BAY AREA WELLNESS CENTER
PRIVATE PRACTICE-PATIENT AGREEMENT

This Private Practice-Patient Agreement ("Agreement") specifies the terms and conditions under which, you, the undersigned patient ("Patient") may voluntarily elect to participate in the healthcare services defined below offered by Frank Tortorice, M.D., Inc., a California professional corporation dba Bay Area Wellness Center ("Practice"), with such services further described in Schedule A and as follows:

- Practice's comprehensive, annual integrative/Functional medicine-based diagnostic routine exam services, provided regardless of medical condition or necessity, supported by follow-up routine diagnostic exams, as further specified in Schedule A (collectively "Wellness Exams"); and
- An online health data storage and communication facilitation platform plan designed to provide efficient and reliable electronic communication and health data storage support for Wellness Exams and to help Patient to achieve Wellness Exams-based health goals ("Health Data Plan"). Wellness Exams and the Health Data Plan described in Schedule A are collectively the "Wellness Exam Services" and Patient and Practice are referred to individually as "Party" or collectively as the "Parties".

WELLNESS EXAM SERVICES

Practice makes Wellness Exam Services available to Patient in exchange for Patient's payment of the program subscription fees outlined in Schedule A ("Services Fees"). Services Fees may increase from time to time with Patient's voluntary consent in advance but will apply to renewal terms. If Services Fees increase, Practice will notify Patient in writing with the option to consent to the increase.

Practice reserves the right to update the Wellness Exam Services in Schedule A from time to time, and if it does, Practice will notify Patient of any changes within thirty (30) days after a change is made and shall secure Patient's voluntary consent to any such modification of Wellness Exam Services or Services Fees. Wellness Exam Services exceed or are beyond those covered by Patient's Medicare, Medicaid, or private insurance plan (collectively "Plan"). Because Wellness Exam Services may include integrative medicine alternatives, Patient provides informed consent to such services as documented in the attached Schedule B.

PAYMENT OPTIONS

Patient may pay the Services Fees with a check, credit card, or debit card either monthly, quarterly, or annually. Wellness Exam Services costs are designed to qualify as eligible medical expenses such that Patient may pay Services Fees with health saving account ("HSA") funds or with flexible spending account ("FSA") fund or health reimbursement account ("HRA") funds, but this is not assured or promised. Patient must confirm eligibility with Patient's tax expert or FSA/HRA plan coordinator as Practice cannot guarantee medical expense eligibility due to variable factors applicable to each Patient. Services Fees cover the availability of the Wellness Exam Services selected by and subscribed to by Patient for a period of one (1) year.

RENEWALS AND TERMINATION

This Agreement will automatically renew one (1) year from the date of this Agreement unless the Practice receives written notice from Patient to terminate this Agreement thirty (30) days before Patient's renewal date or Practice terminates the Agreement. Failure to pay the renewal Services Fees before the expiration of the prior period may result in termination of this Agreement. The Practice is permitted to terminate this Agreement with thirty (30) days' prior written notice to Patient, in which case Patient will receive a prorated refund of the Services Fees but the delivery of any Wellness Exams renders Services Fees substantially earned by Practice.

HEALTH CARE SERVICES EXCLUDED FROM SERVICES FEES

Services Fees cover only the availability of Wellness Exam Services subscribed to by Patient. If the Practice provides services other than the Wellness Exam Services listed in Schedule A, Patient and Practice may mutually agree upon any additional charges, if any, to the extent the Patient's Plan does not cover those services. Patient acknowledges that either Patient or Patient's Plan may be responsible for any applicable additional charges for services outside of those described in Schedule A. Any charges to Patient for any services outside of Plan coverage and not reflected in Schedule A will be at Practice's usual, reasonable, and customary rates and consented to in advance by Patient. Practice will collect any applicable co-payments or deductibles related to Plan-covered services the Practice delivers to the Patient to the extent that the Practice is in-network with the applicable Plan.

