Client Welcome Packet

We are excited to have you as a client of our Hoag Executive Health Program.
In this packet you will find all of the forms you need to complete to get started.
If you have any questions, or need assistance, please do not hesitate to contact us at 949.999.9300.

Please review and complete the following:

- Client Information
- Fitness Evaluation Informed Consent
- Program Agreement

Additionally, in order to make your physical experience as successful as possible, we gather personal information via the below forms:

- Client Questionnaire
- Medication & Supplement Summary
- Payment Authorization

All of your information is confidential and will only be available to your Hoag Executive Health medical team.

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Client Information

Patient's Name

❑ Mr. ❑ Mrs. ❑ Ms. _____ _____ _____ _____

LAST | FIRST | MIDDLE INITIAL | DATE OF BIRTH

Home Address

_____ _____ _____ _____

STREET | CITY | STATE | ZIP

_____ _____ _____

HOME PHONE: | CELL PHONE: | BUSINESS PHONE:

_____ Contact Preference: ❑ Home ❑ Business ❑ Cell ❑ Email

EMAIL ADDRESS *(By providing your email address, you are electing to receive email communication from Hoag Executive Health.)*

Sex: ❑ M ❑ F Martial Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

_____

SOCIAL SECURITY NUMBER

Employer

_____ _____

EMPLOYER NAME | OCCUPATION

_____ _____ _____ _____

STREET | CITY | STATE | ZIP

Spouse's Name

_____ _____

LAST | FIRST

_____ _____ _____

NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY | RELATIONSHIP TO PATIENT | PHONE

Children/Dependents

1. _____ _____
   NAME | DATE OF BIRTH
2. _____ _____
   NAME | DATE OF BIRTH
2. _____ _____
   NAME | DATE OF BIRTH

Referred By

_____ _____ _____

PRIMARY CARE PHYSICIAN | PHONE NUMBER | DATE OF LAST PHYSICAL EXAM

❑ No Primary Care Physician

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Fitness Evaluation Informed Consent Form

The tests included in the fitness evaluation will assess the following areas of physical fitness:

(1) body composition, (2) cardiorespiratory endurance, (3) muscular strength/muscular endurance, (4) stability, and (5) mobility.

1. **Explanation of the Tests**

   The **bioelectrical impedance procedure** involves passing a low-level electrical current through your body. This test provides an accurate estimation of your body composition. As a measure of aerobic fitness and efficiency, **the cardiorespiratory endurance test** is performed on a cycle ergometer or motor-driven treadmill. The exercise intensity will begin at a low level and may be advanced in stages depending on your fitness level. We may stop the assessment at any time because of signs of fatigue, changes in your heart rate or blood pressure, or symptoms you may experience. It is important for you to realize that you may stop when you wish because of feelings of fatigue or any other discomfort. For **muscle fitness testing,** you will perform exercises for a number of repetitions with external resistance using exercise machines and your own bodyweight. These tests assess the strength and endurance of the major muscles in the body. For **evaluation of stability and mobility,** you will perform a number of tests. During these tests, we screen your ability to execute fundamental, unrestricted, and pain-free movement patterns through optimal ranges of motion.

2. **Risks and Discomforts**

   There exists the possibility of certain changes occurring during the assessment. These include abnormal blood pressure, fainting, irregular, fast or slow heart rhythm, and in rare instances, heart attack, stroke, or death. There is also a slight possibility of pulling a muscle or spraining a ligament. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness, careful observations during the assessment, and by performing warm-up exercises prior to taking the tests. Emergency protocols have been established to deal with unusual situations that may arise.

3. **Responsibilities of the Participant**

   Information you possess about your health status or previous experiences of heart-related symptoms (such as shortness of breath with low-level activity, pain, pressure, tightness, heaviness in the chest, neck, jaw, back and/or arms) with physical effort may affect the safety of your evaluation. Your prompt reporting of these and any other unusual feelings with effort during the assessment itself is of great importance. You are responsible for fully disclosing your medical history, as well as symptoms that may occur during the assessment. You are also expected to report all medications (including non-prescription) taken recently and, in particular, those taken today, to the assessment staff.

4. **Benefits to be Expected**

   These tests allow us to assess your physical working capacity and to appraise your physical fitness status. The results are used to prescribe a safe, sound exercise program for you.

5. **Inquiries**

   Any questions about the procedures used in the fitness evaluation or the results of your evaluation are encouraged. If you have any concerns or questions, please ask us for further explanations.

6. **Use of Evaluation Results**

   The information that is obtained during your fitness evaluation will be treated as privileged and confidential. It is not to be released or revealed to any person except your physician without your written consent. The information obtained, however, may be used for statistical analysis or scientific purposes with your right to privacy retained.

7. **Freedom of Consent**

   I hereby consent to voluntarily engage in a fitness evaluation to determine my overall fitness. I acknowledge that I have either been given my physician's permission to perform this fitness evaluation or that I have decided to perform this fitness evaluation without the approval of my physician. My permission to perform this evaluation is given voluntarily. I understand that I am free to stop the assessment at any point, if I so desire.

