ARTICLE 28 EFFECTIVE DATE OF AGREEMENT.

28.01 ASH Group shall determine the Effective Date of this Agreement upon completion of all necessary pre-contractual requirements, including but not limited to credentialing. Contracted Practitioner agrees to be bound by the Effective Date as determined by ASH Group and indicated immediately below.

The Effective Date of this Agreement is _____.
[To be completed by ASH Group Only]

IN WITNESS WHEREOF, the Parties have executed this Agreement on the dates set forth below.

PRACTITIONER
(type or print clearly, no signature stamp)

Name Signed:_____

Name Printed:_____

Title:_____

Date of Signature:_____

AMERICAN SPECIALTY HEALTH GROUP, INC.

_____
ASH Group Representative Signature

_____
ASH Group Representative Name Printed

_____
Title

_____
Date of Signature

Primary Office Address

Office Name_____

Address_____

City:_____

State:_____Zip+4:_____

Mailing Address
American Specialty Health Group, Inc.
P.O. Box 509001
San Diego, CA 92150-9001

Office Address
American Specialty Health Group, Inc.
10221 Wateridge Circle
San Diego, CA 92121

Group Practice or Professional Corporation: If payments for services rendered by a Contracted Practitioner are to be made to a Group Practice or a Professional Corporation, the Group Practice or Professional Corporation must agree to comply with the provisions of Attachment O of this Agreement.

The Group Practice or Professional Corporation named below hereby agrees to comply with the provisions of Attachment O of this Agreement as witnessed by the signature of its duly authorized representative below:

Group Practice or Professional Corporation Name:_____

Authorized Representative Signature: _____

Authorized Representative Name Printed: _____

Authorized Representative Title: _____

NUTRITION PRACTITIONER SERVICES AGREEMENT

ATTACHMENT A - CONTRACTED PRACTITIONERINFORMATION SHEET

Please complete this sheet for your primary office. Complete a separate sheet for each additional office where you practice and which you want listed in practitioner directories.

CONTRACTED PRACTITIONER NAME: _____

CLINIC NAME: _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER:_____ FAX NUMBER:_____

EMAIL ADDRESS: _____

WEBSITE ADDRESS:_____

Check the box which best describes Office Information/Type of Structure:

☐ Attached to/within Home ☐ Professional Office Building ☐ Health Club/Gym ☐ Salon/Day Spa

☐ Professional Office Suite in a Commercial Mall or Shopping Center ☐ Educational Setting (University/College)

☐ Mobile ☐ Other (describe)_____

Check the box which best describes your relationship with the above location:

☐ Individual/Sole Proprietor ☐ Owner/Co-Owner ☐ Partner of a Professional Corporation or Group Practice.

☐ Employee of a Professional Corporation, or Group Practice.

For the Professional Corporation or Group Practice, provide the names of the Persons with an Ownership or Control Interest (*For purposes of this section "Persons with an ownership or control interest" is defined as a person who (A) (i) has directly or indirectly an ownership interest of 5% or more in the entity; or (ii) is the owner of a whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the business or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5% of the total property and assets of the entity; or (B) is an officer or director of the entity, if the entity is organized as a corporation; or (C) is a partner in the entity, if the entity is organized as a partnership [Social Security Act § 1124 (a) (3)]):*

If you are an owner of, an employee in or a partner of a Group Practice or Professional Corporation, additional conditions apply for contracting and payment purposes. Please review Attachment O of this Agreement: Requirements for Group Practices or Professional Corporations for the specific provisions. Also an authorized representative of the Group Practice or Professional Corporation will be required to sign the Agreement.

NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER:

NPI Number Type 1 (Individual): __ __ __ __ __ __ __ __ __ __

If applicable, NPI Number Type 2 (Organization): __ __ __ __ __ __ __ __ __ __

CAQH ID Number (if available):_____

Please complete the attached Request for Tax Payer Identification Number and Certification Form (W-9) included here as Exhibit 1 to this Attachment A.

STATEMENT AND SIGNATURE:

I, _____, represent that all the information submitted in this Attachment A, Contracted Practitioner Information Sheet, is correct to my best knowledge and belief. I understand that any material misstatement or omission of any information on this Attachment A, Contracted Practitioner Information Sheet, may result in the immediate termination of this Agreement. I understand and agree that I, as the Contracted Practitioner, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any questions about such qualifications. I release from liability all representatives of ASH Group for their acts in good faith, and without malice, in connection with evaluating my Attachment A, Contracted Practitioner Information Sheet, and my credentials for qualification. I hereby authorize ASH Group to consult with individuals and organizations having information bearing on my qualifications and to inspect all documents from such individuals and organizations, and I hereby consent to the release and exchange of information relating to any disciplinary action, suspension, professional malpractice insurance history, curtailment of practice privileges by any outside organization or individual or any other information to ASH Group.

Signature of Practitioner _____ Date _____

Name of Practitioner _____