ELECTRONIC COMMUNICATIONS

If Patient wishes to communicate through electronic mediums with the Practice, Patient needs to be aware that electronic mediums may not always constitute a secure method for sending or receiving sensitive personal health information. Practice will take reasonable steps to keep Patient's communications confidential and secure and comply with applicable health data privacy obligations under applicable laws. In the event the communication is time-sensitive and requires quick or urgent or emergent healthcare response, Patient must communicate with their primary care healthcare professional and/or secure immediate emergency room/ER medical attention. If Patient experiences any side effects or worsening conditions (that do not constitute an emergency or time-sensitive situation) related to Integrative Services (defined in Schedule A), or therapies or medications related to Integrative Services, Patient agrees to inform Practice of such side effects or worsening conditions in accordance with the procedures specified in Practice's separate Electronic Communications Agreement. Electronic communications must be non-urgent, and will be responded to on a next day or two-day basis, not including non-business days. Please refer to Practice's separate Electronic Communications Agreement for further applicable details in this regard, which is integrated herein by this reference.

APPOINTMENTS AND SCHEDULING

Appointments with the Practice are scheduled through the Practice office to ensure ample time is given to each Patient. If Patient has an urgent concern, Patient shall call the Practice office and Patient will be given an appointment that will accommodate the urgency. Walk-ins are not conducive to the thoughtfully planned schedule, so we advise Patient to schedule appointments in advance.

MEDICARE/PRIVATE INSURANCE

If Patient is or becomes Medicare eligible, Patient acknowledges that Practice is a participating Medicare provider. While Practice does not anticipate providing any healthcare services covered by Medicare or any other Plan, should Practice provide any services covered by Patient's applicable Plan then Practice may submit to such Plan to the extent Practice is in-network with such Plan and collect any applicable co-payment or deductible as required by Plan terms. Patient shall **not** submit to Medicare any claim for payment of Services Fees or request that Practice submit such a claim. Patient acknowledges and understands that Medicare does not cover and will not pay for the Wellness Exam Services, and Patient agrees **not** to submit Services Fees to Medicare for reimbursement.

VACATIONS AND ILLNESS FOR PRACTICE HEALTHCARE PROFESSIONAL(S)

Patient acknowledges that there may be times that Patient cannot contact a Practice healthcare professional due to vacations or illness, or due to technical defects with either Patient's or Practice's electronic communication equipment. Patient acknowledges that, should a Practice healthcare professional become unavailable, the Practice shall make every effort to give advance notice to Patient so that scheduled

Wellness Exam Services can be scheduled on another date. In all cases of emergency, Patient must call 9-1-1 and/or seek emergency/ER medical attention.

COMPLIANCE WITH LAW

In establishing the Wellness Exam Services programs, Practice intends to do so in compliance with all applicable laws. This Agreement shall be governed by and construed in accordance with the laws of the state in which Practice is licensed and practicing, without application of choice-of-law principles. If there is a change of any law, regulation or rule, federal, state or local, which affects the Agreement or the activities of either Party under the Agreement, or any change in judicial or administrative interpretation of any such law, regulation or rule, this Agreement shall be deemed modified so as to remain in compliance with such laws.

PRACTICE IS NOT AN INSURER

Practice is not an insurance company and is not promising or delivering unlimited care for Services Fees. The Practice presumes that Patient is either eligible for Medicare, or otherwise has a private Plan that provides health care coverage for essential healthcare services not covered by the Services Fees.

AGREEMENT ASSIGNMENT AND MODIFICATIONS

Patient may not assign this Agreement. This Agreement replaces and supersedes all prior agreements of any kind, oral or in writing, between Patient and Practice. This Agreement may not be modified absent a writing signed by Patient and an authorized representative of Practice.

PATIENT ACKNOWLEDGES THAT HE/SHE HAS CAREFULLY READ THIS AGREEMENT, WAS AFFORDED SUFFICIENT OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL OF HIS/HER CHOICE AND TO ASK QUESTIONS AND RECEIVE SATISFACTORY ANSWERS REGARDING THIS AGREEMENT, UNDERSTANDS HIS/HER RESPECTIVE RIGHTS AND OBLIGATIONS UNDER THIS AGREEMENT, AND SIGNS THIS AGREEMENT OF HIS/HER OWN FREE WILL AND VOLITION.

By signing below, I am agreeing to enrollment in the Wellness Exam Services and the terms of this Agreement as detailed above and in Schedule A and Schedule B.