I have read this form, and I understand the assessment procedures that I will perform and the attendant risks and discomforts. Knowing these risks and discomforts, and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to participate in this assessment.

_____ _____

SIGNATURE DATE

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EFFECTIVE: MARCH 1, 2019

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.

The following is the Notice of Privacy Practices ("Privacy Policy") of Hoag Clinic. ("Covered Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. As a Covered Entity we are required by law to maintain the privacy of your protected health information ("PHI") and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are also required by law to abide by the terms of this Notice currently in effect.

1. **Your Protected Health Information.** We collect PHI from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and other information, that could be used to identify you as the individual patient who is associated with that health information.

2. **Uses or Disclosures of Your Protected Health Information.** Generally, we may not use or disclose your PHI without your permission. Further, once your permission has been obtained, we must use or disclose your PHI in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your PHI.

   a. **Without Your Consent.** Without your consent, we may use or disclose your PHI in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. We are permitted to disclose your PHI within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of PHI that is reasonably required to provide those services or complete those activities. Covered Entity also abides by all sale of PHI and fundraising rules and regulations as implemented by the HIPAA Omnibus Rule, the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Genetic Information Nondiscrimination Act of 2008 (GINA). Specifically, Covered Entity is prohibited from selling your PHI without first obtaining specific authorization to do so, with exceptions. For instance, the prohibition on sale of PHI and specific authorization requirement does not apply to disclosures of PHI in the following situations: for public health purposes; for treatment and payment purposes; the sale, transfer, merger, or consolidation of all or part of Covered Entity and related due diligence; disclosures required by law; research purposes, where the only remuneration received by Covered Entity is a reasonable cost-based fee to cover the cost of preparing and transmitting PHI; to you to respond to an access request; or to a business associate or subcontractor for services undertaken on behalf of a covered entity. There is also a catchall exception for any permissible disclosure if remuneration is limited to only the cost of PHI preparation and transmittal.

      For Treatment Activities: Covered Entity may use or disclose your PHI in order to provide medical treatment to you. Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

      For Payment Activities: Covered Entity may use or disclose your PHI in order to receive payment for services provided to you. Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer repotting agencies of information relating to collection of premiums or reimbursement.

      For Health Care Operations: Covered Entity may use or disclose your PHI for health care operation purposes. Examples of health care operation activities include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

   b. **Health Information Exchange:** This Covered Entity is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation. If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), we will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

      To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.

   c. **As Required By Law.** We may use or disclose your PHI to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required by law to disclose your PHI include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social services or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of

identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety, (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and (n) for workers' compensation.

d. **Specific Authorizations.** Covered Entity will not release any Psychotherapy Notes about you, use your PHI for marketing purposes, or sell your PHI without your specific authorization.

e. **All Other Situations.** Except as otherwise permitted or required, as described above, we may not use or disclose your PHI without your written authorization. Further, we are required to use or disclose your PHI consistent with the terms of your authorization. You may revoke your authorization to use or disclose any PHI at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy. Be advised that you have the right to restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for the healthcare item or service.

f. **Miscellaneous Activities, Notice.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

3. **Your Rights With Respect to Your Protected Health Information.** Under HIPAA, you have certain rights with respect to your PHI. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

a. **Right to Request Restrictions on Use or Disclosure.** You have the right to request restrictions on certain uses and disclosures of your PHI about yourself. You may request restrictions on the following uses or disclosures: (a) to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of PHI directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of PHI; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your PHI in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

b. **Right to Receive Confidential Communications.** You have the right to receive confidential communications of your PHI, which you may request in electronic or hard copy format. We may require written requests. Additionally, you are afforded with the right to have a copy of your PHI transmitted directly to another person whom you designate in writing. Covered Entity shall comply with this written request so long as you sign in writing and clearly identify the designated person and where the PHI is to be sent. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled. We may not require you to provide an explanation of address or other method of contact. We may require that a request contain a statement that disclosure of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of PHI from us by alternative means or at alternative locations.

c. **Right to Inspect and Copy Your Protected Health Information.** Your designated record set is a group of records we maintain that includes medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy of your PHI contained in your designated record set, except for (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your PHI in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy or electronic form or such other form or format. We may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your PHI or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your PHI or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain PHI as permitted or required by law. We will reasonably attempt to accommodate any request for PHI by, to the extent possible, giving you access to other PHI after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

d. **Right to Amend Your Protected Health Information.** You have the right to request that we amend your PHI or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your PHI that is the subject of the

requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received your PHI prior to amendment, and persons that we know have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Compliance Officer, Privacy Officer, PersonalCare Physicians, LLC, 2100 Main Street, Suite 360, Irvine, California, 92614.

e. **Right to Receive an Accounting of Disclosures of Your Protected Health Information.** You have the right to receive a written accounting of all disclosures of your PHI that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to April 14, 2003. We reserve our right to temporarily suspend your right to receive disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Compliance Officer, PersonalCare Physicians, LLC, 2100 Main Street, Suite 360, Irvine, California, 92614.

f. **Right to Receive a Physical Copy of this Notice.** You have a right to receive a copy of this Notice. Any individual who has agreed to receive this Notice electronically may also obtain a paper copy of this Notice from PersonalCare Physicians, LLC.

g. **Right to Receive Breach Notification.** You have a right to receive breach notifications.

