### Capital One

**EXPERT MEDICAL OPINION CONTACT FORM**

1. **General Information**

<table>
<thead>
<tr>
<th>Patient’s Full Name:</th>
<th>Patient’s Date of Birth:</th>
<th>Gender of Patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male □ Female □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Month/Day/Year</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Full Name of Applicant (if different):</th>
<th>Relationship to Patient:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Brief Description</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Preferred Tel. Number:</th>
<th>Alt. Tel. Number:</th>
<th>Fax number:</th>
<th>E-mail address (Non-work E-mail preferred):</th>
</tr>
</thead>
</table>

   Preferred time of day to be called: ____________________________

2. **Treating Physician (add'l pages if necessary)**

<table>
<thead>
<tr>
<th>Full Name of Physician:</th>
<th>Specialty:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tel. Number:</th>
<th>Address:</th>
<th>E-mail address/website URL:</th>
</tr>
</thead>
</table>

3. **Please describe what you would like to learn from your Expert Medical Opinion (add'l pages if necessary)**

   ____________________________________________

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ENROLLMENT AGREEMENT

Prior to beginning the Expert Medical Opinion service you must read, understand and agree to the following terms and conditions.

1. You hereby authorize your treating physicians and other healthcare providers to release all relevant personal and medical data to ADVANCE MEDICAL to be used in obtaining a second opinion and you grant ADVANCE MEDICAL permission to use and disclose this information as described in our privacy notice. If requested, you will sign separate authorization forms for each physician or other healthcare providers to permit them to share protected health information with us. You agree that the information that you provide to us will be accurate and complete to the best of your knowledge. It is your responsibility to ensure that all relevant information has been provided to ADVANCE MEDICAL.

2. The Report is the opinion of medical experts based on the medical information regarding your case that you provide us and that we obtain from your doctors with your permission. The physician rendering the Expert Medical Opinion Report will not have the benefit of examining you in person, the ability to order additional tests, or have any information beyond what you provide. Since the medical experts will not personally examine you or order additional tests, it is not a medical diagnosis. Medical experts through the Expert Medical Opinion program do not and cannot take responsibility for your care based only on the information we receive. Medical decisions should be made only after an in-person medical examination and diagnostic tests, as indicated by the examination and your medical history. The Report is intended to provide you with information to supplement the information you have already received from your treating physicians. The information contained in the Expert Medical Opinion Report shall not be used to substitute for your physician’s recommendations. You should discuss the Report with your own doctors, who are responsible for your care.

3. ADVANCE MEDICAL disclaims all warranties, express or implied, including without limitation any warranty of merchantability or fitness for a particular purpose, regarding any information you obtain through or from ADVANCE MEDICAL.

4. You hereby hold harmless and release Capital One and ADVANCE MEDICAL, its officers, directors, employees and agents, and the opining physician(s) from any liability arising out of preparation or delivery of the Report and your use of the Report. In no event will Capital One or ADVANCE MEDICAL, their officers, directors, employees and agents, and the opining physician(s) be liable for special or consequential damages, even if those damages are otherwise foreseeable or even if any of them have been advised of the possibility of such damages.

5. You acknowledge that your health insurance might not cover a particular test or treatment recommended in the Expert Medical Opinion Report, as coverage depends on the terms of your health insurance. ADVANCE MEDICAL and the medical experts do not make health benefits coverage decisions for your health insurance. Please refer to your insurance company to verify coverage and pre-authorize treatment.

6. In order to perform its services for you, Advance Medical will collect your medical information from you and your healthcare providers and transfer it to our offices in the United States of America or other Advance Medical offices. Details of the individuals and countries involved in your case can be provided on request. By signing below, you agree that we can make these transfers for the purpose of providing services to you.

7. If the applicant is not the patient or patient’s representative, we require written authorization from the patient for release of any medical or personally identifying data.

8. This Enrollment Agreement represents the entire agreement between us, and can be modified only by a written document signed by you and an authorized representative of ADVANCE MEDICAL. This Agreement is governed by the laws of the Commonwealth of Massachusetts, USA without regard to the conflicts of law provisions thereof. Any disputes arising out of this Agreement, its interpretation or enforcement, the delivery or use of the Report, or any related matter shall be resolved by binding arbitration carried out in Boston, Massachusetts before a single arbitrator. The arbitration shall be carried out in accordance with the rules of the American Arbitration Association. The decision of the arbitrator may be entered for judgment in a court of competent jurisdiction.

I have read and understood the preceding information. I agree to these terms.

_________________________  ___________________________  ________________
Signature                              Printed Name                             Date
Authorization to disclose Personal Health Information

I, ______________________________________, ______________________,
(Print name of patient) (Date of birth)

hereby authorize Advance Medical to obtain my medical records and related information and documentation, including my
health history, x-rays, films, pathology slides and specimens and other diagnostic data (collectively, my “Protected Health
Information or “PHI”) and send this information to:

Address:
Advance Medical
100 Lowder Brook Drive
Suite 2200
Westwood, MA 02090

Fax:
617-987-0633

My medical records will include information regarding diagnosis and treatment. I understand that such information is confidential
and is protected by State and Federal Law and as described in the Privacy Notice.

I understand that I have the right to revoke this authorization at any time for any reason by giving written notice to Advance
Medical. This authorization will automatically expire in 365 days after the date of signature.

__________________________________________________________  __________________________
Signature of patient or patient representative                  Date (mm/dd/yyyy)
PRIVACY NOTICE

This Notice describes the privacy practices of ADVANCE MEDICAL, Inc. which is referred to as “ADVANCE MEDICAL” in this Notice. This Notice applies to uses and disclosures of medical information collected by ADVANCE MEDICAL about persons in the Expert Medical Opinion program. We are required by law to comply with this Notice. Other policies may apply with respect to information collected from persons residing in other countries.