PRACTICE:

FRANK TORTORICE, M.D., INC.
A CALIFORNIA PROFESSIONAL
CORPORATION DBA BAY AREA WELLNESS
CENTER

Signature:_____

Name/Title: Dr. Frank Tortorice/President

Date:_____

PATIENT:

Signature:_____

Printed Name:_____

Relationship to Patient:_____

Date:_____

SCHEDULE A
WELLNESS EXAM SERVICES & SERVICES FEES

1. Wellness Exams

Practice will provide Patient the availability of one (1) annual comprehensive root cause of illness diagnostic Wellness Exam, and follow-up routine Wellness Exams, intended to help guide health goals identified in the annual comprehensive Wellness Exam with focuses as specified below. A Wellness Exam is a routine integrative/Functional medicine-based root cause of illness diagnostic evaluation and diagnosis physical exam, detached from medical condition or necessity. Wellness Exams may include: analysis of hormone replacement therapy options and other integrative medicine alternative services as referenced below (collectively "Integrative Services").

Wellness Exams may also include the need for Wellness Exams-based labs and Wellness Exams-based treatments. Wellness Exams-based labs and Wellness Exams-based treatments constitute out-of-pocket Patient costs that Patient may be able to submit to Patient's Plan for reimbursement, but such reimbursement is not guaranteed. Such out-of-pocket Patient cost items are not included in or covered by Services Fees. Patient understands that Wellness Exams may involve the delivery of hormone health treatments on an integrative and not strictly allopathic basis, and Patient provides informed consent to such services as documented in the attached Schedule B.

Wellness Exams shall integrate the following health principles and goals:

- Optimizing health
- Promoting weight management via diet and nutrition-based goals
- Creating and guiding fitness and lifestyle goals
- Improving overall health awareness and equipping Patient with enhanced health education

2. Health Data Plan

The Health Data Plan ("Health Data Plan") assists with storing Patient's Wellness Exams health data and improves Patient's electronic communication connection with Practice to facilitate Wellness Exams health goals and education as outlined above. The Health Data Plan facilitates and empowers Patient to interact with Practice via electronic communication regarding Practice's Wellness Exam Services. Practice's Health Data Plan will keep Patient's medical information electronically stored so that, upon request of Practice, information can be retrieved and furnished to further support the Wellness Exam Services Patient receives from Practice on the terms outlined below.

3. Services Fees

Wellness Exam Services **(Wellness Exams + Health Data Plan)** $4,250/year or $355/month

• One (1) annual Functional Medicine comprehensive Wellness Exam to detect root cause of disease and achieve healthcare prevention/mitigation goals
• Follow-up Wellness Exams (virtual and in person) to support comprehensive annual Wellness Exam health goals
• Follow-up Wellness Exams may include (if applicable/as noted):
  • Cognitive assessment administration and review of cognitive assessment results (dementia related only)
  • Cardiovascular disease assessments/support
  • Pre-diabetes/diabetes assessment/support
• Health coaching sessions to support annual comprehensive Functional Medicine Wellness Exam health goals and desired behavior modifications
• Wellness Exams-supportive Health Data Plan electronic communication services aimed toward reaching Patient/Practice Wellness Exam health goal objectives

4. Additional Terms

Due to the smaller patient panel size of the Practice, Practice anticipates Patient will enjoy little or no wait times for exams scheduling and related electronic Practice communications. Practice's healthcare professional(s) will also have the extended time and availability to provide unhurried visits to support ongoing health guidance and education. Due to the Health Data Plan, Patients will enjoy direct and immediate communication with Practice using an electronic communications portal designed to achieve HIPAA/privacy compliance.

For Medicare/Medicaid eligible Patients, and with respect to any services other than the Wellness Exam Services identified above, Practice may deliver services specifically covered by applicable Plan at Patient's request and as medically indicated and consistent with those Plan's reimbursement requirements. Medicare Patients may request and receive the Welcome To Medicare Checkup, the Annual Wellness Visit, and chronic care management/CCM services—such services are not part of the private fee Wellness Exam Services identified above and not provided for Services Fees. Any services covered by any applicable Patient Plan are **not** the private fee Wellness Exam Services outlined above, and such additional Plan-covered services can and will be provided by Practice as indicated and billed to the applicable Plan to the extent Practice is in-network with such Plan. Applicable Plan-required co-payments and deductibles will be collected as required by Plan terms. Patient will enjoy communications and visits from Practice's healthcare professional(s) that are neither hurried nor restricted by Plan coverage/reimbursement requirements. In no

event may Patient submit to Medicare or Medicaid any private fee paid for Wellness Exam Services and/or Services Fees, as Wellness Exam Services are **not** covered or reimbursed by Medicare or Medicaid.