4. **Covered Entity's Duties**.

   a. **Duty to Maintain Privacy of Protected Health Information.** Covered Entity is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to your PHI, and to notify you in the case of a breach of your PHI. Breach notification will include the nature and extent of the PHI involved, the identity of the unauthorized person who used the PHI or to whom the disclosure was made, whether the PHI was actually acquired or viewed, and the extent to which the risk to the PHI has been mitigated.

   b. **Duty to Abide by the Terms of this Notice.** Covered Entity is required by law to abide by the terms of this Notice, as this is the Notice which is currently in effect.

5. **Complaints.** You may file a complaint with Covered Entity and/or with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing to Covered Entity by mail or electronically to our Compliance Officer, Compliance Office, PersonalCare Physicians, LLC at 2100 Main Street, Suite 360, Irvine, California, 92614. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us within one hundred and eighty (180) days of when you knew or should have known that the act or omission complained of occurred. YOU WILL NOT BE RETALIATED AGAINST FOR FILING A COMPLAINT.

6. **Amendments to this Privacy Policy.** We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all PHI we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change. 7. On-going Access to Privacy Policy. We will provide you with a copy of the most recent version of this Privacy Policy at any time by contacting Compliance Officer, PersonalCare Physicians LLC, 2100 Main Street, Suite 360, Irvine, California, 92614, or at the following email address; privacyofficer@personalcarephysicians.com. For any other requests or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint with us, please contact our privacy officer Compliance Officer at the address or telephone number listed below:

   Compliance Officer, PersonalCare Physicians, LLC
   2100 Main Street , Suite 360
   Irvine, California 92614
   949-566-8420

SIGNATURE DATE

ENTITY REPRESENTATIVE SIGNATURE DATE

PRINTED NAME

hoag
Executive Health

Hoag Executive Health Program

PARTICIPATION AGREEMENT

This Participation Agreement, ("Agreement"), is entered into effective as of _____(the "Effective Date"), by and between the Hoag Clinic Inc., dba Hoag Executive Health (the "Hoag Program Medical Group"), and Participant's Name _____ ("Purchaser"), with reference to the following facts:

A. The Hoag Program Medical Group is a California professional corporation which employs or contracts with licensed California physicians who practice internal medicine or family medicine in Orange County, California (the "Hoag Program Physicians").

B. The Hoag Program Medical Group operates the "Hoag Executive Health Program" (the "Hoag Program") and utilizes the "Hoag" name under a license arrangement with Hoag Memorial Hospital Presbyterian ("Hoag Hospital"). The Hoag Program is a state-of-the-art medical, fitness and nutrition evaluation program designed to provide a robust, comprehensive portrait of a person's health. The Hoag Program consists of various health assessments, including physical examinations, diagnostic tests, and fitness and nutrition evaluations, customized to an individual's own circumstances, followed by compilation and presentation of a comprehensive Wellness Report, which Hoag Program physicians will review with the participant in person or by telephone. Persons who participate in the Hoag Program will be assigned a Hoag Program Relationship Manager ("Relationship Manager") for scheduling, answering questions and otherwise making all necessary arrangements. The Hoag Program may be conducted at one or more Hoag Executive Health facilities in Orange County.

C. The Hoag Program Medical Group also offers optional access to on-going concierge medical services through a subscription membership program (the "Concierge Program"). Participants in the Hoag Program may wish to enroll in the Concierge Program and are offered preferred pricing under this Agreement for membership in the Concierge Program, which, among other benefits, provides 24/7 access to primary care physicians, same day appointments, coordination with specialists, and advocacy.

D. The Hoag Program and the Concierge Program may be referred to in this Agreement collectively as the "Programs". Administrative services including front and back office support, scheduling and customer relationship management for the Hoag Program are provided by Hoag Clinic Inc., through a Management Services Agreement with the Hoag Program Medical Group, dated December 1, 2014.

E. Clinical physician services for the Programs are provided by Hoag Personal Care, Inc., and its employed physicians.

F. The purpose of this Agreement is to document the terms and conditions under which Purchaser's designated Participants (as defined in Section 2 below) will participate in the Hoag Program and have optional access to the Concierge Program.

NOW, THEREFORE, THE PARTIES HEREBY AGREE AS FOLLOWS:

1. **Delivery of Program Services.** Throughout the term hereof, the Hoag Program Medical Group shall use commercially reasonable efforts to maintain or contract for facilities and personnel sufficient, in its reasonable discretion, to deliver Hoag Program and Concierge Program services in accordance with the terms and conditions hereof.

