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WHOLEHEALTH LIVING® CHOICES NETWORK

PARTICIPATING PRACTITIONER AGREEMENT
CERTIFICATE OF PARTICIPATION FOR *CHOICES PROGRAMS*

INSTRUCTIONS

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application, please return this application along with the necessary documentation to the address listed at the top of the page.

- ❑ Copy of license(s) if applicable
- ❑ Copy of insurance face sheet for professional and business liability policy
- ❑ Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- ❑ Signed release and attestation statement, with professional liability form if applicable.

SIGNATURE LINE

This Agreement is a contract between WholeHealth Networks, Inc. ("WHN"), a subsidiary of Tivity Health Support LLC, and the undersigned practitioner ("Practitioner"), (each a "Party," and together the "Parties") and consists of page 1 and 2, and the Terms and Conditions on Pages 4 and 5 ("Terms").

PRACTITIONER SPECIALTIES

Please check all specialties for which you are applying for network participation. **You must include the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty Specific Credentials Requirements section).

____ Acupuncture
____ Acupuncture, MD/DO
____ Acupuncture, DC/ND
____ Behavioral Health
____ Biofeedback
____ Childbirth Educators
____ Chinese Herbal Medicine
____ Chiropractic Physician
____ Dietician - Registered/Licensed
____ Doulas
____ Energy Healing Practitioner
____ Feldenkrais
____ Guided Imagery/Hypnotherapy
____ Hellerwork
____ Herbal Consultant
____ Holistic Nurse Practitioner
____ Homeopathy
____ Hypnotist, non-clinical
____ Integrative Holistic Physician (MD/DO)
____ Massage Therapy
____ Massage Therapy – Clinical
____ Mind-Body Skills Instructor
____ Mindfulness-Based Stress Reduction Teacher
____ Music Therapy
____ Naturopathic Physician
____ Nutritional Counselor
____ Occupational Therapist
____ Asian/Oriental Bodywork Therapist
____ Pain Practitioner
____ Personal Trainer/Exercise Specialist
____ Physical Therapy
____ Pilates Instructor
____ Post Birthing & Lactation Counselor
____ Qi Gong Instructor
____ Reflexologist
____ Tai Chi Instructor
____ Yoga Instructor

DISCOUNT AGREEMENT

Practitioner will offer Services to Network participants at a discount of _____% (minimum of 10%-30%) to all of Practitioner's usual charges for Services (the "Discount"). If the Discount is left blank, Practitioner will provide a **20% Discount**. ***Practitioner acknowledges that certain Network group clients only agree to accept Practitioners who offer discounts of 20% or more***.

This Agreement and the Discount are effective on the date that Practitioner signs this Agreement ("Effective Date"). This Agreement will continue until the date that is one year after the Effective Date, and on such date and on each one-year anniversary thereof will automatically renew for additional consecutive one-year renewal terms unless a Party gives written notice to the other Party that it does not seek to renew this Agreement. Such notice of non-renewal must be sent at least **90** days (**30** days for Practitioners in Illinois) prior to the expiration of the then-current term.

In consideration of Practitioner providing the Services at the Discount, WHN shall: (i) certify Practitioner as a Participating Practitioner in its Network; (ii) advertise Practitioner's Services to Network clients; and (iii) extend the term of this Agreement to one-year renewable terms. Practitioner has reviewed all provisions of this Agreement, including the Terms, understands the meaning and consequences of such provisions, has had the opportunity to consult with counsel, and voluntarily agrees that the Terms will govern the relationship of the Parties.

_____ _____ _____
Practitioner's Printed Name | Practitioner's Signature | Date

_____ _____
Accepted by: Martie Stabelfeldt, VP, WholeHealth Living | Date

Primary Location:

Clinic Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Office Fax: _____

Office Contact: _____ Title: _____

Website Address: E-Mail:

Secondary Location:

Clinic Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Office Fax: _____

Office Contact: Title:

Website Address: E-Mail Address:

* If you have additional locations, please list them on a separate sheet.

