

# athenahealth Enrollment

To CA - Senior Care Medical Assocs

From athenahealth, Inc.

Re: Enrollment forms

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Enrollment forms requiring your attention are attached. Please follow the instructions included with each form and return the completed forms and instruction cover sheets to the address included below.

Important - All attached enrollment forms must be returned to athenahealth by 12/13/2017

Enrollment Forms:

1. DARTNET Client Instructions.1 (1 page)
2. DARTNET DUA.5 (3 pages)

If you need assistance, please select the Task Action of "Request help from athena (Please describe the problem in the Notes field below)"

Thank you,

The Enrollment Services Team

athenahealth, Inc.

Attn: Enrollment Services

3 Hatley Rd

Belfast, ME 04915

# athenahealth Enrollment

**Task ID: E5863e11277**

Return to Sarah Black

Payer: DartNet Institute Practice Performance Registry  
Group: CA - Senior Care Medical Assocs

Total Pages: 1  
Last Action: Client has not worked task

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## Enrollment Form Instructions

Please have an authorized representative complete this form using BLUE ink.

When you are ready to return this completed form, please follow these steps:

1. Go to the Client Enrollment Dashboard (Admin > Billing Admin)
2. Click the appropriate link in the Enrollment Forms column
3. Click the Forms to Mail tab on the Enrollment Forms page
4. Select all forms you wish to mail and click "ready to mail"
5. Print a prepaid UPS label or indicate your preferred mailing method
6. If this is an EFT form, please remember to include a copy of your Bank Letter or a Voided Check

IMPORTANT - Please include this instruction cover sheet with your completed form.

Send completed forms to:

The Enrollment Services Team

athenahealth, Inc.  
Attn: Enrollment Services  
3 Hatley Rd  
Belfast, ME 04915

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## DARTNET Client Instructions.1

Page 1



## Client Instructions:

### DARINET

#### Overview:

**You have the option to meet your public health measure by enrolling with a specialized registry. Please visit your pay of performance dashboard for more specific requirements of what is needed to meet your public health measure.**

1. To start the enrollment process you will need sign the DUA that is attached to this task. Please have the authorized signer sign this form. The authorized signer will be the person responsible for entering information to DARINET.
2. We will send a copy of the DUA to the registry for their records and athena will also keep a copy for themselves.
3. DARINET is free for MU Data transmission, however if you wish to complete additional reporting and services please visit the Marketplace for more information as there is additional fees.

#### **\*\*\*IMPORTANT\*\*\* MUST READ\*\***

If you print the forms to sign please check your printer settings before doing so. When you go into print preview please make sure Document and Markups are selected. If you do not select this the signature from DARINET might not print correctly.

**If you have any questions during this process please status the task to help requested or e-mail [clinicaldataregistry@athenahealth.com](mailto:clinicaldataregistry@athenahealth.com).**

**Thank you,**

**Public Health Enrollment Team**

# athenahealth Enrollment

**Task ID: E5863e11277**

Return to Sarah Black

Payer: DartNet Institute Practice Performance Registry  
Group: CA - Senior Care Medical Assocs

Total Pages: 3  
Last Action: Client has not worked task

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## Enrollment Form Instructions

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1. Go to the Client Enrollment Dashboard (Admin > Billing Admin)
2. Click the appropriate link in the Enrollment Forms column
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IMPORTANT - Please include this instruction cover sheet with your completed form.

Send completed forms to:

The Enrollment Services Team

athenahealth, Inc.  
Attn: Enrollment Services  
3 Hatley Rd  
Belfast, ME 04915

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## DARTNET DUA.5

Page 1



Three horizontal lines, the top one is shaded gray, intended for a signature and printed name.

Have the Authorized Representative sign here in blue ink.

Print the Name of the Authorized Representative here in blue ink.

Print the Title of the Authorized Representative here in blue ink.

## **DATA USE AGREEMENT FOR DARTNET REGISTRY REPORTS**

This Agreement is entered into by and between the **Covered Entity** named on **Schedule 1** and the DARTNet Institute ("**Recipient**") (attached hereto and by this reference incorporated herein).

