severe allergic reaction, permanent disability, and death. I understand that it is my responsibility to make an informed decision whether to accept a proposed treatment plan after weighing the risks and benefits of the proposed treatment plan with my primary care physician and/or other doctors, considering alternative treatment options and the risks and benefits of such alternatives, and the option of not seeking any treatment. I understand the importance of reading the manufacturer's leaflet that comes with a medicine, including an over-the-counter or behind-the-counter medicine, before taking a medicine because this leaflet includes important information about risks and warnings. I understand that adverse events can be caused by a number of things, including an allergic reaction, side effects, or interactions between a medicine that the doctor prescribes and any medical conditions I may have, other prescription medicines or other things (e.g., supplements, herbs, over-the-counter medicines, or recreational drugs) I am are taking, and lifestyle choices such as smoking tobacco products or drinking alcohol.

5. **CLIENT RESPONSIBILITIES:** I acknowledge and understand that I am voluntarily becoming a Client of Company and that this agreement is non-transferable and will govern my relationship for all Services provided by Company for my care. I acknowledge and understand that this Agreement does not provide health insurance coverage, is not a contract of insurance and that it provides only access to the particular Services specifically described herein, subject to Company policies. I acknowledge and understand that I am responsible for any charges incurred for healthcare services received outside of Company. In order to receive the best possible care, I agree to be actively involved in my care decisions and to disclose all relevant information to Company to achieve my health goals. I also agree to inform Company of care received elsewhere. I agree to maintain insurance coverage to obtain hospital or catastrophic services if needed. I acknowledge that, in an emergency, I must call 911 immediately before contacting Company and seek any needed emergency care without waiting for Company to respond.

6. **HEALTH INFORMATION:** I acknowledge and understand that Company maintains a record of my health information and protects the privacy of my health information as per the terms of the accompanying **Notice of Privacy Practices.**

7. **TERMINATION:** This Agreement shall become effective on the first date of Services and shall continue in full force and effect unless and until terminated by Company or me. This Agreement may be terminated by me at any time and for any reason, or for no reason, by sending a written Services Cancellation Form by email to support@circadia.health. Upon termination, Company shall cease to be responsible for my care. Such notice will be effective on the date actually received. Should I terminate the Agreement after Company has begun to provide services, I will be responsible for payment for all services rendered by Company through the date on which services actually terminate. I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my Services cancellation. I acknowledge and understand that Company reserves the right to terminate this Agreement and discharge me as a Client at any time, with or without cause, including failure to pay bills and refusal to cooperate. I will be provided with written notice of termination thirty (30) days in advance of the effective date by email. Company will not terminate this Services Agreement solely on the basis of my health status.

8. **FINANCIAL RESPONSIBILITY:** I hereby acknowledge that payment in full for services rendered or other claims is due upon the services being rendered. Services may be discontinued on either a temporary or permanent basis if the balance is not paid as provided for herein. I understand and agree that I am accepting financial responsibility for this debt and will be required to pay for all services provided by Company I agree to pay any and all costs and expenses incurred by Company in the collection of this debt, including but not limited to court costs, attorneys' fees, and costs of appeal.

9. **PRICES, TERMS AND CONDITIONS:** Company reserves the right to amend the prices, terms, and conditions of this Agreement without advance notice to me, which may be given by email or directly on the Platform. Subject to applicable laws, rules, and regulations, this Agreement represents the entire agreement of the parties regarding the medical services provided by Company. No other amendments or modifications may be made by either party without notice to and acceptance in writing by both parties.

10. **BINDING:** This is part of a legally binding contract by and among Company, me, and any other entity through which services are delivered in connection with Company. In the event that I receive services on more than one occasion and/or at more than one location and/or through more than one of Company's affiliated entities, this Agreement govern the parties' relationship continuously throughout its term. This Agreement incorporates by reference as if set forth here all other documents that Company provides or asks me to complete, including without limitation the Notice of Privacy Practices.

11. **CONSENT FOR SERVICES:** I am voluntarily seeking Services that Company provides for the purpose of medical diagnosis and or medical consultation, and do hereby consent to all related examinations, treatments, and/or diagnostic procedures as may be deemed advisable by Company. In the event that payment is made and/or the Platform is used by a minor, the minor's parent(s) and/or guardian will be deemed to have given consent through the provision of a credit card to initiate payment and utilization of the Platform.