State License # _____State License Expiration Date_____

Malpractice Carrier (attach current face sheet) _____ Malpractice Limits: _____

Malpractice Policy #_____ Malpractice Expiration: _____

Colleges/Specialty Institutions: _____ Graduation Date(s): _____

Do you wish to have your Website listed on your profile? _____

What is your first year of practice? _____

What non-English languages do you or your office staff speak fluently? Please list_____ _____

Practice Focus:

_____

_____

Payment Methods Accepted:

- ❑ Visa
- ❑ MasterCard
- ❑ American Express
- ❑ Discover
- ❑ Cash
- ❑ Personal Check

Average Fee Range: **$_____ - $_____**

Special Offers:

_____

_____

Correspondence/Communication Preference:

- ❑ Email Email Address_____
- ❑ Fax Fax Number _____
- ❑ United States Postal Service

PRIMARY LOCATION OFFICE HOURS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM

SECONDARY LOCATION OFFICE HOURS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM

DEFINITIONS

1. **Choices Program** means a discount cash payment arrangement where the Practitioner agrees to provide Participants in WHN- contracted Choice programs access to practitioner's services at a specific discount % off the practice's Published Fee Schedule. Practitioner has specified a discount within the range of 10% to 30%, on services not covered by any health insurance or governmental program. Discount does not apply to co-payments or deductibles for covered services. This discount is to be offered to all Participants in all WHN contracted Group Choice programs, for which WHN provides notice to Practitioner. Participants simply show the Practitioner their Group ID card or WHN discount card to receive the discount. Payment for services, after the discount, is the complete responsibility of the Participant. (Discount must be applied to personal health services and therapies delivered by Practitioner's office, and may extend, at the Practitioner's discretion, to dispense health related supplies and durable medical goods).
2. **Published Fee Schedule** means the current retail or non-discounted fee schedule that applies to the Practitioner's services to the general public and to the fees for service charged to patients when Practitioner is a non-participating provider in the patient's insurance plan.
3. **Unrestricted License** means that the practitioner's healthcare license, registration, or certification is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and is not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. Limitations include peer review actions and malpractice claims settled or pending.

TERMS AND CONDITIONS OF PARTICIPATION

1. **Practitioner Portal; Policies and Procedures**. Practitioner shall fully comply with WHN's Network policies and procedures, including credentialing, quality management, utilization review, audit, investigation, licensure, insurance, non-discrimination, participation criteria, authorization to contract, billing and accounting requirements, experience and language requirements, premises standards, state-specific Network business requirements established by WHN, and legal compliance addenda, all of which are expressly incorporated into this Agreement and can be found on the Network electronic resource library at **https://www.wholehealthpro.com ("Practitioner Portal")**.
2. **Non-Discrimination.** No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any WHN contracted Choices Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. **Termination.** WHN may terminate this Agreement at any time for cause without prior written notice. Practitioner's failure to fully comply with the requirements found on the Practitioner Portal or in this Agreement shall be deemed to constitute cause.
4. **Provision of Services**. In respect of the Services, Practitioner shall do the following: (i) provide the Discount; (ii) provide Services at standards of professional practice applicable to Practitioner; (iii) comply with all Network requirements as notified on the Practitioner Portal; (iv) provide Services in an efficient, cost effective, and high quality manner, within the business requirements for participation included in Practitioners' application for membership in the Network; (v) provide Services under the conditions and limitations contained in this Agreement and in group contracts; (vi) not be obligated to provide any service to Network participants that the Practitioner does not usually provide to others; (vii), not provide Services that Practitioner is not authorized by law or by WHN to provide to Network participants; (vii) not illegally discriminate against any Network participant in providing, refusing, or declining to provide Services.
5. **Directory Listing**. WHN will identify Practitioner in its Network group-specific online and offline practitioner directories. Listings in the online directories will include name, specialty(ies) and discount percentage.
6. **Practitioner Licensure Requirements**. At any time upon **5** days' advance notice and within **5** days of renewal, loss, or lapse of licensure, Practitioner shall submit to WHN, documentary evidence acceptable to WHN that Practitioner holds a current unrestricted license and/or certification to provide the Services.
7. **Published Fee Schedule**. Practitioner is entitled to change its agreed upon Discount to Services no more than once every six (**6)** months. Practitioner agrees to notify WHN a minimum of thirty (30) days in advance of any change in name, address, phone number practice status or Discount to Services rate. Failure to apply the Discount to Services shall be a material breach of this Agreement. Practitioner shall seek payment for Services (after application of the Discount) only from Choices Program participants and not from WHN.
8. **Indemnification; Hold Harmless**. Practitioner shall indemnify, defend, and hold harmless WHN and its directors, officers, subsidiaries, affiliates, employees, subcontractors, and agents ("Representatives") from and against any and all claims for losses, costs, or damages of every kind and character arising out of or in connection with the actions of Practitioner in performing Services or caused by the negligence or misconduct of Practitioner or its agents, contractors, or employees (for example, claims made against WHN or its Representatives by Network participants, groups, members, customers and/or clients).
9. **Claim**. The term "Claim" means any dispute, claim or controversy arising between Practitioner and WHN and/or its Representatives, whether known or unknown, pre-existing, present, or future, or arising out of or relating to this Agreement, or the breach of this Agreement, whether based in tort, statute, or in contract, pursuant to applicable law, or otherwise, whether in connection with the actions of a Party or an agent, employee, or subcontractor of that Party (all a "Claim").
10. **Waiver of Class Actions**. As of the Effective Date, each Party waives any equitable, constitutional, or statutory right to have any Claim adjudicated in a court of law or to join or consolidate its Claim with any other practitioner, or enforce any claim as a class representative, in a class action, or as a private attorney general. Neither Party shall mediate, arbitrate, or seek adjudication of any Claim on a class action basis. Each Party will affirmatively opt out of any class action regarding a Claim or dispute between the Parties and a Party shall be entitled to specific performance to enforce the provisions of this section.
11. **Mandatory Arbitration Agreement**. Any Claim shall be determined by final and binding arbitration by a single arbitrator administered by the American Arbitration Association under its Commercial Arbitration Rules. No Party shall be able to join or consolidate Claims with any other Party. Judgment on any award rendered by the arbitrator may be entered in any court having jurisdiction. Neither Party may disclose the existence or results of any arbitration. THE PARTIES HAVE READ AND UNDERSTAND THIS ARBITRATION AGREEMENT AND KNOWINGLY AND VOLUNTARILY AGREE TO ITS TERMS.
12. **Compliance with Laws**. Practitioner and all persons providing the Services, including employees, representatives, or agents of Practitioner's practice shall comply with all state, federal, and local laws and regulations applicable to the Services, including laws and regulations regarding privacy, security, and confidentiality of information received from Network participants.

