



CliniSync Participant Agreement (Physician) v7.1

ADDENDUM

THIS ADDENDUM supplements and is made a part of the Participant Agreement (the "Participant Agreement") entered into by and between the Ohio Health Information Partnership, Inc. ("**Company**"), and the entity ("Participant") listed below.

For Participant:	For Company:
Organization Name: <input type="text"/>	Ohio Health Information Partnership, Inc.
Primary Address: <input type="text"/>	3455 Mill Run Drive, Ste. 315
City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/>	Hilliard, Ohio 43026
Name: <input type="text"/>	Name: <input type="text"/>
Title: <input type="text"/>	Title: <input type="text"/>
Phone: <input type="text"/>	Phone: <input type="text"/>
Email: <input type="text"/>	Email: <input type="text"/>
EIN/NPI: <input type="text"/>	
County: <input type="text"/> Country: <input type="text"/>	

RECITALS

Company and the Participant are parties to the Participant Agreement pursuant to which Company provides certain Health Information Exchange ("HIE") services to the Participant. As required by Section 2 and Section 3 Paragraph 3.1, the parties desire to amend the Participant Agreement to add CliniSync Additional Services. The parties intend for this addendum to supplement and become effective as of the date signed.

STATEMENT OF AGREEMENT

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

1. Unless otherwise provided in this Addendum, capitalized terms have the same meanings as set forth in the Participant Agreement.
2. **Site Administrator.** Participant will designate a person ("Site Administrator") to whom all CliniSync communications may be addressed and who has the authority to act on all aspects of the services. The Site Administrator is responsible for ensuring understanding of their responsibilities. The Site Administrator will also coordinate participant participation and ensure timely management decisions are made. In addition to the above, the Site Administrators responsibilities include:
 - i. The Site Administrator's responsibilities include, but are not limited to, performing duties related to authentication, determining appropriate access requirements, and notifying CliniSync in instances of improper use as defined by CliniSync policy.
 - ii. The Site Administrator's identity must be verified in accordance with the Partnership's Identity Proofing Procedure. The Site Administrator will then be authorized to provision access to those within their organization in accordance to the minimum necessary requirement as defined by HIPAA in the same HIPAA-compliant manner used when issuing other credentials to conduct their organizations business.
3. To the extent provided herein, this Addendum supersedes or modifies any inconsistent provision of the Participant Agreement to the contrary.
4. All other terms and conditions of the Participant Agreement shall remain in full force and effect.

Signatures

FOR PARTICIPANT:

Organization: _____

Signed: _____

To electronically sign this contract, please type "/s/" before your name or insert photo of your signature.

Name: _____

Title: _____

Date: _____

FOR COMPANY:

Ohio Health Information Partnership, Inc.

Signed: _____

Name: _____

Title: _____

Date: _____

Section 2 CliniSync Additional Services

1. CliniSync Additional Service Options for Fee

The following Additional Services are available from CliniSync. If the Additional Service is selected by Participant, it shall be incorporated into this Agreement and the Project Scope Document and subject to the terms of this Agreement.

Please select the CliniSync Services you are interested in implementing.

Chart 2.1.1 Fees

Service	Description	Implementation Fee	Annual Subscription Fee	Service Selected (Y/N)
CCD Publishing / Contribute Data to CliniSync (PnR)	Ability to contribute data to CliniSync for the purposes of updating patient identification, consent, and/or other clinical information (e.g., CCD) within the Community Health Record.	N/A	Yes, see Table 2.2.1 .	
Notify (Stand Alone Solution)	Allows Providers to receive notifications on patients who are included in a Patient Panel and uploaded to the Notify application (Either Admit or Discharge). These notifications can be sent by Direct message, regular email or SMS (text message). Providers can also receive notification on patients when they are the provider of record as reported by the patient on admission or discharge at a Participating Organization. These notifications can also be sent by Direct messages, regular email or SMS (text message).	N/A	Yes, see Table 2.2.1 .	
Clinical Dispatcher (Integrated Solution)	Receipt of Participant Active Patient List to support the "push" or delivery of admission/discharge/transfer notifications ("ADT)" for Participant's Active Patient List from mutually selected Hospital Participant(s) directly to the Participant system via Clinical Dispatcher (HL7) software.	\$16,000 See Section 3 below.	Yes, see Table 2.2.1 . <i>If participant is paying annual subscription fees for Notify or Contribute, additional annual subscription fees for Clinical Dispatcher will not be incurred.</i>	

2. CCD Publishing and/or Notify: Annual Subscription Fees

Annual Subscriptions Fees are calculated per fulltime equivalent physicians (e.g. MD, DO) per year and is cumulative as noted in **Table 2.2.1**. For Participating Organizations over 10 physicians, the cost for each additional physician goes down, so the sliding scale keeps the price affordable for larger Participating Organizations. For example, a Participating Organization with 2 physicians would pay \$300 each or \$600 per year for the practice. A Participating Organization with 21 physicians would pay \$300 each for the first 10 physicians and \$240 each for the next 10 physicians and \$180 for the last physician which would equal \$5580 per year for the Participating Organization.

