Pro Health Advisor

## Participation Agreement

Objective: The purpose of the Pro Health Advisor program is to assist patients in poor health caused by certain diseases to improve their health and reduce complications.

Purpose: In many cases patients with complicated diseases on good treatment programs make little or no progress towards health improvement. Frequently, the lack of success is related to misunderstandings, unaffordable medications or barriers to access. Your Health Advisor's job is to help make your treatment plan work for you by improving your health. In some cases all this requires is additional information or your special training. In other cases your provider may need to modify the treatment plan because of your special circumstance. In whatever case your health advisor can help.

Approach: The primary focus of PHA is on removing barriers to care, solving treatment plan dilemmas and customizing lifestyle changes that will improve, resolve and sustain health indefinitely.

Eligibility: All patients who have complicated medical problems that need assistance implementing their primary providers plan of action. Also, patients who have made the informed decision to choose alternative or complimentary medical approaches.

Incentive: PHA has been very successful reducing the costs of care for the ER, Hospitalizations and medications. One large group client has reduced co-pay and eliminated deductible insurance expenses for outpatient visits (excluding ER), prescription medication (generic), or durable medical equipment related to the diseases mentioned above, for patients who enrolled in PHA. We cannot promise this for you but overall we believe you will see substantial savings in your medical care costs for you and your insurer.

Participation: In order to be enrolled in the program and participate patients must agree to comply with the following guidelines:

-Provide full access to medical information about the above conditions
-Follow 100% of attending Physician's Treatment Plan
-Attend all appointments
-Meet with your Health Advisor monthly or as requested
-Provide requested self-treatment information and results
-Not make false statements

Duration: members enrolled in Pro Health Advisor program may continue to participate until they are unable to show further health improvement or violate the following standards:
-Not be available for a scheduled appointment two or more times with your Health Advisor or your health care provider
-Not contact Pro Health Advisor for more than 30 days
-Not comply with your physician's Treatment Plan
-Decline to follow 2 or more Pro Health Advisor' recommendations

Decision process: dis-enrollment of members will be decided by Pro Health Advisor Board consisting of the program medical director, at least two health advisor. Exceptions to policy will be considered for extraordinary situations. Members will be notified by telephone and in writing.

| | Primary Provider Name | Specialty | City | Phone |
|---|---|---|---|---|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |

Signed: _____ Date_____

Name: _____ DOB, _____, SSN_Last 4: ____

Version._150101

Pro Health Advisor, A Patient Assistance Program
Dr. Philip Blair, MD; Nancy J. Weber, RD CSR (renal nutrition specialist)
Rachel Wemple, RD CDE; Linda Engleking-Cooper, LCSW; Laura Wittke, RD
fax 888-909-5897; voice 843-839-9088 Info@prohealthadvisor.com

# Pro Commitment

I, _____, will take charge of my health. I will improve my life and my future by facing my health problems and conquering them! I will recover from or improve the illnesses that I already have. I will avoid the chronic diseases that I am starting to develop. I wish to avoid or prevent diseases that will hurt me. I will feel good and feel good about myself.

I understand that:
- Participating in this health program requires effort on my part;
- Pro Health Advisor makes tools available to me that assist me in achieving my goals;
- Pro Health Advisor recognizes I am an individual;
- Pro Health Advisor personalizes my program based on information I have provided.

I commit to do Pro best.

I will:
• Participate in all parts of Pro Health Advisor program.
• Meet with Pro Health Advisor each month.
• Follow my personal doctor's medical treatment plan.
• Follow the recommendations of Pro Health Advisor.
• Follow my food, activity, and lifestyle program as directed by Pro Health Advisor.
• Record my food intake in my personal journal.
• Maintain an open mind- try something new- foods, beverages, recipes, or even a different grocery store.
• Eat REAL FOOD, and to learn to prepare REAL FOOD.
• Ask for help when I need it by contacting Pro Health Advisor.
• Comply with the participation rules for Pro Health Advisor.

Signed: _____ Date_____
Name: _____ DOB, _____, SSN_Last 4: ____

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# Consent

Title: Consent to Release Personal Health Information
Purpose: Consent for the release of protected health information
Use: Exclusively for treatment, payment or healthcare coordination activities
Restrictions: No acquired information will be released beyond PHA.

I, _____, hereby consent to allow Pro Health Advisor (PHA), a clinical case management company to view my protected health information (PHI) so as to advise me regarding my health care issues: heart disease, kidney disease, diabetes, metabolic or nutritional disorders.

Duration: Expiration Date _____ (one year suggested from today's date)

This information may include all treatments, diagnoses, health care notes and results. The sources of information may include family members, present and past providers and specialists. Any information obtained will be accessible only to need-to-know members of the PHA for the sole purpose of managing treatment and will not be released to any other entity without your express permission.

Requested information usually includes provider office notes and lab/clinical test results from providers or discharge summaries, operative reports, clinical notes, and management notes from hospitals or treatment facilities for the last visit but may include the previous year.

Federal Privacy Rule Disclosure Information:
I can cancel my consent at any time in writing to Pro Health Advisor.
If I refuse to provide this consent PHA will not refuse to treat me.
I read the HIPAA disclosure document provided by PHA.
I can also specifically restrict information about certain diagnoses of HIV, AIDS or mental health.
If I share information with PHA it could, possibly, be further released and unprotected by confidentiality laws due to error or loss.

I consent to this release of information to Pro Health Advisor:

Signed: _____ Date_____
Name: _____ DOB, _____, SSN_Last 4: ____

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Pro Health Advisor

# Health Care Provider

1/2/2015

Dear Provider,

Your patient, _____, has enrolled in Pro Health Advisor, a patient assistance program to improve their health condition with information, support and health training.

Pro Health Advisor gives patients direct access to a health coach by phone or video-conference using a home computer. It's entirely voluntary, meant to support your treatment plan and supplement your recommendations. Our goal is to improve health and prevent complications requiring hospitalization and emergency care. To participate patients must follow a provider's treatment plan, attend all appointments, and make every effort to improve their health. Of course, health information is confidential and will not be shared with the employer or anyone without patient's permission.

Pro Health Advisor has great success in helping people with serious illness overcome barriers to good health. We feel we can do that for your patient, too. Please, allow us access to this patient's health information on request so we can all achieve our health goals.

If you have any questions about the program, please call Pro Health Advisor directly at voice 843-839-9088.

Kind regards,

Philip Blair, MD

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