ACCOUNT PROFILE FORM

O Molecular PCR O BPP O TOX O PGX O CGX O Blood

PRACTICE INFORMATION

Practice Name	NPI#	Phone	Fax
Voss Family Clinic		281.617.8671	832.944.6133

Address	City	State	Zip
11920 HWY 6 S Ste 1500	Sugarland	TX	77498

Office Manager	Phone	Email
Syed Ahmed	832.205.2456	info@vossfamilyclinic.com

Lab Supervisor (If any)	Cell	Email

OFFICE HOURS Monday 9 to 5 Tuesday 9 to 5 Wednesday 9 to 5 Thursday 9 to 5 Friday 9 to 5
Saturday ____ to ____ Sunday ____ to ____

PHYSICIAN INFORMATION

Please list all Doctors, Physician Assistants, and Nurse Practitioners. Use another Account Profile Form if additional space is needed for more Doctors.

Provider Name	NPI #	Cell	Email
Jinny Narula MD	1801095880	281.617.8671	info@vossfamilyclinic.com
Regina Ottan Obi FNP	1164950283	281-617-8671	
Leslie Byrd FNP	1750851325	281.617.8671	

TOP 5 INSURANCE PAYERS 1.____ 2.____ 3.____ 4.____ 5.____

Fedex PICK UP NEEDS Is client interested in participating in Fedex Lab Specimen Pickup Point Program? O Yes O No
A designated area to place lab specimens and a UPS placard is required in the clinic in order to participate in FEDEX Lab Specimen Pickup Point Program.

Please specify days and pick up times needed: Will Call when Pick-Up Required

Days of the week:	X Monday	X Tuesday	X Wednesday	X Thursday	X Friday	O Saturday	O Sunday
Desired pick up time:							
Latest pick up time:							

Physician Authorization & Acknowledgment

I understand that as policy, ImmunoGenomics provides convenient options for clients and assists in the best patient care possible. ImmunoGenomics offers an account profile option to all of their physicians and practices. This profile allows each physician to create a testing panel that fits directly with their treatment plans. Besides requesting my ImmunoGenomics Account Profile, I can also order any combination of individual tests. I certify that the tests ordered are medically necessary for the benefit of my patients. I agree to contact ImmunoGenomics immediately if my Account Profile does not adequately reflect my patient's needs. I may modify my Account Profile at any time if needed. I understand and agree to the statement above. I authorize ImmunoGenomics to create my Account Profile that I have designated on this form, as I authorize it for my patients on their order forms. At any time, I can modify my Account Profile by contacting ImmunoGenomics and may also order individual tests on any specimen, as well as call ImmunoGenomics to schedule a pick-up. I understand and agree to the Physician Acknowledgment and Authorization Statement above.

Medical Provider: By providing a signature you confirm that lab tests can or will be ordered via electronic web portal. Your signature serves as a consent for web ordering if applicable.

Physician Name	Physician Signature	NPI	Date
Regina Ottan Obi	Regina Ottan Obi		11/29/22

ImmunoGenomics Marketing Representative Name	ImmunoGenomics Marketing Representative Signature	Date

NEW ACCOUNT FORM

Date: 11/29/2022
Contact Name: Syed Ahmed 832.205.2456
Phone/Email:
Projected Start Date: 12/1/2022

Email to: info@immunogeno.com
Fax to: 832.276.7352

1.0 Account Information

Account Name	Office Hours	Address	Phone	Fax
VOSS Family Clinic	9am - 5pm	11920 SHWY 6 1500 Sugarland TX 77498	281.617.8671	832.944.6133

2.0 Physician Information

Name (M.D., D.O., CRNP)	NPI	
Jinny Narula MD	1801095880	
Regina Ottan-Obi FNP	1164950283	
Leslie Byrd FNP	1750851325	

3.0 Office Contact Information

Name Syed Ahmed	Phone 832.205.2456	Job Title Manager

4.0 Account Preferences

Pick-Up: ☒ Will-Call ☐ Daily ☐ FedEx ☐ Courier / FedEx ☐ Daily, Specific Days: _____
Drop Box Location: _____
Pick-Up Special Instructions: _____
Report Delivery: ☐ Fax ☒ Web Portal ☐ Hard Copy
Critical/Malignancy Calls: ☒ Critical Clinical Results ☒ Malignancy
After Hours Phone #: 832.205.2456

5.0 Billing Information

☐ Commercial Insurance (%) ☐ Client Bill ☐ Workers Comp. ☐ Medicare / Medicaid

Estimated Monthly Volume: _____

6.0 Supply Request

☐ Pathology ☐ Toxicology ☐ Clinical ☐ Requisitions (Quantity/Type): _____
☐ Send Supplies to Account Representative ☐ Send to Account Attn: _____

7.0 Physician Authorization

Physician Name (printed): Regina Ottan Obi FNP Physician Signature: Regina Ottan Obi
Date Signed: 12 / 29 / 22

FOR ALL NEW ACCOUNTS, WE MUST RECEIVE CONFIRMATION OF THE ORDERING PHYSICIANS SIGNATURE. PLEASE HAVE THE ORDERING PHYSICIAN SIGN OFF AND ACKNOWLEDGE THEIR SIGNATURE ON A PRESCRIPTION PAD.

HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("Agreement") is made effective as of November 22, 2020, by and between ImmunoGenomics ("Covered Entity"), of 202 Industrial BLVD, STE 501, Sugar LAnd, Texas 77478 and VOSS ("Business Associate"), of _____, _____, _____ _____ (collectively, the "Parties").

WHEREAS, Business Associate, in connection with its services, may maintain, transmit, create or receive data for or from Covered Entity that constitutes Protected Health Information ("PHI");

WHEREAS, Covered Entity is or may be subject to the requirements of the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and related regulations;

WHEREAS, with respect to the foregoing, Business Associate is or may be subject to the requirements of HIPAA, HITECH and related regulations;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties hereby agree as follows:

1. Definitions.

a. General. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Electronic Protected Health Information, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

b. Specific.

i. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean VOSS.

ii. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean ImmunoGenomics .

iii. Electronic Health Record. "Electronic Health Record" shall have the same meaning as the term "electronic health record' in the HITECH Act, Section 13400.

iv. HIPAA. "HIPAA" collectively refers to the HIPAA Statute, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164, the HITECH Act, and any associated Regulations, as such may be amended from time to time.

2. Obligations and Activities of Business Associate.

a. Business Associate agrees to not use or disclose PHI other than as permitted or required by the Agreement or as required by law.

b. Business Associate agrees to use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement.

c. Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 CFR 164.410, and any security incident of which it becomes aware.

d. In accordance with 45 CFR 164.502(e)(1) and 164.308(b)(2), if applicable, Business Associate agrees to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

e. In accordance with 45 CFR 164.524, Business Associate agrees to make available PHI in a designated record set to the Covered Entity within twenty (20) days of a request by Covered Entity for access to PHI about an individual. In the event that any individual requests access to PHI directly from Business Associate, Business Associate shall forward such request to Covered Entity within twenty (20) days of receiving such request.

f. In accordance with 45 CFR 164.526, Business Associate agrees to make any amendment(s) to PHI in a designated record within twenty (20) days of a request by Covered Entity. Business Associate shall provide such information to Covered Entity for amendment and incorporate any amendments in the PHI as required by 45 CFR 164.526. In the event a request for an amendment is delivered directly to Business Associate, Business Associate shall forward such request to Covered Entity within twenty (20) days of receiving such request.

g. Except for disclosures of PHI by Business Associate that are excluded from the accounting obligation as set forth in 45 CFR 164.528 or regulations issued pursuant to HITECH, Business Associate shall record for each disclosure the information required to be recorded by Covered Entities pursuant to 45 CFR 164.528. Within twenty (20) days of notice by Covered Entity to Business Associate that it has received a request for an account of disclosures of PHI, Business Associate shall make available to Covered Entity, or if requested by Covered Entity, to the individual, the information required to be maintained pursuant to this Agreement. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall forward such request to Covered Entity within twenty (20) days of receiving such request.

h. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate agrees to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).

i. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary for purposes of determining compliance with HIPAA.

3. Permitted Uses and Disclosures by Business Associate

a. Business Associate may use or disclose PHI for the following purposes: As necessary to perform the services as agreed to between the Parties, notwithstanding the restrictions on such uses and disclosures as set forth in HIPAA and this Agreement.

b. Business Associate may only de-identify PHI if permitted by Covered Entity and in any event may only de-identify PHI in accordance with 45 CFR 164.514(a)-(c).

c. Business Associate may use or disclose PHI as required by law or where Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity except for the specific uses and disclosures set forth herein.

4. Permissible Requests by Covered Entity

a. Except as otherwise permitted by this Agreement, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by Covered Entity.