SCHEDULE B
CONSENT FOR INTEGRATIVE SERVICES

Wellness Exam Services may include Integrative Services that are provided outside of standard traditional allopathic care models. Such Integrative Services may include testosterone or bio-identical hormone replacement therapy, related hormone assessments/services/recommendations, laboratory tests, hormone related diagnostic procedures, hormone treatments/prescriptions, supplements designed to support hormone therapies, and/or other integrative medicine-based procedures as may be deemed necessary or advisable by Practice and included in Wellness Exams. By signing this Agreement Patient willingly and voluntarily consents to any Integrative Services Patient elects to receive from Practice with an understanding there is no guaranty of benefits, and there is the potential for side effects and negative outcomes. Patient has reviewed this Schedule B in the presence of the Practice healthcare professional, and, by signing this Agreement Patient confirms having received all of the following disclosures and consents to Integrative Services as part of Wellness Exam Services.

Wellness Exam Services that include Integrative Services, assessments and treatment options may assist with the restoration of health and optimal functional capacity, relief of pain and symptoms, injury and disease recovery, and prevention or reversal of disease or disease progression. But this is not guaranteed, as Patient's health outcomes depend on a wide range of variable factors. No healthcare services are guaranteed to provide positive results. In fact, Integrative Services pose risks and may cause potential complications. Practice's healthcare professional has explained those risks and potential complications, and this Schedule B is intended to confirm Patient's acknowledgment of those explanations and to confirm Patient's informed consent to such Integrative Services Patient elects to receive.

Practice has not promised or guaranteed any specific benefits from the administration of Integrative Services and has made no warranty or guarantee about the results of any such treatment. Patient has weighed the benefits of, and alternatives to, Integrative Services. Practice's healthcare professional cannot know or anticipate and explain every possible risk or complication that may connect to Integrative Services.

There are alternatives to Integrative Services. Traditional allopathic diagnosis and treatment of detected illness constitutes standard healthcare. Lifestyle/behavior changes, including beneficial changes to nutrition, exercise, improved mental health/wellness support, cessation of smoking, limiting, or reducing alcohol or recreational drug intake, ensuring adequate sleep/rest, have all also proven to help reduce risk of illness and increase wellbeing. Adopting some or all of these lifestyle changes, in tandem with traditional allopathic diagnosis and treatment of illness, can provide Patient important and substantiated health benefits. Health coaches routinely provide support with lifestyle change efforts toward improved health outcomes. Licensed healthcare professionals can assist with health conditions that are directly and obviously connected to lifestyle issues and may provide referrals to a wide variety of professionals who can assist (nutritionists, dietitians, physical therapists, etc.). In other words, there are viable alternatives to electing to receive Integrative Services.

It is vital for Practice to receive complete and accurate information from Patient about Patient's health, whether Patient elects to receive Integrative Services or not. Patient agrees to accurately report any side-effects or worsening conditions related to Integrative Services, or therapies or medications related to Integrative Services, to Practice or to any other healthcare professional providing Patient healthcare services according to the procedures specified in Practice's separate Electronic Communications Agreement, which is integrated herein by this reference.

Integrative Services do not replace: regular allopathic healthcare monitoring, preventative measures in general, and specifically recommended tests and preventative procedures such as complete physicals, rectal examinations and/or colonoscopy, EKG, lab tests, x-rays, ultrasounds, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc., at least on a yearly basis. Integrative Services are intended to enhance, not replace, traditional allopathic healthcare.