2. **Participants.** By executing and delivering this Agreement and paying the fees set out in Exhibit A, Purchaser hereby purchases Hoag Program services for the benefit of the persons designated on Exhibit A (each, a "Participant" and collectively the "Participants"). Purchaser, if designated on Exhibit A shall also be a Participant for all purposes of this Agreement. A Participant may obtain Hoag Program services at any time within the term of this Agreement simply by contacting the Relationship Manager at the telephone number set forth below and making the necessary arrangements. So long as a Participant has not yet elected to participate in the Hoag Program, Purchaser may substitute another person to become a Participant in lieu of such other Participant by notice to such effect given to the Hoag Program Medical Group during the term of this Agreement.

3. **Compensation.** All fees for Hoag Program services are payable in advance and are non-refundable, except as otherwise expressly provided. By way of explanation, and without limiting the generality of the foregoing, fees are not refundable merely because one or more Participants do not elect to receive Hoag Program services. Nonetheless, the Hoag Program Medical Group will take reasonable steps to encourage all Participants to participate. The fees set forth on Exhibit A are full and complete payment for all Hoag Program services contracted for and the Hoag Program Medical Group shall not impose or otherwise seek to recover any additional fees from any Participant. Notwithstanding the foregoing, in the event that a Participant requests and receives services from the Hoag Program Medical Group or Hoag Program Physicians that are beyond the scope of Hoag Program services, nothing in this Agreement shall be deemed to prevent the Hoag Program Medical Group or Hoag Program Physicians from seeking and obtaining payment for such additional services. Payment of the fees set forth on Exhibit A shall constitute satisfaction of all payment obligations of Purchaser hereunder with respect to the Hoag Program, and the Hoag Program Medical Group shall be responsible for paying and satisfying all the costs and expenses of persons and supplies engaged and obtained by the Hoag Program Medical Group for purposes of providing Hoag Program services, and the Hoag Program Medical Group shall indemnify, defend and hold harmless Purchaser and each Participant from and against any claims made against Purchaser or a Participant in connection with such costs and expenses. Participants desiring access the Concierge Program ("Concierge Program Enrollees"), shall be entitled to the preferred pricing for membership in the Concierge Program that is set forth in Exhibit B provided they enroll in the Concierge Program during the term of this Agreement, subject to participation of the specific medical group elected by the Participant. Concierge Program Enrollees shall sign a Concierge Program Membership Agreement, in the form provided by PCPLLC on behalf of the Participant's elected medical group, and pay fees as set forth on Exhibit B before starting the Concierge Program. The terms and conditions of such Membership Agreement shall govern the Concierge Program Enrollees' participation in the Concierge Program.

4. **Third Party Reimbursement.** The Hoag Program Medical Group will not bill Medicare or any other governmental payment program or any private insurance company or other third party payor for Hoag Program services rendered pursuant to this Agreement. Purchaser acknowledges the foregoing and further acknowledges that the Hoag Program Medical Group has made and makes no representations, express or implied, that Hoag Program services qualify for reimbursement under any governmental or private payment program. Among other things, the Hoag Program Medical Group has not required the physicians or other persons who provide Hoag Program services to

be eligible to render services that qualify for reimbursement under the Medicare or any other governmental or private health care payment program. Prior to receiving services under the Hoag Program, each Participant that is otherwise eligible for coverage under Medicare or any other governmental health care payment program shall sign an "Opt-out" agreement in the form provided by PCPLLC.

5. **Term and Termination.** This Agreement shall have a term that commences as of the date first set forth above and terminates one year later. Notwithstanding the foregoing, the Hoag Program Medical Group may terminate this Agreement at any time by its notice to Purchaser to such effect. In the event that the Hoag Program Medical Group terminates this Agreement: (i) the Hoag Program Medical Group shall refund to Purchaser a pro rata portion of the fees set forth on Exhibit A based upon the number of Participants who are eligible to receive Hoag Program services but have not elected to do so as of the date of the notice of termination; and (ii) all rights and obligations of the parties hereunder shall terminate and be of no further force or effect as of the date of the notice of termination, provided that the Hoag Program Medical Group shall continue to be obligated to render Hoag Program services to any Participant who has elected to receive Hoag Program services as of the date of the notice of termination, but who has not yet received all Hoag Program services.

6. **Confidentiality; Notice of Use.** The Hoag Program Medical Group shall by notice advise Purchaser when a Participant has elected to receive Hoag Program services. Except for such notice, all information and records derived from a Participant's participation in the Hoag Program are confidential and, with limited exceptions not here applicable, the Hoag Program Medical Group is legally bound to preserve the confidentiality of those results and records, and not to disclose them to any person, without the prior written consent of the Participant to whom the records relate. All records relating to the delivery of Hoag Program services to a Participant shall remain the property of the Hoag Program Medical Group (and/or the physicians or other persons who render Hoag Program services hereunder), and the Hoag Program Medical Group shall retain and safeguard (and/or assure that such physicians or other persons retain and safeguard) the same in accordance with applicable law and regulation and the Hoag Program Medical Group's own policies. In addition, the terms and conditions of this Agreement shall be deemed confidential and neither party shall disclose them to any other person.

