PreventativeHealth
SCREENINGS & VACCINATIONS

SERVICES AGREEMENT
Health Screenings & Influenza Vaccinations
Insurance Billed

Company:	Minidoka County School District
Company Mailing Address:	1151 7th Street Heyburn, Idaho 83336
Company Contact Information:	(t) 208-679-2400 (f) 208-679-5877 (e) mwidmier@minidokaschools.org
Company Contact Person:	Michele Widmier

Date(s) of Service:	Jan. 17th-20th, 2017. - Exact clinic dates/times are TBD and will be approved by Minidoka School District
Clinic Location(s):	TBD. See above.
Company Health Plan:	Select Health
Other Applicable Plan Types:	

Service Provider:	Preventative Health, LLC
Provider Address:	531 S. Fitness Pl., Suite 100 Eagle, Idaho 83616
Provider Contact Information:	Brad Mauzerall (t) 208.853.2273 (f) 208.376.3831 (e) brad@preventativehealthscreenings.com

1. **Agreement**. This Agreement is between Minidoka County School District (the "**Company**") and Preventative Health, LLC ("**Preventative Health**").

2. **Services**. Preventative Health will provide the services described in Exhibit A (the "**Services**"), at the above-stated "**Clinic Location(s)**" on the above-stated "**Date(s) of Service**" for the Company's employees, employees' spouses and/or employees' dependents ("**Participant(s)**") who, as of the Date(s) of Service, are enrolled in the above-referenced Company Health Plan (the "Plan"). Prior to the commencement of the Services, the Company will certify the Plan enrollment. The Company acknowledges that all Services may be performed by Preventative Health, in addition to other services as requested by the Participant and deemed medically necessary. Preventative Health will obtain a signed Patient Registration and Consent Form from each Participant in a form substantially similar to the form attached hereto as Exhibit B prior to performing the Services, together with a copy of Participant's photo identification. Preventative Health will retain such forms securely and confidentially in its records.

3. **Payment for Services**. Preventative Health shall seek payment for the Services solely from the Plan and/or the Participant's insurance. In the event the Participant requests additional services not set out in Exhibit A, Preventative Health will bill the Participant's insurance, if any, and then will invoice the Participant for any uncovered costs. The Company will provide Preventative Health with any contact and/or insurance information in its possession as may be necessary or appropriate to contact a Participant for payment for any services rendered by Preventative Health on the Participant's behalf, as determined by Preventative Health, as consented to by Participant. Preventative Health acknowledges and agrees that the Company will have no obligation to pay Preventative Health for Services provided to any Participant. Preventative Health agrees to verify insurance benefits for each Participant prior to the Date(s) of Service to ensure coverage, where given reasonable time to do so.

4. **Cancellation**. In the event the Company cancels the Services with less than ten (10) business days' advance written notice from Date of Service, and does not reschedule the Date of Service for another mutually agreed upon date within 6 months of the original Date of Service, the Company will pay $500.00 to Preventative Health as liquidated damages, and not as a penalty, payment of which will be Preventive Health's sole and exclusive remedy and the Company's only liability for cancellation of the Services under this Agreement.

5. **Health Insurance Portability and Accountability Act (HIPAA).** Preventative Health acknowledges that in performing its services herein, it will have access to and receive protected health information ("PHI") of Participants. Preventative Health agrees to take appropriate steps to protect the privacy and security of the PHI as required by applicable law, including without limitation, the Health Insurance Portability and Accountability Act of 1996 as amended, and its implementing regulations and adopted standards ("HIPAA"), the Health Information Technology and Economic and Clinical Health Act, as incorporated into the American Recovery and Reinvestment Act of 2009 ("HITECH") and the Final HIPAA Omnibus Rules of 2013 ("New Omnibus Rules"). Preventative Health and the Company acknowledge that Participants will provide their PHI directly to Preventative Health and not to the Company. The Company will not have and does not desire access to the Participants' PHI, with the exception of an aggregate data report with non-identifying information.

6. **Insurance**. Preventative Health will maintain Professional Liability Insurance in the amount of $1,000,000 per claim and $3,000,000 in the aggregate, and General Liability Insurance in the amount of $1,000,000 per claim and $3,000,000 in the aggregate.

7. **Governing Law; Jurisdiction; Venue**. This Agreement, including the Exhibits attached hereto and incorporated herein will be governed by the laws of the State of Idaho. The State of Idaho will have exclusive jurisdiction for any dispute arising out of or relating to this Agreement, and Ada County, Idaho, will be the exclusive venue for any court action with regard to the subject matter herein.

8. **Entire Agreement**. This Agreement, including all Exhibits attached hereto and incorporated herein supersede any prior agreements or understandings (whether in writing or oral) between the parties with respect to the subject matter herein. Any amendment to this Agreement must be in writing and signed by both parties.

SERVICES PROVIDER:

Preventative Health, LLC

By: Brad Mauzerall

Printed Name: Brad Mauzerall

Title: Director of Operations/Business Development

Date: 11/9/2016

COMPANY:

Minidoka School District

By: _____

Printed Name: Dr. Ken Cox

Title: Superintendent

Date: _____

Exhibit A – "Services"

- ✔ LIPID PANEL
- ✔ THYROID SCREENING (TSH)
- ✔ PROSTATE SCREENING (PSA) (MEN OVER 40, BLOOD TEST ONLY)
- ✔ DIABETES (HEMOGLOBIN A1c)
- ✔ COMPLETE BLOOD COUNT (CBC)
- ✔ COMPREHENSIVE METABOLIC PANEL (CMP)
- ✔ BODY MASS INDEX (BMI)
- ✔ INFLUENZA VACCINATIONS
- ✔ PREVENTATIVE WELLNESS VISIT by Nurse Practitioner/Medical Doctor
- ✔ LAB RESULTS REVIEW by Nurse Practitioner/Medical Doctor
- ✔ SECURE AND CONFIDENTIAL LAB RESULTS including
  - FOLLOW UP RECOMMENDATIONS
  - EDUCATIONAL MATERIALS
- ✔ PERSONALIZED WELLNESS CONSULTING
- ✔ VITALS, INCLUDING:
  - BMI • WEIGHT • HEIGHT • PULSE
  - TEMPERATURE • OXYGEN SATURATION • BLOOD PRESSURE