BAY AREA WELLNESS CENTER
ELECTRONIC COMMUNICATIONS AGREEMENT

Frank Tortorice, M.D., Inc., a California professional corporation dba Bay Area Wellness Center ("we", "us" or "Practice"), and the undersigned patient ("you" or "Patient") enter into this Electronic Communications Agreement ("EC Agreement") regarding the use of e-communications/transmissions, such as e-mail, mobile or cellular telephone, Skype, FaceTime, internet portal-enabled communications, or any other version of electronic communication (collectively "E-Communication") with respect to Patient protected health information ("PHI"). (Practice and Patient are each individually called "Party" or collectively as "Parties").

PATIENT AUTHORIZATION DESPITE RISKS OF PRIVACY BREACH

While Practice and Patient commonly rely on electronic communication platforms and services to achieve immediate communication, there are risks that you acknowledge that are outside the Practice's control. You authorize all forms of E-Communications exchanged between Parties unless you instruct us otherwise in writing. You acknowledge that the use of E-Communication is inherently risky and prone to unintentional release of data. E-Communications may incorporate or communicate references to your PHI with sensitive health and personal identification information included. You acknowledge that E-Communications lack any absolute guaranty of privacy and are subject to: system privacy failure, cookies and other tracking efforts, phishing attacks, hacking attacks, data breaches, unintended misdirections, misidentifications of senders/recipients, technology failures, and user errors.

You agree to undertake efforts to protect your privacy, which include refraining from including sensitive information in E-Communications that you do not want to be at risk of any data security breach. Practice will undertake reasonable efforts to protect your privacy to the extent required by applicable laws. You authorize us to respond electronically to all E-Communications that appear to be provided by you, whether or not such communications arrive from the electronic contact information that you provide us.

PATIENT MUST PROVIDE ACCURATE AND UPDATED CONTACT INFORMATION

You agree to provide us with your accurate electronic contact information (mobile telephone number for phone calls and text messaging, email address, Skype or FaceTime contact information, and any other applicable E-Communication contact information). You will immediately inform us of any changes or corrections to your electronic contact information as an effort to avoid misdirected E-Communications.

PATIENT MUST NOT RELY ON ELECTRONIC COMMUNICATION IN EMERGENCIES: USE 911 AND GET TO THE EMERGENCY ROOM

Practice does not guarantee that we will read your E-Communications immediately or within any specific amount of time. You agree not to utilize E-Communications to contact us regarding an emergency or time-sensitive situation, as there is too much risk that the communication response may be delayed, ineffective, untimely, or inadequate. You MUST call 9-1-1 in an emergency, immediately seek emergency medical attention, or both.

PATIENT AGREES TO UTILIZE ELECTRONIC COMMUNICATION TO REPORT ANY NEGATIVE CONDITIONS RESULTING FROM INTEGRATIVE SERVICES

If Patient experiences any side effects or worsening conditions (that do not constitute an emergency or time-sensitive situation as mentioned above) related to Integrative Services, or therapies or medications related to Integrative Services, Patient agrees to utilize E-Communications to timely inform Practice of such side effects or worsening conditions.

PRACTICE WILL COMPLY WITH HIPAA

The Practice values and appreciates your privacy and will take commercially reasonable steps to protect Patient's privacy in compliance with the Health Insurance Portability and Accountability Act of 1996 and related laws ("HIPAA").

We will obtain your express written or electronic consent (to the extent required by applicable law) if we are required or requested to forward your identifiable PHI to any third party other than as authorized in our Notice of Privacy Practices or as authorized or mandated by applicable law. You hereby consent to the use of E-Communication of Patient's information as we consider it helpful to coordinate care and schedule mobile visits with you and all those responsible for providing or overseeing your care. You agree to identify individuals or entities authorized to receive your PHI from us in connection with authorized consulting, education, and all other aspects of your care, and we may share your PHI with such parties without additional written or electronic consent from you.

You have the right to ask us for a copy of your PHI, including an explanation or summary. These services that we perform will not be the subject of additional charges to you: maintaining PHI storage systems; recouping capital or expenses for PHI data access, PHI storage, and infrastructure; or retrieval of PHI electronic information.