7. **Informational Packets.** More specific information relating to the delivery of Hoag Program services is contained in informational packets, as further described below. The Hoag Program Medical Group shall provide informational packets to Purchaser in sufficient numbers to permit distribution to all Participants. Such informational packets shall include: (i) a description of additional terms and conditions under which Hoag Program services are provided; (ii) information how to contact the Hoag Program Medical Group to schedule and obtain Hoag Program services; (iii) a copy of relevant privacy policies (together with acknowledgement of receipt); (iv) forms for Participants to provide background information needed to customize and otherwise plan the delivery of Hoag Program services to be rendered (to be completed in the days prior to receiving Program services); and (v) other materials as appropriate. When and as any information in an information packet is updated or changed, the Hoag Program Medical Group shall promptly provide an adequate number of replacement copies to Purchaser.

8. **Notices and Other Communications.** When a Participant wishes to schedule Hoag Program services, such person should contact the Hoag Program Relationship Manager named below by telephone or e-mail (unless and until the Hoag Program Medical Group otherwise advises Purchaser):

   Client Solutions Manager
   (949) 999.9300
   email: info@hoagexecutivehealth.com

All other notices, requests, demands and other communications required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been duly given to a party when personally delivered to the person identified below; when transmitted if sent by telecopy or e-mail; the day after being sent, if sent for next day delivery to a domestic address by recognized overnight delivery service (e.g., Federal Express); and upon receipt, if sent by certified or registered mail, return receipt requested. In each case notice shall be sent to:

If to the Hoag Program Medical Group, to:
Jim Lindberg, M.D.
Hoag Executive Health, Chief Medical Officer
2995 Red Hill Ave, Suite 100
Costa Mesa, CA 92626
jlindberg@hoagexecutivehealth.com

With a copy to:
Justin Davis
VP Business Development
Hoag Executive Health
2995 Red Hill Ave, Suite 100
Costa Mesa, CA 92626
jdavis@hoagexecutivehealth.com

If to Purchaser, to the address or other contact information specified on the signature page of this Agreement or to such other place and with such other copies as a party may designate by written notice to the other party.

9. **Complaints; Remedial Action.** Purchaser shall advise the Hoag Program Medical Group of any complaints or other dissatisfaction with the delivery of Hoag Program services, whether experienced by Purchaser or another Participant, promptly after Purchaser becomes aware

of the same. Likewise, if a Participant complains to any person employed or otherwise engaged by the Hoag Program Medical Group relative to the delivery of Hoag Program services, the Hoag Program Medical Group shall promptly so advise Purchaser. In the event of any complaint made with respect to the Hoag Program, either Purchaser or the Hoag Program Medical Group may, by notice to the other, request a meeting for purposes of discussing the same and considering and discussing proposed changes to the Hoag Program or other action designed to remedy or improve the cause or other basis of the complaint. Any such request shall specify the nature of the complaint and may specify any proposed remedial action. The parties shall use commercially reasonable, good faith efforts to schedule and attend such a meeting at a mutually agreeable location within ten (10) days of the meeting request.

10. **Arbitration.** Upon the request of either party, any controversy or claim (whether such claim sounds in contract, tort or otherwise) arising out of or relating to this Agreement, or the breach thereof, shall be settled by binding arbitration in accordance with California Code of Civil Procedure Sections 1280 et seq., and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The arbitrator shall be selected from a list of retired Superior Court Judges for the County of Orange in accordance with the rules and procedures of JAMS/Endispute. Notwithstanding any other provision of this Agreement, in the case of a dispute involving a claim for equitable relief, a court with equitable jurisdiction may grant temporary restraining orders and preliminary injunctions to preserve the status quo existing before the events which are the subject of the dispute. Any final equitable or other relief shall be ordered in the arbitration proceeding. Each party shall pay an equal-share of the fees and expenses of any arbitrator and any administrative fee of JAMS/Endispute. Subject to Section 16 of this Agreement, each party shall pay the fees and expenses of its own attorney and witnesses.

11. **Amendment.** This Agreement may be amended only by a writing signed by both parties hereto.

12. **No Waiver.** It is understood and agreed that no failure or delay by either party in exercising any rights, power, or privilege under this Agreement shall operate as a waiver thereof, nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power, or privilege under this Agreement.

13. **Assignment; Successors and Assigns.** No party may assign its rights or delegate its duties under this Agreement to any other person without the prior written consent of the other party. Notwithstanding the foregoing, Participant recognizes and acknowledges that the Hoag Program Medical Group will discharge and satisfy its obligations to provide Hoag Program services hereunder at least in part by engaging physicians and other health care providers in the community who will perform Hoag Program services as independent contractors and not as employees of Hoag Hospital nor the Hoag Program Medical Group, and that the Hoag Program Medical Group need not obtain Participant's consent to do so. Subject to the foregoing limitations, this Agreement shall be binding upon and inure to the benefit of the parties and their respective legal representatives, agents, successors and assigns.