ADDITIONAL SERVICES FOR Minidoka County School District

- ✔ AGGREGATE DATA REPORT

Exhibit B – Example Patient Registration Form

Exhibit B

PreventativeHealth
SCREENINGS & VACCINATIONS

Company/Location _____ Date of Service _____

☐ HS with NP
☐ HS no NP
☐ Flu Shot
☐ Additional Labs
☐ Cash ☐ CC ☐ Check ☐ Ins. Billed
☐ Company Invoice
☐ Other _____

Patient Registration Form

Important: Please Print CLEARLY

Last Name: _____ First Name: _____ M.I _____

Date of Birth: _____ | _____ | _____ Age: _____ Sex: M / F
month day year

Residential Mailing Address: _____ | _____ | _____ | _____
Street City State Zip Code

How would you like to receive your lab results? ☐ via secure email at: _____
☐ via U.S. Mail at the address, above.

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physician: _____ I have seen my physician within the last 12 months: ☐ Yes ☐ No

Consent to Treat, Release Information, Payment & Notice of Privacy Practices

By signing this form, and on behalf of my heirs, executors, administrators and assigns, I agree to release Preventative Health, LLC, and/or the Company or Institution where these tests, screenings and/or vaccinations are performed today ("procedures" or "services," as context may require), and Preventative Health's officers, employees, agents and subcontractors, from any liability for any injury suffered as a result of undergoing the procedures, and for any liability, claim or damage suffered as a result of any actions or inactions taken stemming from the services. I understand my results will be released to me and the responsibility of obtaining follow up medical treatment is solely my own. I further release, give permission and consent to Preventative Health to disclose to the Company or Institution that I participated in this clinic, but not to disclose any of the results thereof. I understand this information may be used for statistical reporting, but that I will not be individually identified in any recognizable way. I consent to allow Preventative Health to contact me at the contact information I provided above regarding the results of the procedures. I certify that as of the date of service, I am enrolled in the Company's insurance plan and/or under the insurance provided to Preventative Health for verifying my benefits. I acknowledge that I could be responsible for charges for these services if I am not enrolled in Company's insurance plan or my insurance benefits have not been verified prior to the date of service. I further give permission and consent to the Company to provide Preventative Health with any contact and/or insurance information in their possession as may be necessary or appropriate to contact me for payment for any services rendered by Preventative Health on my behalf. I acknowledge that benefits received from my insurance are an estimate only and final determination will be made once claims have been received and reviewed by my insurance company. **I further acknowledge that I may be responsible for any moneys my insurance company applies to my deductible, co-pay and/or coinsurance (out of pocket). I understand that I, the patient, will be responsible for the cost of any additional labs rendered on my behalf. I also acknowledge that I have received a copy of Preventative Health's Notice of Privacy Practices, or that such Notice of Privacy Practices has been made available to me.**

Signature: _____ Date: _____

If your insurance will be billed for services, please bring this form with your insurance card and photo ID (driver's license, company ID).

Insurance Card: | Insurance | Group # | Member # | Photo ID:

TC: _____
Trig: _____
LDL: _____
HDL: _____
TSH: _____
A1C: _____
Gluc: _____
Serum: _____
PSA: _____

*CBW
TC: _____
HDL: _____
Ratio: _____
Trig: _____
LDL: _____
Glucose: _____
A1C: _____
Cotinine: _____

Notations:
- ☐ Fasting
- ☐ Not Fasting
- ☐ No Hx
- ☐ Hx TSH
- ☐ Hx Diabetes

Notes: _____

Resulted By: _____

Rev 11/18/15

Date	Day	Set Up Time	Clinic Time	Clinic Location	Substitute (Y/N)	Clinic Address	Area	Room at Clinic Location	Site Contact	Site contact cell #	Sign Up Genius (y/n)	# total Staff	Parking
Jan 17th	Tuesday	6:00a	7:00a-12:00p	District-TLC, Food Service, Maintenance & Transportation		292 West 100 South Rupert, ID 83350	Between Paul & Rupert				Y	67/52	
Jan 18th	Weds	6:00a	7:00a-12:00p	Minico High School		310 10th Street Rupert, ID 83350 / 300 7th Street Rupert, ID 83350 (corner of 7th St. and D Street)	Rupert				Y	94	
Jan 18th	Weds	2:30p	3:30p-5:00p	Acequia Elementary		360 North 350 East Rupert, ID 83350	Outside of Town.				Y	33	
Jan 19th	Thurs	6:00a	7:00a-12:00p	Paul Elementary / W. Minico Middle School		201 North 1st West Paul, ID 83347 / 155 S. 600 W. Paul, ID 83347	Paul				Y	48/44	
Jan 19th	Thurs	2:30p	3:30p-5:00p	Heyburn Elementary/Mnt Harrison HS		1151 7th Street Heyburn, ID 83336 / 1431 17th Street Heyburn, ID 83336	Heyburn				Y	51/23	
Jan 20th	Fri	6:00a	7:00a-12:00p	Rupert Elementary (Big Valley Ele)./ East Minico MS		202 18th Street Rupert, ID 83350 / 1805 H Street Rupert, ID 83350	Rupert				Y	57/42	