12. **NOTICE OF CHARGES:** I am responsible for the payment of the fees described on Company's website for the Services. Company's charges do not include any fees for hospital- or other facility-based care, laboratory fees or medication fees. I agree that payment of Company's Fees is my sole and exclusive responsibility. A late fee of ten percent (10%) per annum will accrue on any unpaid balances' delinquent for more than thirty (30) days. Delinquent accounts will be referred for collection. Bank charges on returned checks are my responsibility in the amount of $50.00.

13. **NO GUARANTEES:** I acknowledge and agree that the results I receive are not guaranteed and the Services may not work for me given the unique issues presented by me and the nature of the treatment I will receive. The efficacy of the Services does not relieve me of my obligation to pay.

14. **AGREEMENT TO PAY FEES:** In exchange for receiving the Services described in this Agreement, I agree to pay Company's Fees. I agree to prepay the Fees via cash, check, credit card or any other method as Company requests and accepts. I acknowledge that Company does not participate in any health insurance plans, does not bill insurance, and Company fees are not covered or reimbursable by Medicare or any other insurance.

15. **CREDIT CARD AUTHORIZATIONS:** If I pay by credit card, I authorize the Company to charge the credit card for services rendered in accordance with the terms and conditions of this Agreement. I understand and acknowledge that any charges made to my credit card under this Agreement will constitute a "final sale." The amount to be charged to the credit card shall be determined in accordance with the payment terms of the Agreement. Notwithstanding any rejection or declination of the credit card for any reason, I agree to be liable and financially responsible for any and all Fees and charges due for the Services. If there is a credit card dispute, Company may immediately suspend acceptance of the credit card and demand payment in full of all amounts due in cash, by electronic transfer or by certified check. If there is a limitation on individual transactions, Company may divide the total charge into incremental portions in order to process the charge on the credit card.

16. **TERM AND TERMINATION OF SERVICES:** Company may terminate services to me for any reason, at any time, subject to applicable law. Without limiting the foregoing, Company may terminate treatment services in the following situations: If I were not truthful during my encounter with Company or about my health condition; or if I breach the terms of this Agreement. The obligations set forth in this Agreement shall survive termination and remain enforceable.

17. **CONTACTING US:**

18. **EMERGENCY**: If I am experiencing severe pain, distress, or any medical emergency, call 911 and/or go to the nearest hospital emergency room immediately without delay. Contact Company only after first seeking emergency care and contacting my primary care physician.

19. **TELEPHONE**: Provider may not immediately be available by telephone. Company return messages as promptly as Company can, but may be delayed outside of regular business hours, on weekends, and holidays. If Provider is unavailable for an extended period, Company will provide I with an alternative contact.

20. **EMAIL**: I may email Company at support@circadia.health regarding administrative matters. Although privacy and security regulations limit the modalities of communication, I hereby authorize Company to communicate with me by email message and SMS text, or any other method to which I have consented by providing contact information in my registration and request for Services from Company. I acknowledge that Company is communicating in this manner irrespective of HIPAA or state legal requirements solely at my direction. I may revoke that permission in writing, at any time, in which event Company will stop any further use or disclosure of my medical information by email, except to the extent Company has already acted in reliance on my permission. I understand that Company is unable to take back any disclosure Company has already made with my permission and that Company is required to retain records of the communications prior to any revocation of authorization to utilize email in communicating with me.

21. **COOPERATION:** Company and I agree to cooperate on all matters regarding this Agreement, including, without limitation, taking actions as the other party may reasonably request, for the purpose of carrying out the intent of this Agreement.

22. **CLIENT RECORDS:** Company will retain the original signed Agreement in my personal record and provide me with a copy of the signed Agreement at any time upon my request. Company is required to keep an archive of my health records as a Client. The archive is maintained under lock and key, for a minimum of seven (7) years from the date of services on the Platform. I am entitled to receive a copy of my health record under most circumstances.

23. **CONFIDENTIALITY:** Information regarding my healthcare, including payment for healthcare, is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d et seq., 45 C.F.R. Parts 160 & 164. Under this law, Company may not disclose any protected information except as permitted by law. The law allows us to share information with my caregivers, to bill and collect, to communicate with financially responsible people, and for Company operations. Please see the Notice of Privacy Practices for more information. Company will obtain my consent and written authorization prior to the release of information concerning I except in those circumstances when permitted or required by law to release information. Without limiting any of the foregoing, if payment is made by credit card, I further agree as follows: in the event of any credit card dispute as to any services rendered, Company staff or representatives are authorized to submit to the applicable credit card company, this Agreement or any other agreement or documents Company or its staff deems reasonably necessary to establish that services were rendered and that I agreed to be responsible for payment. Company shall submit only minimally necessary portions of my identifying information/records and if further information is required to establish the provision of services, I agree to provide any necessary authorizations in an expeditious manner. *Please note that, as a condition of this Agreement, I authorize Company to record any videoconferencing interactions (for purposes of ensuring compliance and quality improvement). I also agree that the recording by me of any video or audio recording of any encounter on the Platform or during the Services is prohibited without written permission from Company. Unless I have otherwise specified in writing to* support@circadia.health, *I authorize Company to contact me through any modality of communication or contact information provided in the registration.*