We may charge you fees for actual costs that we incur to provide such electronic PHI, but only to the extent authorized by applicable laws. Such fees may include, to the extent lawful: skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media (with media costs charged to you); and time spent by our administrative staff preparing additional explanations or summaries of PHI. If you request PHI on a paper copy, or portable media (such as compact disc/CD, or universal serial bus/USB flash drive), we may charge you for our actual supply costs for such equipment, and you agree to pay us any such costs.

PATIENT ACCEPTS RESPONSIBILITY FOR ELECTRONIC COMMUNICATION RISKS

You will hold Practice (and our owners, officers, directors, agents, and employees) harmless from and against any and all demands, claims, and damages to persons or property, losses, and liabilities, including reasonable attorney fees arising out of or caused by E-Communication (whether encrypted or not) losses or disclosures caused by any of the risks outlined above, by some person or entity other than Practice, or not directly caused by us. Patient acknowledges and understands that, at our discretion, E-Communication may or may not become part of your permanent medical record. These terms do not relieve Practice from Practice's obligations to comply with all applicable E-Communication laws.

You acknowledge that your failure to comply with the terms of this EC Agreement may result in our terminating the use of E-Communication methods with you and may cause the termination of your Agreement for our services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you a copy of our Notice of Privacy Practices, which states how we may disclose your health information. You hereby acknowledge receipt of the Notice of Privacy Practices.

CONSENT TO DISCLOSURE OF BILLING INFORMATION

By signing this EC Agreement, you consent to Practice disclosing all information relevant to billing, insurance, and reimbursement regarding any and all substance abuse disorders that you might have, for the purpose of obtaining reimbursement from private or public insurers.

ADDITIONAL TERMS

This EC Agreement will remain in effect until either Party provides written notice to the other Party revoking this EC Agreement or otherwise revoking consent to E-Communications between the Parties. Such revocation will occur thirty (30) calendar days after written notice of such revocation.

Revocation of this EC Agreement will preclude us from providing treatment information in an electronic format other than as authorized or mandated by applicable law or by you. Either Party may use a copy of this signed original EC Agreement for all present and future purposes.

Parties agree to take such action as is reasonably necessary to amend this EC Agreement from time to time as it is necessary for the Parties to comply with the requirements of the Privacy Rule, the Security Rule, and other provisions of HIPAA, or other applicable law. Parties further agree that this EC Agreement cannot be changed, modified or discharged except by an agreement in writing and signed by both Parties.

If any term of this EC Agreement is deemed invalid or in violation of any applicable law or public policy, the remaining terms of this EC Agreement shall remain in full force and effect, and this EC Agreement shall be deemed amended to conform to any applicable law.

Each participating Patient (and authorized representative when applicable) must sign this EC Agreement. Your signature represents that you understand and agree to the terms and conditions described within this EC Agreement.

PRACTICE:

**FRANK TORTORICE, M.D., INC.
A CALIFORNIA PROFESSIONAL
CORPORATION DBA BAY AREA WELLNESS
CENTER**

Signature: _____

Name: Dr. Frank Tortorice/President

Date: _____

PATIENT:

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____

BAY AREA WELLNESS CENTER
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to undersigned patient ("Patient"):

Frank Tortorice, M.D., Inc., a California professional corporation dba Bay Area Wellness Center ("Practice"), is required to provide Patient with a copy of Practice's Notice of Privacy Practices ("Notice"), which states how Practice may use and/or disclose Patient's health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of Practice's Notice of Privacy Practices.

Patient's name (please print): _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Practice made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from Patient but it could not be obtained because:

- ☐ Patient refused to sign.
- ☐ Due to an emergency, it was impossible to obtain an acknowledgment.
- ☐ Practice was unable to communicate with Patient.
- ☐ Other: _____

_____

_____

BAY AREA WELLNESS CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dear Patient:

Frank Tortorice, M.D., Inc., a California professional corporation dba Bay Area Wellness Center ("we", "us", "our", "Practice"), understands that patient ("you", "your") privacy is important. This Notice of Privacy Practices ("Notice") applies to Practice and each of our Business Associates, as applicable.

Protected Health Information

Protected health information ("PHI") relates to information about you and your health, which could be used to identify you. Each time that you visit us, we create a medical record of your PHI and services that you receive.

Our Obligations Regarding Your Protected Health Information

We recognize that information about you and your health is confidential, and we are committed to protecting this information. This Notice applies to all your health records that we create.

