Patient Consent Agreement for
IAQplus Collaborative Care Management Program Participation

Program Background

I understand that Physician Practice Legal Name through its IAQplus Collaborative Care Management Program is collaborating with a health management company called IndividuALLytics, Inc. and Advanced Precision Health Management PLLC ("IndividuALLytics"). This team developed IAQ HealthQuest™ which uses a mobile app to collect, sync and analyze personal health information from your Remote Patient Monitoring devices (blood pressure cuff, weight scales, heart rate, Genus Connect, other devices and FitBit).

My Care Team

I understand that my personal health information is being used to create highly individualized health and wellness plans which are based on my program goals. I understand that my plans will be developed by a Care Team comprised of Physician Practice Legal Name and IndividuALLytics. Through my participation in the program, I am agreeing to play an essential role in the development and execution of my wellness plan to achieve and maintain lifestyle changes that support my optimal health and quality of life.

I understand that my personal health information may be used for research purposes only if it does not include my name, or any personally identifiable information unless I authorize such use in advance. I can cancel my permission to use my personally identifiable information for research at any time upon notice to Physician Practice Legal Name and this cancellation by me shall not change my participation in the Program.

My Primary Care Doctor

I understand that it is a priority of the IAQplus Collaborative Care Management Program to coordinate my care with my primary care doctor.

I agree to provide my health insurance information and my primary care doctors name and contact information so that my Care Team may contact my doctor to explain the IAQplus Collaborative Care Management Program.

If your doctor agrees to participate, we may request and collect medical records from your past, current, and future health care providers. This may include information about your diagnosis, previous treatments, general health, laboratory and pathology test results and reports, social histories, any family history of illness, and records about phone calls and emails related to your illness.

Remote Patient Monitoring

I agree to use the Remote Patient Monitoring devices given to me as prescribed, so that my Care Team can get the daily data needed to provide best practices care to me. I understand that these devices are made available to me for as long as I participate in the IAQplus Collaborative Care Management Program. The goal of this cutting-edge approach is to create a more clinically meaningful virtual connection between patients and their family wellness team resulting in personalized treatment plans, which minimize their health risks while supporting the behavioral changes needed to achieve a healthy lifestyle. I understand that I will receive by mail or shipping service the RPM devices that are prescribed for me, and that my Care Team will be available to assist me in the use of these RPM devices.

If the Program is cancelled at any time for any reason, then my Care Team will schedule a pick-up of the RPM devices to return them. I understand and agree that if I do not return to IndividuALLytics in good working condition then I will be charged for their cost.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Your personal medical data is uploaded into a secured site in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that all my personal health information is protected Patient Health Information (PHI) and may not be shared with others without my consent. Additional data privacy information is at https://individuallytics.com/Data-Privacy/ .

We use third party vendors and hosting partners to provide the necessary hardware, software, networking, storage, printing, packaging, mailing, content, customer service tools, and related technology to operate and maintain the program. If we provide your personal information to these approved third parties, we only provide the personal information needed to deliver the program. They are required to maintain high standards of confidentiality and security when using personal information and are explicitly prohibited from using that information for any other purpose. IAQplus Program includes secure online access for you to see your health care goals and status per license at: https://individuallytics.com/end-user-license-agreement/ .

Communicating with My Care Team
I authorize my Care Team to communicate with me through group video meetings, and one-on-one contact in the form of phone and text or other means including telemedicine video consultation for as long as I am a participating participant with this Program.

I understand that I can cancel my participation in the IAQplus Collaborative Care Management Program at any time, by notifying my Care Team. This program cancellation by me shall not change my ability to continue to receive treatment from my primary care doctor.

Consent Terms
By signing this agreement**, I am authorizing** my Care Team to collect my personal health information from me for purposes of providing care and to use secure electronic communication of other treating providers as part of coordination of my care.

Upon receipt of your electronic acceptance and consent as confirmed here, your doctor, along with your Care Team, will provide you with health and wellness management services using the IAQplus Collaborative Care Management Program. IndividuALLytics will bill your insurance and you agree to pay deductibles, co-pay or co-insurance, if any. IndividuALLytics provides device kits and supportive equipment that is financed for your care that can take up to 6 months to repurpose, so you can be responsible for financing until equipment is put back to productive use for up to 6 months.

Your signature below indicates your understanding of and agreement with the information provided in this document.

_____	_____	_____
Patient Signature	Patient Full Name Printed	Date
_____	_____	_____
Guardian / Medical Power Attorney Signature	Guardian Full Name Printed	Date