24. **GRIEVANCES:** If I feel that I am being mistreated or treated inappropriately and wish to complain, I may do so by submitting a written complaint to Company at support@circadia.health. Company will review my complaint and the findings and recommendations will be reported back to me within three (3) business days.

25. NOTICE TO CONSUMERS: I acknowledge that I understand that physicians in California are licensed and regulated by the Medical Board of California. More information is available from the Medical Board at (800) 633-2322 and www.mbc.ca.gov.

26. **DISPUTE RESOLUTION:** In the event that any disagreement, dispute or claim arises among the parties hereto with respect to the enforcement or interpretation of this Agreement or any specific terms and provisions hereof or with respect to whether an alleged breach or default hereof has or has not occurred (collectively, a "Dispute"), such Dispute shall be settled in accordance with the arbitration provisions of this Agreement. All other disputes that cannot be resolved by the parties within sixty (60) days of a demand shall be resolved by final and binding arbitration before a single arbitrator who shall be a retired judge or attorney (the "Arbitration"), which shall be initiated and administered by and in accordance with the then current arbitration rules of JAMS in Los Angeles County, with the exact time and location decided by the arbitrator selected in accordance with the then current arbitration rules of JAMS, subject to the requirement that the arbitration be completed within 60 days. The arbitrator shall apply California substantive law or federal

substantive law where state law is preempted. Discovery shall be limited and minimal, with the arbitrator selected having the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions, and penalties as can be imposed in like circumstances in a civil action by a court of competent jurisdiction of the State of California. The arbitrator(s) shall have the power to grant all legal and equitable remedies provided by California law and award compensatory damages provided by California law, except that punitive damages shall not be awarded. The arbitrator(s) shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based. The arbitration award may be enforced through an action thereon brought in the Superior Court for the State of California in Los Angeles County. The prevailing party in any Arbitration hereunder shall be awarded reasonable attorneys' fees, expert and non-expert witness costs and any other expenses incurred directly or indirectly with said Arbitration, including without limitation the fees and expenses of the arbitrator(s).

27. MISCELLANEOUS

27.1. Amendments. This Agreement shall not be modified or amended except by a written document executed by all parties to this Agreement, and such written modifications shall be attached hereto.

27.2. Successors and Assigns. I may not assign this Agreement or delegate any right or duty hereunder without the prior written consent of Company. Subject to the foregoing, this Agreement shall be binding on, and shall inure to the benefit of, the parties to it and their respective heirs, legal representatives, estates, successors in interest, legatees, permitted transferees, and assigns.

27.3. Severability. If any provision in this Agreement is found to be invalid or unenforceable by acourt of competent jurisdiction, I agree that the remainder of this Agreement shall remain in full force and shall not be affected by the invalid or unenforceable provision. No provision in this Agreement shall be deemed dependent on any other provision unless expressly stated in this Agreement.

27.4. Notices. All notices, requests, demands, and other communications under this Agreement shall be in writing and shall be deemed to have been duly given on the date of Services if served personally on the party to whom notice is to be given, or within four (4) days after mailing, if mailed to the party to whom notice is to be given, by first class mail, registered or certified, postage prepaid, and properly addressed to Company at the address set forth above or me at my address as set forth above, or any other address that any party may designate by written notice to the others.

27.5. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of California, without giving effect to its conflict of law or choice of law provisions or decisions.

27.6. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

27.7. Integration. This Agreement, and all attachments, exhibits, and other agreements referenced herein or contemplated hereby constitute the entire agreement between the parties hereto pertaining to the subject matter hereof and supersede all prior agreements, understandings, negotiations, and discussions, whether oral or written, of the parties, and there are no warranties, representations or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein.

27.8. Waiver. No waiver of any of the provisions of this Agreement shall be deemed to be or shall constitute a waiver of any other provision hereof, whether or not similar, nor shall such waiver constitute a continuing waiver unless otherwise expressly provided.

