ignitehealth wellness management services

Fueling a passion for healthier living.

SUBMITTING PRIMARY CARE PHYSICIAN (PCP) FORMS TO IGNITEHEALTH

Dear Participant:

Ignitehealth is pleased to support your company's biometric screening data collection efforts. The use of the attached documents will allow you to submit biometric data obtained through your own primary care physician. Once Ignitehealth has received the information, a letter will be sent to the address listed on the PCP form indicating receipt.

Instructions:

Please review the included documents:

- The Primary Care Physician Proof of Biometrics Screening Form
- The Ignitehealth HIPAA Notice of Privacy Practices

Be sure to read and complete the first section of the PCP Biometric Screening Form prior to submitting to your physician.

Please contact your Human Resources Department for information about the deadline and acceptable timeframe for the results to be submitted.

If you have any questions, please contact Ignitehealth at 855-206-4690.

Thank you!

Primary Care Physician Proof of Biometrics Screening Form:

To be Completed by the Program Participant:

I hereby request that Ignitehealth Wellness Management Services, LLC include the following biometric data for use in my employer's biometric screening program. I understand the following:

- The submission of biometric data is voluntary and not required as a condition of employment.
- If submitting biometric screening data is a requirement of a wellness reward offered by my employer, then a reasonable alternative to this submission is available by contacting the designated individual at my employer.
- It is my responsibility to discuss this information with my primary care physician and arrange for appropriate follow up care as indicated for any results which are outside of the normal ranges.
- I hereby acknowledge that I have received a copy of Ignitehealth Wellness Management Services' Notice of Privacy Practices.
- By signing below, I agree and acknowledge that I have read and understand this consent and the statements above.

Print Name: _____ Signature: _____ Date: ____/____/_____

Employer: _____ Circle One: Employee Spouse

Personal Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: ____/____/_____ Personal Phone Number: ( ) ____-_____

To be Completed by the Physician:

This is to certify that (patient name) _____ had the following tests/measurements

Performed on (date) ____/____/_____ Print Name or Office Stamp: _____

Physician Signature: _____ Date Signed: ____/____/_____

BIOMETRIC VALUES	
Total Cholesterol	
HDL	
LDL	
Triglycerides	
Blood Pressure (systolic/diastolic)	/
Fasting Glucose and/or HbA1c	
Body Mass Index	
Height	___ ft ___in
Weight	lbs
Waist Circumference	in

PLEASE CIRCLE	
Gender	M / F
Fasting Bloodwork?	Yes / No
Current Smoker?	Yes / No
Currently Pregnant?	Yes / No
Diagnosed Diabetic?	Yes / No
Currently taking Blood Pressure Meds?	Yes / No
Currently taking Cholesterol Meds?	Yes / No

Please submit this form to:

Ignitehealth Wellness Management Services
400 WillowBrook Office Park, Ste 400
Fairport, NY 14450

Thank you!

HIPAA Notice of Privacy Practices and Notice Concerning Employee Wellness Program

Effective Date: *12/28/2016*

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. This notice also explains what information will be collected in connection with your employer-sponsored wellness program that we administer, how it will be used, who will receive it, and what will be done to keep it confidential.

If you have any questions about this notice, please contact our Privacy Officer at 855-206-4690.

OUR OBLIGATIONS: We are required by law to:

Maintain the privacy of protected health information

Give you this notice of our legal duties and privacy practices regarding health information about you

Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example:

• We may use and disclose information to make sure the care you receive is of the highest quality by reviewing and improving the quality, efficiency and cost of care that we provide.

• Improving health care and lowering costs for groups of people who have similar health problems and helping to manage and coordinate the care for these groups or people.

• Reviewing and evaluating the skills, qualifications, and performance of health care providers.

• Participating in training programs for students, trainees, health care providers, or non-health care professionals.

• Cooperating with outside organizations that assess the benefits that we provide and that evaluate/design strategies for improvement.

We also may share information with other entities that have a relationship with you (for example, your health plan, plan sponsor, or the plan sponsor's insurance broker) for their health care operation activities. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services, audit services; and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

• Managing the business and general administrative activities, including our activities related to complying with the HIPAA Privacy Rule and other legal requirements.

• Creating "de-identified" information that is not identifiable to any individual.

Important note about administration of your employer-sponsored wellness program

Your employer sponsors a voluntary wellness program, which we administer in whole or in part. If you choose to participate in a wellness program administered by us, you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease)]. You may also be asked to complete a biometric screening, which may include a blood test for total cholesterol, HDL cholesterol, triglycerides, LDL cholesterol, blood glucose, or other medical examinations that test such conditions such as your blood pressure, BMI, waist circumference and cotinine. You are not required to complete the HRA or to participate in the blood test or other medical examinations. Although you are not required to complete the HRA or participate in the biometric screening, you may receive an incentive from your employer for doing so. Additional incentives may be available from your employer for those who participate in certain health-related activities or achieve certain health outcomes. Contact your employer for more information about incentives that may be offered in connection with any employer-sponsored wellness program.

Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, any wellness program administered by us will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided by us in connection with any wellness program we administer will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information in connection with the wellness program administered by us will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of that health information as a condition of participating in any wellness program that we administer or receiving any incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program administered by us will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program that we administer will be maintained separate from your personnel records, and no information you provide as part of the wellness program that we administer will be used in making any employment decision.

You may not be discriminated against in employment because of the medical information you provide as part of participating in any wellness program administered by us, nor may you be subjected to retaliation if you choose not to participate.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities We will not use your information (name, address, telephone number, age, date of birth, gender, health insurance status or dates of service) to contact you for the purpose of raising money.

Genetic Information Use of genetic information for underwriting purposes is prohibited, including genetic tests and manifested diseases/disorders of family members.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Special Rules for Electronic Breach of Unsecured PHI. In the event of a "breach" of unsecured PHI (as defined in Section 13400(1) of the American Recovery and Reinvestment Act of 2009 ("ARRA"), except as otherwise not required by law, we will report any breach of unsecured PHI (as defined in 45 C.F.R. § 164.402) which notice will include (i) a list of all individuals whose unsecured PHI has been, or is reasonably believed by us to have been, accessed, acquired, used, or disclosed during such breach, and (ii) any other available information that the we are required to provide under applicable law. As necessary, we will provide notice as required by applicable law, including to the extent applicable 45 C.F.R. § 164.406, if the legal requirements for media notification are triggered by the circumstances of such breach. The foregoing will not apply if PHI has been rendered unreadable, unusable and indecipherable in accordance with federal rules.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our Privacy Officer at the address noted below. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer at the address noted below.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer at the address noted below.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer at the address noted below. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer at the address noted below. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.ignitehealthnow.com. To obtain a paper copy of this notice, please contact our Privacy Officer at the address noted below.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice on our website at www.ignitehealthnow.com. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint**. You may contact our Privacy Officer at:

Ignitehealth Wellness Management Services, LLC
400 Willowbrook Office Park, Suite 400
Fairport, NY 14450