13. **Insurance**. Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.
14. **Severability**. If a court or government authority with competent jurisdiction over the Parties or the subject matter of this Agreement finds any term of this Agreement illegal, invalid, or unenforceable, that term shall be excluded to the extent of such illegality, invalidity, or unenforceability and all other terms of this Agreement shall remain in full force and effect. To the extent permitted and possible, the illegal, invalid, or unenforceable term shall be deemed replaced by a term that is valid and enforceable and that comes closest to expressing the intention of such invalid or unenforceable term.
15. **Existing Business Relationship**. The Parties have a pre-existing business relationship and are sophisticated business parties with knowledge of contractual agreements and other legal business matters.
16. **Damages Cap**. Money damages awarded by an arbitrator or any court of law related to any Claim shall be capped at the aggregate amount of discount applied to Services to Network participants by Practitioner provided pursuant to this Agreement within the prior **3** months. No Party shall be liable to the other for special, consequential, incidental, indirect, punitive, indirect, lost profits, trebling of damages, pain and suffering (including mental), or speculative damages even if the Party has been advised of such possibility.
17. **Attorney's Fees**. If a Party fails to submit its Claim to arbitration, unsuccessfully challenges the arbitrator's decision, fails to comply with the arbitrator's decision or award, or joins or does not opt out of a class action relating to any Claim, the other Party is entitled to all costs of suit, including reasonable attorneys' fees.
18. **Consent to Communicate**. Practitioner expressly consents to any communication sent by or on behalf of WHN, received before the Effective Date of this Agreement or after, whether by telephone, letter, email, facsimile, or otherwise.
19. **Notices.** The Parties agree that all notices shall be sent to a Party's address as provided on the first page of this Agreement.
20. **Applicable Law; Venue**. This Agreement and any Claim shall be governed by the laws of the State of Tennessee. The venue for any dispute arising out of Practitioner's performance of Services shall be the state where such Services were performed. Venue for all other purposes and for any Claim shall be in Nashville, Tennessee.
21. **Waiver of Breach**. A Party's waiver of a breach of this Agreement by the other Party shall not effect a waiver of any subsequent breach of the same or any other provision of this Agreement.
22. **Agency, Successors; Third Party Beneficiaries; Assignment**. Neither Party is an agent of the other. This Agreement shall inure to the benefit of, and be binding upon the Parties and their respective successors and assigns. This Agreement is entered into for the sole benefit of the Parties and their Representatives, and nothing contained herein or in the Parties' course of dealings shall be construed as conferring any third party beneficiary status on any person or entity who is not a Party or its Representative. This Agreement may not be assigned by Practitioner without the prior written consent of WHN.
23. **Survivability**. Termination of this Agreement shall not relieve the Parties of the obligations set forth in Sections 7-15, terminate any provision that by its terms is intended to survive termination, or relieve Practitioner of obligations with respect to Services provided before termination or obligations to protect Network participants.
24. **Entire Agreement**. This Agreement constitutes the entire agreement of the Parties and supersedes all prior oral or written communications, contracts, or agreements between the Parties.