27.9. Force Majeure**.** Company shall not be liable for any injury, damage, claim, loss, or failure in performance under this Agreement resulting, directly or indirectly, from activities beyond Company's control, including without limitation acts of God, accidents, fires, explosions, earthquakes, floods, failure

of transportation, equipment, or supplies, vandalism, strikes, infectious diseases, or other similar causes beyond control.

***I HEREBY CERTIFY THAT I HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE ABOVE TERMS AND CONDITIONS OF THIS SERVICES AGREEMENT, USE OF THE COMPANY PLATFORM, AND RECEIPT OF SERVICES THROUGH COMPANY. I ACKNOWLEDGE* AND AGREE TO ALL OTHER TERMS PUBLISHED ON COMPANY'S WEBSITE, INCLUDING WITHOUT LIMITATION THE TERMS OF USE, PRIVACY POLICY, AND TELEHEALTH AUTHORIZATION AVAILABLE ON THE WEBITE, WHICH ARE INCORPORATED BY REFERENCE AS IF SET FORTH HEREIN.**

BY CLICKING ABOVE, I AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT. IF I DO NOT AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT, I WILL NOT CLICK ABOVE AND WILL NOT USE THE SERVICES. MY USE OF THE PLATFORM AND THE SERVICES ARE SUBJECT AT ALL TIMES TO THE TERMS AND CONDITIONS OF THIS AGREEMENT. IF, AT ANY TIME, I NO LONGER WISH TO BE BOUND BY THE TERMS AND CONDITIONS OF THIS AGREEMENT, I MUST IMMEDIATELY CEASE ALL USE OF THE SERVICES. FOR THE PURPOSES OF THIS AGREEMENT, "I" REFERS TO THE INDIVIDUAL TO WHOM THE USERNAME AND PASSWORD USED TO ACCESS THIS AGREEMENT IS ASSIGNED AND HIS, HER OR ITS AFFILIATES, EMPLOYEES, AGENTS AND PERMITTED SUCCESSORS AND ASSIGNS.

SIGNATURE

_____

PATIENT/LEGAL REPRESENTATIVE NAME DATE

_____ _____

NOTICE OF PRIVACY PRACTICES

The purpose of this notice is to inform you about the privacy practices of RPM Care Coordination, PC, RPM Care Coordination, P.C., and RPM Care Coordination, P.A. ("Group") which may do business as Circadia Health.

Group is dedicated to maintaining the privacy of your protected health information ("PHI"). PHI is information about you that may be used to identify you (such as your name, social security number or address), and that relates to (a) your past, present or future physical or mental health or condition, (b) the provision of healthcare to you, or (c) your past, present, or future payment for the provision of healthcare. In conducting its business, Group may receive and create records containing your PHI. Group is required by law to maintain the privacy of your PHI and to provide you with notice of its legal duties and privacy practices with respect to your PHI.

Group must abide by the terms of this Notice while it is in effect. This Notice is in effect from the date noted above until Group replaces it. Group reserves the right to change the terms of this Notice at any time, as long as the changes are in compliance with applicable law. If Group changes the terms of this Notice, the new terms will apply to all PHI that it maintains, including PHI that was created or received before such changes were made. If Group changes this Notice, it will post the new Notice on its Platform and will make the new Notice available upon request.

1. **Uses and Disclosures of PHI**. Group may use and disclose your PHI in the following ways:

- **Treatment, Payment and Healthcare Operations.** Group is permitted to use and disclose your PHI for purposes of (a) treatment, (b) payment and (c) healthcare operations. For example:

    - **Treatment.** Group may disclose your PHI to a physician in connection with the provision of treatment to you.

    - **Payment.** Group may use and disclose your PHI to your health insurer or health plan in connection with the processing and payment of claims and other charges.

    - **Healthcare Operations.** Group may use and disclose your PHI in connection with its healthcare operations, such as providing customer services and conducting quality review assessments. Group may engage third parties to provide various services for Group. If any such third party must have access to your PHI in order to perform its services, Group will require that third party to enter an agreement that binds the third party to the use and disclosure restrictions outlined in this Notice.

- **Authorization.** Group is permitted to use and disclose your PHI upon your written authorization, to the extent such use or disclosure is consistent with your authorization. You may revoke any such authorization at any time.

- **As Required by Law.** Group may use and disclose your PHI to the extent required by law.