5. Term and Termination

a. Term. The Term of this Agreement shall be effective as of November 22, 2020, and shall terminate on the date the business relationship, or any services agreements, between the Parties end or are terminated or on the date Covered Entity terminates for cause as authorized in paragraph (b) of this Section.

b. Termination for Cause. Business Associate authorizes termination of this Agreement by Covered Entity, if Covered Entity determines Business Associate has violated a material term of the Agreement and Business Associate has not cured the breach or ended the violation within 1 month days written notice. If it is determined by Covered Entity that cure is not possible, Covered Entity may immediately terminate this Agreement. The termination of this Agreement shall automatically terminate the business relationship and any services agreements between the Parties.

c. Obligations of Business Associate Upon Termination. Upon termination of this Agreement, Business Associate shall either return or destroy all PHI that Business Associate still maintains in any form. Business Associate shall not retain any copies of such PHI. In the event Business Associate determines that returning or destroying the PHI is infeasible, the terms of this Agreement shall survive termination with respect to such PHI and limit further uses and disclosures of such PHI for so long as Business Associate maintains such PHI. In addition, Business Associate shall continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI for as long as business associate retains the PHI.

d. Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

6. General Provisions.

a. This agreement sets forth the entire understanding of the Parties. Any amendments must be in writing and signed by both Parties. This Agreement shall be construed under the laws of the State of Texas, without regard to conflict of law provisions. Any ambiguity in the terms of this Agreement shall be resolved to permit compliance with HIPAA. Any references in this Agreement to a section in HIPAA means the section as in effect or as may be amended. This Agreement may be modified or amended from time to time as is necessary for compliance with the

requirements of HIPAA and other applicable law. Amendments must be made in writing and signed by the Parties. The failure of either Party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that Party's right to subsequently enforce and compel strict compliance with every provision of this Agreement. The terms of this Agreement are hereby incorporated into any service or business agreement that may be entered into between the Parties with the intent to form a business relationship. In the event of a conflict of terms between this Agreement and any such service or business agreement the terms of this Agreement shall prevail.

IN WITNESS WHEREOF, I have hereunto set my hand to this HIPAA Business Associate Agreement as of the date set forth above.

Covered Entity

By: Twinkle Patel
Title: CEO

Business Associate

VOSS Family Clinic
11920 SHWY 6 Ste 1500

By: Syed Ahmed
Title: manager

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HIPAA IGL
SECURITY NETWORKING GROUP

REMOTE ACCESS REQUEST FORM

Systems Licenses for use are specific to each named profile and may not be used for any person other than its authorized user. Systems Licenses may not be transferred to a new authorized user. To register an additional System access licenses, you must fill out the information below in its entirely. Please submit the completed form to IGL(Immunogenomics Lab) at secured@immunogeno.com

Employee Name: Syed Ahmed

Employee email address: Syedafraz@live.com

Position/Role: Manager

Name/Role of Requestor: _____

Remote or Onsite work: _____

Date of Access Requested: 11/29/2022

I, (print name) Syed Ahmed agree to comply with the HIPAA EFH Security Networking Group Remote Access Policy and the Access Form in its entirety.

_____ 11/28/22
Signature of Employee Date

_____ _____
Signature of Requestor Date

Do not write below this line. Official use only.

Approved by: _____ Date _____

Created by: _____ Date _____

AUTHORIZATION FOR ELECTRONIC SIGNATURE

This request, from ImmunoGenmics to have your signature on file, to ensure that your electronic orders are verified with your full intent and knowledge; by having your signature on file, you will be able to maintain your patient's records and electronically sign your clinical orders.

This is to confirm your signature will be encrypted and will only be used for the sole purpose of ordering of diagnostic tests for your patients, in compliance with HIPPA standards. Should you choose to remove your signature at any time, please notify us, and it will be removed.

X_____ _____/_____/_____

Physicians Signature Date

_____ _____/_____/_____

Physician Name (Printed) Date

X_____ _____/_____/_____

Witness Date

Requisition

Will Sign

POLICY

Discontinuing Laboratory Services to an Account

ImmunoGenomics reserves the right to discontinue services to any account and anytime.

If we have come to the decision to discontinue services to an account, these are the steps that must be followed:

1. We will contact the account to advise them that we will no longer be servicing their account. We will inform them that we will give them 5 business days to find another laboratory to send their samples to. We will also send a hard copy of this notice via UPS/FedEx with a signature on delivery required. This written notice will have a date for which the last day we will accept samples from their account.
2. If on the 5th day we are still receiving samples, we will make a phone call to the account to advise them that it is the last day that we can accept their samples.
3. If on the 6th day samples are still coming in, we will make a phone call to the account to advise them that the samples are going to be discarded.

Please sign and date below to acknowledge you received notification of this policy.

Date: 11/29/2022

Print Name: Syed Ahmed

Signature: _____

Date 11/29/22

I Regina Offenbach attest that the below signature is indeed my own.
(Doctor's name)

Our Office is located at 11920 HWY 6 S Ste 1500. Please fax this form from
(Office Address)

your office back to ImmunoGenomics

Regina Offenbach
(Doctor's Signature)