PARTICIPATION REQUIREMENTS

Liability/Insurance: All Practitioners with health care licenses and Practitioners with specified unlicensed hands-on specialties (see specialty list) agree to maintain professional liability insurance. Per the current WHN policy for CAM practitioners, a minimum of $200,000 per occurrence and $500,000 aggregate is required while limits of 1M/3M are required for all MD's and DO's, as well as ND's and DC's who also are credentialed for acupuncture. (Members who participate in certain regional contracts involving both covered benefits and choice programs may be required to have higher limits.) Practitioner agrees to maintain required premises and comprehensive general liability insurance in amounts of $100,000 per claim and $100,000 per year, or the minimum required by state law, whichever is greater. Furthermore, the Practitioner agrees to obtain extended liability insurance (sometimes called "nose" or "tail" policies), to insure retroactive coverage for professional acts performed during the term of this agreement, should the Practitioner terminate this agreement and change or terminate professional malpractice coverage.

Practice Experience: All practitioners are required to have 12 months experience in the credentialed practice specialty.

Patient Services: Practitioners must speak fluent English or have access to an interpreter.

Health Information Privacy Regulatory Compliance and Business Associate Agreement:

Practitioner agrees that practitioner's practice will remain compliant with applicable state and federal regulations regarding privacy and confidentiality of individually identifiable health information.

WHN agrees to adhere to applicable state and federal privacy regulations with respect to Protected Health Information, as defined under the Health Insurance Portability and Accountability Act of 1996, received from Practitioner's practice.

Premises Standards: Health care office locations must follow OSHA safety standards, and home offices must have separate treatment room or studio and professional signage as allowed by local zoning.

Practitioner Licensure Requirements:

- Practitioners must give evidence of current unrestricted license in the specialty (ies). With some practitioner types; WHN has established additional criteria, such as dual credentialing in both a licensed field as well as by meeting certification standards for the unlicensed practice specialty.
- Acceptance of practitioner types who meet WHN credentialing criteria for training and certification is also subject to state-by-state application of network business criteria established by WHN and their network clients.

NETWORK CERTIFICATION AND RELEASE OF INFORMATION

QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD

State and federal licensing and regulatory boards will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.

RIGHT TO CORRECT ERRONEOUS INFORMATION

Practitioner has the right to review information submitted in support of your Network Application and contract to the extent permitted by law and WHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from WHN.

CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS

- I certify all statements in this application are correct and I agree with the terms of this agreement with WHN.
- I certify that I have and will maintain during the course of my contractual relationship with WHN the unrestricted healthcare license(s) required for my specialties as a WHN network practitioner. Unrestricted license means that the practitioner's healthcare license is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. I will notify WHN if my license status changes.
- If there are national standards and/or state licensure standards for a practitioner type that is not licensed, registered, or certified by the applicable state jurisdiction, WHN has recognized certain national standards applicable for its network. I certify that I meet these standards for training, experience, and examination, as summarized in this application, in the absence of local licensure, or in addition to any existing lesser local requirements. I recognize that WHN standards do not substitute for my meeting such state licensure requirements for health care practice as may periodically be instituted or updated by state jurisdictions.
- I have __, have not ___had any malpractice claims or award involvement. **If you have past or current claims, please fill out the professional liability section.**

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize WHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of WHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to WHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of WHN a copy of my application for membership and related documents.

I release from liability all representatives of WHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to WHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: _____ Date: _____

Practitioner Name: _____ Title or Designation (DC, LAc, GCFP, etc): _____

A photocopy of this document shall be as effective as the original when so presented (Signature stamps are not acceptable).

PROFESSIONAL LIABILITY INFORMATION FORM

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. Copy this form if you have more than one claim to report.