14. **Severability.** If any provision of this Agreement shall be held or deemed to be or shall, in fact, be inoperative or unenforceable as applied in any particular case and any jurisdiction or jurisdictions or in all jurisdictions, or in all cases, because it conflicts with any other provision or provisions hereof or any statute, rule or public policy, or for any other reason, such circumstances shall not have the effect of rendering the provision in question inoperative or unenforceable in any other case or circumstance, or of rendering any other provision or provisions herein contained invalid, inoperative or unenforceable to any extent whatever.

15. **Authority.** Each party hereto hereby represents and warrants to the other that the person signing this Agreement in its name and on its behalf is duly authorized and empowered to do the same.

16. **Attorneys' Fees.** If any legal action, arbitration or any other proceeding is initiated in order to interpret or enforce this Agreement or any portion hereof, or because of any alleged dispute, breach, or misrepresentation in connection with any of the provisions of this Agreement, in addition to any other relief to which such party may be entitled, the prevailing party in such action shall be entitled to recover its reasonable attorneys' fees, as determined by the court or arbitrator, plus all other costs and expenses incurred in connection with such action or proceeding.

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the Effective Date.

PURCHASER

_____

SIGNATURE

_____

PARTICIPANT'S PRINTED NAME

whose address and other contact information follows:

_____

_____

_____

_____

THE HOAG PROGRAM MEDICAL GROUP

Hoag Clinic, dba Hoag Executive Health

By: _____

Its: _____

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EXHIBIT A

Eligible Program Participants & Fee Schedule

Fee Schedule

In consideration of the Hoag Program Medical Group undertaking to provide Hoag Program services to the Participants designated below, Purchaser shall pay to the Hoag Program Medical Group the sum of $2,350, payable in full upon Purchaser's execution and delivery of this Agreement (or, if this Agreement is amended to add to the number of Participants, the additional payment shall be due at the time of execution and delivery of such amendment). An exam that is cancelled within 2 weeks of the scheduled appointment shall automatically be pre-paid and the collected amount shall be credited to a future scheduled exam at the rates described herein. An additional rescheduling fee of $150 shall be charged for each missed appointment or any appointment that is cancelled with less than 72 hours prior notice. This fee will be nonrefundable.

Hoag Program Participants

The following persons are eligible to receive Hoag Program services ("Participants" as that term is used in the Agreement). Purchaser, if named below, shall also be a Participant for all purposes of this Agreement. Purchaser may substitute one person, to become a Participant, for another in accordance with the terms of this Agreement upon providing notice to the Hoag Program Medical Group. Purchaser may add to the number of Participants by entering into an amendment to this Agreement and paying such additional fees that the Hoag Program Medical Group may establish.

_____

PARTICIPANT NAME

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EXHIBIT B

Concierge Medical Membership Program

Preferred Pricing Schedule – OPTIONAL Executive Health Participant Upgrade to Concierge Program

In the event that a Participant elects to enroll in the Concierge Program he/she shall first sign the form of Membership Agreement (and shall become a "Concierge Program Enrollee").

Eligibility: Within two (2) months after completing the executive physical, a Participant may elect a one-time, one-year upgrade to participate in the Concierge Program. Please inquire at the time of enrollment regarding participating affiliated medical groups and locations.

Upgrade Fee: $1,900/year covering such Participant alone. Such prices shall replace the standard Membership Fees described in Section 4 of the Membership Agreement for the 12 months following the date of enrollment. After 12 months at the discounted rate, membership will be automatically renewed at the current rate as shown in the Membership Agreement. If you do not wish to renew automatically, you may notify the Practice Manager in the practice you are enrolled at the time of signing or at any time during your membership.

Family Pricing: Additionally, the following prices will be extended to such Participant's family members if any such individuals enroll in the Concierge Program within 6 months of the Participant's enrollment date:

Spouse/Partner	$3,600 per year
Dependent*	$2,400 per year

If additional enrollments are desired after six months, there may be discounted pricing available, but the rates may vary from those described herein and can be accessed by notifying the Practice Manager of the practice in which you are enrolled.

**To qualify for this pricing, dependents must be of an age eligible under the same defined eligibility as described in the Affordable Care Act (as of the date of this agreement, up to their 26th birthday) and paid in conjunction with a paying parent member.*

Exclusions: The foregoing fee includes all membership and non-medical Concierge Program services provided by the Hoag Program Medical Group and its affiliated or contracted medical groups. Concierge Program Enrollees will be financially responsible for any medical services provided by the Hoag Program Medical Group and its affiliated or contracted medical groups during the member period. The Hoag Program Medical Group's affiliated and contracted medical groups do not participate in Medicare. Some of the Hoag Program Medical Group's affiliated and contracted medical groups do not accept many PPO insurance plans; specific details of plan participation and fee schedules are available upon request.

(Note: Regardless of whether the Hoag Program Medical Group participates in a particular insurance plan, cash pricing is available for medical services provided by the Hoag Program Medical Group and participation in cash-based payment for services rendered at the practice may not impact eligibility for coverage of services provided by specialists or ancillary providers to which the Hoag Program Medical Group may refer.)