We are required by law to preserve the privacy and security of your PHI. While there is no absolute guarantee of privacy, we are committed to protecting your privacy. We have established reasonable and appropriate measures to protect your PHI against unauthorized uses and disclosures.

Federal law mandates that we share this Notice with you, and that we make a good faith effort to obtain a signed document acknowledging your receipt of this Notice. We are also required to follow the terms of this Notice. In the event that we are involved in a breach of your PHI, we will immediately notify you.

Notice Effective Date and Potential Changes

This Notice became effective on May 24, 2022, and it applies to health records that we create for you. We reserve the right to change this Notice after the effective date. We can change the terms of this Notice, and the changes will apply to all the information we have about you. The new Notice will be available upon request.

How We May Disclose Your Protected Health Information

The laws of the state where Practice is located, and federal laws, allow disclosures of your PHI in some cases. Some of these disclosures do not require your verbal or written permission. The following information describes how we may share your PHI. We may typically use or share your PHI in these ways:

Treat you

We can use your PHI and share it with other professionals who are treating you.

- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your PHI to run our Practice, improve your care, and contact you when necessary.

- Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your PHI to bill and obtain payment from health plans or other entities.

- Example: We give information about you to your health insurance plan so it will pay for your services.

Help with public health and safety issues

We can share your PHI for certain situations such as:

- Preventing disease;
- Helping with product recalls;
- Reporting adverse reactions to medications;
- Reporting suspected abuse, neglect, or domestic violence; and
- Preventing or reducing a serious threat to anyone's health or safety.

Perform research

We can use or share your PHI for health research.

Comply with the law

We will share your PHI if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share your PHI with organ procurement organizations.

Work with a medical examiner or funeral director.

We can share your PHI with a coroner, medical examiner, or funeral director when an individual dies.

Address other government requests

We can use or share your PHI:

- For workers' compensation claims;
- For law enforcement purposes or with a law enforcement official;
- With health oversight agencies for activities authorized by law; and
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share your PHI in response to a court or administrative order, or in response to a subpoena.

How else can we use or share your PHI?

We are allowed or required to share your PHI in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. We have not listed every use and disclosure in this Notice.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Use and Disclosure of Your PHI with Your Verbal Agreement

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation; and
- Include your information in a hospital directory.

If you cannot tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to your health or safety.

Use and Disclosure of Your PHI Requiring Your Written Permission

If there are situations that have not been described above, we will obtain your written permission. In these cases, we never share your PHI unless you give us written permission:

- Marketing purposes;
- Sale of your information; and
- Most sharing of psychotherapy notes.

With fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

If you provide us with written permission, you may change your mind at any time. Please let us know in writing if you change your mind.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI that is created in our Practice. This section explains some of your rights and our responsibilities to assist you.

Get an electronic or paper copy of your medical record

- You can ask to see or receive an electronic or paper copy of your medical record and other PHI that we have about you. Ask us how to do this.
- We will provide a copy or a summary of your PHI, usually within 30 days of your request. We may charge a reasonable cost-based fee.

Ask us to correct your medical record

- You can ask us to correct PHI about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone), or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain PHI in connection with our services.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- Because you are privately paying for some medical or health services, you may ask us to refrain from sharing information related to those private pay services with your health insurance plan. We will respect that request unless we are legally obligated otherwise under applicable laws.

Get a list of who we have shared information

- You can ask for a list (accounting) of the times we have shared your PHI for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, health care operations, and certain other disclosures (such as any you asked us to make).
- We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Notice

- You can ask for a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person ha4s this authority and can act for you before we take any action.

Ask questions or file a complaint if you believe your rights are violated

- If you have questions about this Notice or you believe that your rights are being violated, please contact us immediately:

Practice Contact Information:

Bay Area Wellness Center
Attention: Dr. Frank Tortorice
1275 California Drive, Suite B
Burlingame, CA 94010
Email: ftort@sbcglobal.net

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

Please provide as much information as possible so that the Department of Health and Human Services can thoroughly investigate your concern or complaint. We will not retaliate against you for filing a complaint with us, or the Department of Health and Human Services.

Thank you,

BAY AREA WELLNESS CENTER