To receive another copy of this notice, electronically or on paper, call 617-987-0018, send an e-mail to privacyofficer@advance-medical.com or send a written request to: ADVANCE MEDICAL, Privacy Officer, 100 Lowder Brook Drive, Suite 2200, Westwood, MA 02090. ADVANCE MEDICAL may change this policy at any time and without prior notice. Those changes will apply to any protected health information already held by ADVANCE MEDICAL. ADVANCE MEDICAL will keep the current policy on the website and available at its offices.

Uses and Disclosures
ADVANCE MEDICAL may collect protected health information for use in our Expert Medical Opinion service (the “Service”). The information will be used and disclosed in creating a medical case and history, identifying physician consultants, and producing the Expert Medical Opinion Report (the “Report”).

ADVANCE MEDICAL usually will remove some personal identifiers (such as name and address) before disclosing your information to expert physicians, but certain personal details may be disclosed and later reflected in the Report. ADVANCE MEDICAL will handle all personally identifiable information in accordance with all legal requirements including those required by HIPAA.

ADVANCE MEDICAL may disclose your health information to case managers, clinical committee members, administrators who will use the information to process your case and other individuals who are involved in providing the Service or generating your Report. In some cases your information may be sent to an outside consulting physician or other consulting medical professionals. For example, a case manager may share your information with a medical director in order to identify an appropriate consulting physician for your case. The case manager may share the information with the consulting physician. We will ask these consultants to sign agreements requiring them to preserve the confidentiality of this information.

Payment
The Service is free to you, paid and provided for by your employer.

Operations
ADVANCE MEDICAL also may use your health information to review or evaluate the performance of our systems in providing the Service to you, to improve the quality or timeliness of our services.

ADVANCE MEDICAL also may create de-identified information based upon information you have provided to us. De-identified information is information that does not include your name, address, birth date, or other information that could be used to identify you. This de-identified information could be used for quality improvement, research and other purposes. For example, ADVANCE MEDICAL could use this de-identified information to demonstrate the reliability of our information management systems or to generate medical research information. We would not identify you by name in any resulting reports or other information.

ADVANCE MEDICAL may disclose information in order to contact you during the course of providing services to you as either part of the ongoing process or as part of an effort to follow-up with you after using the Service or if there was an opportunity to inform you about additional services of interest. We may contact you through the mail, over e-mail or through the phone.

ADVANCE MEDICAL may disclose protected health information for the following purposes without your authorization:

- As required by law
- For public health activities
- To protect victims of abuse, neglect or domestic violence
- For health oversight activities carried out by government agencies
- For judicial and administrative proceedings after proper legal process
- For law enforcement purposes

Other uses or disclosures about your medical information may require your written authorization. The patient can revoke that authorization at any time but that revocation will not affect any use or disclosure made prior to revocation.

ADVANCE MEDICAL may disclose information to you, to your representative or to another individual designated by you.

Individual’s Rights
You have the right to inspect, copy and amend completed medical records maintained by ADVANCE MEDICAL. To inspect your medical records please make a signed and dated written request to ADVANCE MEDICAL. Privacy Officer, 100 Lowder Brook Drive, Suite 2200, Westwood, MA 02090. We may charge you a processing fee for these requests. In some cases we may not honor your requests, such as if disclosing records will cause you harm or if they are part of legal proceedings or if they are part of ongoing research. In the event that we deny your request you will be notified of any denial within 60 days and be given additional options or information. To make an amendment to your medical records, please make a signed and dated written request to ADVANCE MEDICAL, Privacy Officer, 100 Lowder Brook Drive, Suite 2200, Westwood, MA 02090. In the request please describe the changes that you would like to make and the reason why. In the event that we deny your request you will be notified of any denial within 60 days and be given additional options or information.

You have the right to request restricted disclosures or uses or to request that we limit access to your personal health information. Please make a signed and dated written request to ADVANCE MEDICAL, Privacy Officer, 100 Lowder Brook Drive, Suite 2200, Westwood, MA 02090. Please include all of the specific information that you want restricted and the person or categories of persons who should or should not have access to the information. We have the right to deny your requests or ask for additional information. In the event that we deny your request you will be notified of any denial within 60 days.

You have the right to an accounting of certain disclosures of your personal health information that were made without your written authorization. Please make a signed and dated written request to ADVANCE MEDICAL, Privacy Officer, 100 Lowder Brook Drive, Suite 2200, Westwood, MA 02090. We are only obligated to share disclosure accounting for the preceding six years. This accounting will not include disclosures made in the course of providing the Service or generating the Report.

You have the right to request receive confidential communications about your health information, such as having information sent to a particular address or in a particular way. Please make a signed and dated written request to ADVANCE MEDICAL, Privacy Officer, 100 Lowder Brook Drive, Suite 2200, Westwood, MA 02090. In your request specify how you would like us to communicate with you.

You have the right to make complaints about any possible violation of your Privacy Rights to ADVANCE MEDICAL. ADVANCE MEDICAL will not penalize you for making a complaint. To make a complaint to ADVANCE MEDICAL, please make a signed and dated written complaint to ADVANCE MEDICAL, Privacy Officer, 100 Lowder Brook Drive, Suite 2200, Westwood, MA 02090. If, for any reason, you would like to discuss any matter concerning our privacy policies or to request copies of our privacy policies, please contact us at:

Privacy Officer
100 Lowder Brook Drive, Suite 2200
Westwood, MA 02090
617-987-0018
privacyofficer@advance-medical.com

Effective as of January 1, 2015.
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