- A. Covered Entity is providing certain Protected Health Information ("PHI") to Recipient in the form of a Limited Data Set for the purpose(s) identified in paragraphs 2 and 3 of **Schedule 1**.
- B. In connection with the provision of that PHI, pursuant to the Health Insurance Portability and Accountability Act and regulations promulgated pursuant thereto (collectively "HIPAA"), Covered Entity is required to obtain assurances from Recipient that Recipient will only use or disclose PHI as permitted herein.
- C. The parties enter into this Agreement as a condition to Covered Entity's furnishing the Limited Data Set to Recipient, and as a means of Recipient's providing assurances about use and disclosure. The provisions of this Agreement are intended to meet the Data Use Agreement requirements of HIPAA.

**NOW THEREFORE, the parties agree as follows:**

- 1. **Definitions.** Each capitalized term used in this Agreement and not otherwise defined, shall have the meaning given it in HIPAA.
- 2. **Term.** This Agreement shall commence on the Effective Date and continue until terminated in accordance with Section 4 below.
- 3. **Recipient's Obligations.** Recipient shall:
  - a. Comply with all applicable federal and state laws and regulations relating to the maintenance of the PHI, the safeguarding of the confidentiality of the PHI, and the use and disclosure of the PHI.
  - b. Use and disclose the PHI only for the purpose(s) identified in paragraph 2 and 3 of Schedule 1, as otherwise required by law, and for no other purpose.
  - c. Use appropriate safeguards to prevent the use and disclosure of the PHI, other than for a use or disclosure expressly permitted by this Agreement.
  - d. Immediately report to Covered Entity any use or disclosure of the PHI other than as expressly allowed by this Agreement.
  - e. Ensure that its employees and representatives comply with the terms and conditions of this Agreement, and ensure that its agents, Business Associates and subcontractors to whom



Recipient provides the PHI agree to comply with the same restrictions and conditions that apply to Recipient hereunder.

- f. Not identify or attempt to identify the information contained in the Limited Data Set, nor contact any of the individuals whose information is contained in the Limited Data Set.
- g. Not request use, or disclose more PHI than the minimum amount necessary to allow Recipient to perform its functions pursuant to the purpose identified in **Schedule 1**.

4. **Effectiveness and Termination.** This Agreement shall be effective for the period beginning on the date that Data Recipient first provides Services for Covered Entity under this Data Use Agreement (the "Effective Date") and ending on the date that Data Recipient ceases to provide Services for Covered Entity under this Data Use Agreement, unless terminated sooner, as stated herein. Either party may terminate this Data Use Agreement for any reason upon thirty (30) days written notice provided to the other party. In the event of the expiration or termination of this Data Use Agreement, all further obligations of the parties shall terminate as of the effective date of such expiration or termination. Notwithstanding the foregoing, the parties acknowledge and agree that following the expiration or termination of this Agreement: (a) Data Recipient will be entitled to retain all Protected Health Information of Covered Entity received by means of a Limited Data Set; and (b) Data Recipient will only use, disclose, and maintain such Protected Health Information in a matter consistent with the requirements of Section 164.514 of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996.

5. **Governing Law.** This Agreement shall be governed by the laws of the State of Missouri.

6. **Execution.** This Agreement may be executed in one or more counterparts, including by email, facsimile or other electronic means, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one instrument.

**IN WITNESS WHEREOF**, the parties hereby agree to all of the above terms.

\_\_\_\_\_  
(Covered Entity Name)  
  
Signed: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

**DARTNet Institute**  
  
Signed: \_\_\_\_\_  
Name: Allyson Jasper, MEd  
Title: CEO

## Schedule 1

1. Name of Covered Entity: \_\_\_\_\_

2. Purpose of Limited Data Set Disclosure:

☐ Research Study

- Title: \_\_\_\_\_
- Principal Investigator: \_\_\_\_\_
- IRB #: \_\_\_\_\_
- Sponsor: \_\_\_\_\_

☐ Public Health

☒ Health Care Operations (e.g., Quality improvement, patient safety, teaching, accreditation, the development of clinical guidelines.)

3. The recipient of the Limited Data Set provided by the Covered Entity listed in #1 is permitted to use and disclose the Limited Data Set for the following purpose(s):

Data Recipient may make all Uses of the Limited Data Set necessary to generate quality improvement benchmarking reports and patient safety reports; data will also be used for future research project development and may be fully de-identified (with masking of all dates of service and suppression of rare events) and used as a de-identified dataset for other research.