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Hoag Executive Health Client Questionnaire

In order to get prepared for your comprehensive, personalized physical, we ask that you complete the following questionnaire. These questions are used as inputs for several tools used including a Health Age Assessment as well as to provide key inputs for preparing for you physical. Feel free to contact us if you have any questions or would like to discuss anything contained in this questionnaire.

GENERAL INFORMATION

_____ _____

NAME AGE

Race

❑ White ❑ Asian ❑ Black ❑ Hispanic ❑ American Indian ❑ Other Ethnicity: _____

Education

❑ College Graduate or Skilled Craftsman
❑ Some College or Trade School
❑ High School Graduate or GED *(no college or trade school)*
❑ No High School Diploma or GED

FAMILY HISTORY

Longevity

❑ Grandparents lived past 90 or parents past 80
❑ Grandparents lived past 80 or parents past 70
❑ Grandparents lived past 70 or parents past 60
❑ Few relatives lived past 60
❑ Few relatives lived past 50

Family History of Coronary Artery Disease

(CAD) heart attack or blockage in arteries of the heart:

❑ No family history
❑ 1 close relative >60 years old
❑ 2 or more close relatives >60 years old
❑ 1 close relative <60 years old
❑ 2 or more close relatives <60 years old

Family History of Cancer

❑ No
❑ Yes, please explain _____

YOUR MEDICAL HISTORY

Medical Exams & Screenings

❑ Regular medical check-ups, tests
❑ Occasional medical check-ups, tests
❑ Periodic medical check-ups, tests
❑ Rare or no medical check-ups, tests

Heart Disease

(Check all that apply)

❑ No problems
❑ 1 or more heart attacks/strokes
❑ Past heart surgery
❑ Coronary Angioplasty (PTCA)
❑ Congenital heart or heart valve disease, other heart disease or failure
❑ EKG abnormality present or angina or diagnosed heart disease

Diabetes

❑ No problems and no fam hx
❑ Hypoglycemia
❑ Diabetes controlled with medicine
❑ No problem but fam hx
❑ Diabetes controlled with diet/ex

Lungs
(Including TB and Pneumonia)

- ❑ No problems
- ❑ Mild asthma or bronchitis
- ❑ Emphysema, or severe asthma or chronic bronchitis
- ❑ Some past problems only
- ❑ Severe lung problems

Cancer

- ❑ No
- ❑ Yes, please explain _____

Digestive System

- ❑ No problems
- ❑ Occasional diarrhea or loss of appetite
- ❑ Frequent diarrhea or upset stomach
- ❑ Ulcers, colitis, gall bladder or liver problems
- ❑ Severe gastrointestinal disorders

Medication

- ❑ Rarely take any
- ❑ Minimal or regular use of a single OTC or single Rx
- ❑ Heavy use of OTC meds or more than one Rx med daily
- ❑ Occasional, regular, or heavy use of illicit/recreational drugs

When was your last colonoscopy?

- ❑ Date _____
- ❑ Never

A colonoscopy is routinely recommended every 5 years after age 50. As a convenience, we can coordinate scheduling this procedure as part of your examination with preferred pricing. It would need to be done on a separate day because of the required preparation, and is available at the Endoscopy Center, adjacent to the Executive Health Suite.

- ❑ Please coordinate my colonoscopy with my examination this year
- ❑ My personal physician coordinates my Colonoscopy examination

WOMEN ONLY

When was your last mammogram?

- ❑ Date _____
- ❑ Never

This screening test is routinely recommended a baseline mammogram at age 35 and then every year after age 40 in women with average risk. As a convenience, we can coordinate scheduling this procedure as part of your examination with preferred pricing. This can be scheduled the same day as your Executive Physical.

- ❑ Please coordinate my mammogram with my examination this year
- ❑ My personal physician coordinates my Mammogram screening

PAP Smear and Pelvic Exam

- ❑ Please include a PAP smear and Pelvic Exam with my examination this year
- ❑ My personal physician coordinates my PAP smear and exam each year

LIFESTYLE

Smoking

- ❑ Never
- ❑ Quit >10 years ago
- ❑ Quit < 10 years ago>
- ❑ Occasional cigarette/cigar
- ❑ 1 pack/day or daily cigar
- ❑ 1 pack/day

Stress

- ❑ Unhurried, happy
- ❑ Ambitious but relaxed
- ❑ Sometimes competitive or time conscious
- ❑ Competitive and time conscious (type A)
- ❑ Type A with repressed hostility

Sleep
(Average hours sleep per night)

- ❑ 7-8 hours
- ❑ 8-9 hours
- ❑ 6-7 hours
- ❑ >9 hours
- ❑ <6 hours

Happiness

- ❑ Generally feel happy
- ❑ Often unhappy
- ❑ Feel Satisfied
- ❑ Usually unhappy
- ❑ Unsure about life

Depression

- ❑ No Family History
- ❑ Family History, I feel ok
- ❑ Family History, I feel mildly depressed
- ❑ Sometimes feel life is not worth living
- ❑ Thoughts of suicide

Anxiety

- ❑ Seldom anxious
- ❑ Occasionally anxious
- ❑ Often anxious
- ❑ Always anxious
- ❑ Panic attacks