Table 2.2.1 Annual Subscription Fees

# Physicians in Practice (e.g. MD, DO)	Annual Subscription Fee Per Physician Per Year	# of Physicians (FTE)	Cost per group*
First 1-10 physicians	\$300	_____	\$_____
Next 11-20 physicians	\$240	_____	\$_____
Next 21-30 physicians	\$180	_____	\$_____
Next 31-50 physicians	\$120	_____	\$_____
Additional 51+ physicians	\$60	_____	\$_____

***The fee is for the ability to contribute data, use Notify or Clinical Dispatcher.** Additional fees may apply from the Participating Organization's electronic health record vendor.

Beginning on the earlier of either the Live Date or ninety (90) days after the Contribution or Notify Project Kick-Off Date, Participant shall pay the Annual Subscription Fee for Additional Services according to the schedule listed in **Table 2.2.1**. The first Annual Subscription Fee payment shall be prorated from such date to the end of the calendar year. Thereafter, Fees for Additional Services shall be paid annually on a calendar year basis. Fees for Additional Services shall be paid in accordance with Section 3 Paragraph 10.

Participant hereby selects "Contribute Data" and/or "Notify" as an Additional Service and agrees to pay the Annual Subscription Fee for such service.

Total Number of Fulltime Equivalent Physicians per year at all Facilities _____

Price for One Year of Contribution and/or Notify* _____

**Subscription Fee, price will be adjusted annually to account for changes in the number of physician FTEs.*

Billing Contact Name: _____

Billing Contact Email: _____

Billing Contact Phone: _____

Signature _____ **Date** _____

To electronically sign this contract, please type "/s/" before your name or insert a photo of your signature.

Print Name _____

3. Clinical Dispatcher: One-time Implementation Fee and Annual Subscription Fee

Participant hereby selects "Clinical Dispatcher" as an Additional Service and agrees to pay the implementation fee for such service according to **Chart 2.1.1** in Section 2, Paragraph 1 above. Prior to the agreed upon Project Kick-Off Date for Clinical Dispatcher, Participant shall pay 50% of the implementation fee. Participant shall pay the remaining 50% of the implementation fee upon the Clinical Dispatcher go-live date. Fees for Additional Services shall be paid in accordance with Section 3 Paragraph 10.

Beginning on the earlier of the Live Date or ninety (90) days after the Clinical Dispatcher Project Implementation Kick-Off Date, Participant shall pay the Annual Subscription Fee for Additional Services according to the schedule listed in **Table 2.2.1**. The first Annual Subscription Fee payment shall be prorated from such date to the end of the calendar year. Thereafter, Fees for Additional Services shall be paid annually on a calendar year basis. Fees for Additional Services shall be paid in accordance with Section 3 Paragraph 10.

Participant hereby selects "Clinical Dispatcher" as an Additional Service and agrees to pay both the Implementation Fee and Annual Subscription Fee for such service.

Implementation Fee for Clinical Dispatcher: \$16,000

Total Number of Fulltime Equivalent Physicians per year at all Facilities _____

Price for One Year of Clinical Dispatcher* _____

**Subscription fee, price will be adjusted annually to account for changes in the number of physician FTEs.*

Billing Contact Name: _____

Billing Contact Email: _____

Billing Contact Phone: _____

Signature _____ **Date** _____

To electronically sign this contract, please type "/s/" before your name or insert a photo of your signature.

Print Name _____

4. Additional Participant Obligations

The Additional Participant Obligations listed in Section 1 shall apply to the Additional Services selected by Participant.

[End of Additional Services]

Exhibit A

Additional Facilities

Additional facilities shall include the following as wholly owned subsidiaries of Participant:

Entity Name:	
Primary Address:	
County:	
EIN/NPI:	
Entity Name:	
Primary Address:	
County:	
EIN/NPI:	
Entity Name:	
Primary Address:	
County:	
EIN/NPI:	
Entity Name:	
Primary Address:	
County:	
EIN/NPI:	
Entity Name:	
Primary Address:	
County:	
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EIN/NPI:	
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Primary Address:	
County:	
EIN/NPI:	
Entity Name:	
Primary Address:	
County:	
EIN/NPI:	
Entity Name:	
Primary Address:	
County:	
EIN/NPI:	
Entity Name:	
Primary Address:	
County:	
EIN/NPI:	
Entity Name:	
Primary Address:	
County:	
EIN/NPI:	

Additional facilities can be provided in a separate document if the number exceeds the space on this page.