- **Special Circumstances.** The following categories describe unique circumstances in which Group may use or disclose your PHI:

    - **Public Health Activities.** Group may disclose your PHI to public health authorities or other governmental authorities for purposes including preventing and controlling disease, reporting child abuse or neglect, reporting domestic violence and reporting to the Food and Drug

Administration regarding the quality, safety and effectiveness of a regulated product or activity. Group may, in certain circumstances disclose PHI to persons who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

- **Workers' Compensation.** Group may disclose your PHI as authorized by, and to the extent necessary to comply with, workers' compensation programs and other similar programs relating to work-related illnesses or injuries.

- **Health Oversight Activities.** Group may disclose your PHI to a health oversight agency for authorized activities such as audits, investigations, inspections, licensing and disciplinary actions relating to the healthcare system or government benefit programs.

- **Judicial and Administrative Proceedings.** Group may disclose your PHI, in certain circumstances, as permitted by applicable law, in response to an order from a court or administrative agency, or in response to a subpoena or discovery request.

- **Law Enforcement.** Group may, under certain circumstances, disclose your PHI to a law enforcement official, such as for purposes of identifying or locating a suspect, fugitive, material witness or missing person.

- **Decedents.** Group may, under certain circumstances, disclose PHI to coroners, medical examiners and funeral directors for purposes such as identification, determining the cause of death and fulfilling duties relating to decedents.

- **Organ Procurement.** Group may, under certain circumstances, use or disclose PHI for the purposes of organ donation and transplantation.

- **Research.** Group may, under certain circumstances, use or disclose PHI that is necessary for research purposes.

- **Threat to Health or Safety.** Group may, under certain circumstances, use or disclose PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- **Specialized Government Functions.** Group, may in certain situations, use and disclose PHI of persons who are, or were, in the Armed Forces for purposes such as ensuring proper execution of a military mission or determining entitlement to benefits. Group may also disclose PHI to federal officials for intelligence and national security purposes.

2. **Your Rights Regarding Your PHI.** You have the following rights regarding the PHI maintained by Group :

- **Confidential Communication.** You have the right to receive confidential communications of your PHI. You may request that Group communicate with you through alternate means or at an alternate location, and Group will accommodate your reasonable requests. You must submit your request in writing to Group.

- **Restrictions.** You have the right to request restrictions on certain uses and disclosures of PHI for treatment, payment or healthcare operations. You also have the right to request that Group limits its disclosures of PHI to only certain individuals involved in your care or the payment of your care. You must submit your request in writing to Group. Group is not required to comply with your request. However, if Group agrees to comply with your request, it will be bound by such agreement, except when otherwise required by law or in the event of an emergency.

- **Inspection and Copies.** You have the right to inspect and copy your PHI. You must submit your request in writing to Group. Group may impose a fee for the costs of copying, mailing, labor and supplies associated with your request. Group may deny your request to inspect and/or copy your PHI in certain limited circumstances. If that occurs, Group will inform you of the reason for the denial, and you may request a review of the denial.

- **Amendment.** You have a right to request that Group amend your PHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is maintained by Group. You must submit your request in writing to Group and provide a reason to support the requested amendment. Group may, under certain circumstances, deny your request by sending you a written notice of denial. If Group denies your request, you will be permitted to submit a statement of disagreement for inclusion in your records.

- **Accounting of Disclosures.** You have a right to receive an accounting of all disclosures Group has made of your PHI. However, that right does not include disclosures made for treatment, payment or healthcare operations, disclosures made to you about your treatment, disclosures made pursuant to an authorization, and certain other disclosures. You must submit your request in writing to Group and you must specify the time period involved (which must be for a period of time less than six years from the date of the disclosure). Your first accounting will be free of charge. However, Group may charge you for the costs involved in fulfilling any additional request made within a period of 12 months. Group will inform you of such costs in advance, so that you may withdraw or modify your request to save costs.

- **Breach Notification.** You have the right to be notified in the event that Group (or a Group Business Associate) discovers a breach of unsecured PHI.

- **Paper Copy.** You have the right to obtain a paper copy of this Notice from Group at any time upon request. To obtain a paper copy of this notice, please contact Group by calling 800 985 5596.

- **Complaint.** You may complain to Group and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. To file a complaint with Group, you must submit a statement in writing to Group at support@circadia.health. Group will not retaliate against you for filing a complaint.

- **Further Information.** If you would like more information about your privacy rights, please contact Group by calling 800 985 5596 and ask to speak to the Privacy and Security Officer. To the extent you are required to send a written request to Group to exercise any right described in this Notice, you must submit your request to support@circadia.health.

SIGNATURE

_____

PATIENT/LEGAL REPRESENTATIVE NAME

_____

DATE

_____