Relaxation

- ❑ Relax or meditate daily
- ❑ Relax often
- ❑ Seldom relax
- ❑ Usually tense
- ❑ Always tense

Love & Marriage

- ❑ Happily married or in great relationship
- ❑ Separated, divorced, or widowed with significant stress
- ❑ Married or in just satisfactory relationship
- ❑ Extramarital affair or in unhealthy/unhappy relationship
- ❑ Never married, not currently in relationship

Job Satisfaction
(Retired/unemployed = not working)

- ❑ Enjoy work, see results, able to advance, or happy not working
- ❑ Dislike current work, or concerned presently not working
- ❑ Work is OK, no results, nowhere to go, or okay not working
- ❑ Hate current work, or very upset presently not working

Social

- ❑ Have some close friends
- ❑ Have some friends
- ❑ Have no close friends
- ❑ Stuck with people I don't enjoy
- ❑ Do not have any friends

Driving

- ❑ < 7000 miles/year
- ❑ 7000-15,000 miles/year
- ❑ 15,000-20,000 miles/year
- ❑ > 20,000 miles/year

Seat Belt Use

- ❑ Always
- ❑ Most of the time (75%)
- ❑ On highway only
- ❑ Sometimes (25%)
- ❑ Never

Risk-Taking Activities
(motorcycle, high speed driving, mountain climb, skydive, scuba dive, higher risk job, etc.)

- ❑ Never
- ❑ Some with careful preparation
- ❑ Occasional
- ❑ Often
- ❑ Anything for a thrill

FITNESS AND NUTRITION

Weekly Physical Activity

- ❑ 60 minutes, high intensity, most days
- ❑ 30 minutes, moderate, most days
- ❑ 20-30 minutes, moderate, 3-5 days
- ❑ 20-20 minutes, light, 1-2 days
- ❑ None/Sedentary

What is the activity level at your job

- ❑ Very active (heavy manual labor)
- ❑ Moderately active (mostly standing, walking)
- ❑ Some walking
- ❑ Completely sedentary

Daily Regular Meals

- ❑ 3 or more daily meals
- ❑ Not regular
- ❑ 2 daily meals
- ❑ Frequently skip, then stuff

Breakfast

- ❑ Daily
- ❑ Coffee only
- ❑ Coffee and pastry
- ❑ Sometimes
- ❑ None

Daily Fruits and Vegetables *(1 serving = 1 fist)*

- ❑ 5 or more
- ❑ 2-4
- ❑ 1 or less
- ❑ None or rarely

Monounsaturated Fats

(Avocado, olive oil, olives, almonds, cashews, natural peanut butter, peanuts, etc.)

- ❑ Daily consumption
- ❑ Occasional consumption
- ❑ 2-4 times per week
- ❑ Rare consumption

Omega-3 Fatty Acids

(Wild fish and sea food, grass-fed meats, Omega-3 eggs and dairy, flax seeds, walnuts.)

- ❑ Daily consumption
- ❑ Occasional consumption
- ❑ 2-4 times per week
- ❑ Rare consumption

Refined Oils: Omega-6 & Fried Foods

(Corn or soy oil, reduced fat products, deep-fried foods, most store-bought baked goods.)

- ❑ No high Omega-6 or fried foods
- ❑ Occasional consumption
- ❑ Regular hydrogenated fats, deep fried, or shortening in baked goods
- ❑ 2-4 times per week
- ❑ Daily

Refined Foods

- ❑ No refined foods
- ❑ Some refined foods
- ❑ Several servings: bread, rice, cereals, packaged foods
- ❑ Several servings: sugar, soft drinks, sweets, snack foods

Caffeine

- ❑ None at all
- ❑ One serving per day on average
- ❑ ___ servings per day on average

Alcohol

- ❑ None at all
- ❑ 1 drink per day or less
- ❑ 2 drinks per day
- ❑ 3 or more drinks periodically
- ❑ 3-6 drinks per day
- ❑ > 6 drinks per day

Primary Type Consumed: ❑ Beer ❑ Wine ❑ Hard Liquor

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CLIENT SIGNATURE _____ DATE _____

Medications, Vitamins & Supplements

Please record all Over the Counter (OTC) and prescription medications you are currently using along with all vitamins and supplements. Please return this prior to your executive physical.

		DOSING INSTRUCTIONS			
Medication, Vitamin, Supplement Name	Dose	Daily	X Times/ Week	Other	Prescribed by Physician?

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Executive Physical Payment Authorization

Hoag Executive Health Executive Physical

Comprehensive executive physical including advanced diagnostic tests, fitness and nutritional assessment and an actionable Wellness Report

$2,350

	Name of Participant	Fee
1		
2		
3		
4		
	Total:	

I agree to have Hoag Executive Health automatically debit my credit/bank card as indicated above.

CREDIT CARD NUMBER

NAME ON CREDIT CARD

EXP. DATE

3 OR 4 DIGIT SECURITY CODE

BILLING ADDRESS OF CREDIT CARD

SIGNATURE

DATE

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