Practitioner Name: _____Case Number: _____

Current status of legal action:

_____Pending Court Date (if available): _____

_____Dismissed or Dropped Date: _____

_____Closed Date: _____

Resolution:

_____No Payments

_____Out of Court Settlement Amount: $ _____

_____Judgment or Award Amount: $ _____

Date of Filing: _____

Date of Incident: _____

Professional Liability Insurer: _____

Allegation:

_____

_____

Details of incident including your role, relating events, and patient outcome:

_____

_____

Have you made any changes in your practice as a result of this incident? Attach separate sheet if required.

_____

_____

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: _____ Date: _____

PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS

Please check the information that applies to your specialty (ies)*.You will be listed in the directories by these categories.*

Acupuncture	❑ Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program ❑ Hold a valid unrestricted state license and/or NCCAOM certification **OR** ❑ Physician Acupuncturists (**MD/DO**) must hold a valid unrestricted license to practice medicine Including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture ❑ **NDs and DCs** need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria ❑ Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture **OR** liability insurance limits of at least $200,000 / $500,000 for licensed acupuncturists only
Behavioral Health	❑ Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. ❑ Professional liability insurance limits of at least $200,000 / $500,000
Biofeedback	❑ Certification from the Biofeedback Certification Institute of America (BCIA) ❑ Professional liability insurance limits of at least $200,000 / $500,000
Childbirth Educator	Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least **one** of the following programs: ❑ International Childbirth Education Association (ICEA) ❑ Childbirth and Postpartum Professional Association (CAPPA) ❑ American Academy of Husband Coached Childbirth (AAHCC – Bradley ® Method) ❑ ASPO/Lamaze – Lamaze Certified Childbirth Educator ❑ Prepared Childbirth Educators (PCE) ❑ The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) ❑ Birth & Beginnings Education (BABE)
Chinese Herbal Medicine	❑ National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or state license exam for Chinese Herbal Medicine ❑ Credentialed as a licensed acupuncturist or other licensed profession ❑ Professional liability insurance limits of at least $200,000 / $500,000
Chiropractic	❑ Graduation from an accredited college ❑ Hold a valid unrestricted state license ❑ Professional liability insurance limits of at least $200,000 / $500,000
Dietician	❑ Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation ❑ Professional liability insurance limits of at least $200,000 / $500,000
Doulas	Documented training and certification as a prenatal, labor/birth, or postpartum Doulas under the auspices of at least **one** of the following programs: ❑ International Childbirth Education Association (ICEA) ❑ Doulas of North America (DONA) ❑ Childbirth and Postpartum Professional Association (CAPPA) ❑ National Association of Postpartum Care Services **PLUS** ❑ Current professional liability insurance policy of $200,000/$500,000 minimum
Energy Healing Practitioner	❑ Credentialed with WholeHealth Networks, Inc. in another licensed specialty ❑ Professional liability insurance limits of at least $200,000 / $500,000 ❑ Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher **OR** ❑ Healing Touch Certified as a practitioner or teacher by Healing Touch International
Feldenkrais	❑ Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America ❑ Professional liability insurance limits of at least $200,000 / $500,000
Guided Imagery/ Hypnotherapy	❑ Meet WholeHealth Networks, Inc. credentialing criteria in Behavioral Health ❑ Documented training in clinical Guided Imagery or Hypnotherapy ❑ Professional liability insurance limits of at least $200,000 / $500,000
Hellerwork Practitioner	❑ Certified by Hellerwork International as a Certified Hellerwork Practitioner ❑ Professional liability insurance of at least $200,000 / $500,000
Herbal Consultant	❑ Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
Holistic Nurse Practitioner	❑ Hold a valid unrestricted state license as an advanced nurse or nurse practitioner ❑ 200 or more hours course work in alternative medicine or another credentialed CAM specialty ❑ Professional liability insurance of at least $200,000 / $500,000
Homeopath	❑ Certified in Classical Homeopathy by the Council for Homeopathic Certification **OR** ❑ A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise ❑ One year of practice experience as a homeopathic practitioner ❑ Business or professional liability insurance of at least $200,000 / $500,000 or $1M/ $3M based on license level
Hypnotist (non clinical)	❑ Active Certified members of the National Guild of Hypnotists, Inc. ❑ Professional liability insurance limits of at least $200,000 / $500,000
Integrative Holistic Physician	❑ A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine ❑ Hold a valid unrestricted state license to practice medicine ❑ Professional liability insurance of $1,000,000 / $3,000,000

Massage Therapy	❑ Hold a valid unrestricted state massage license **OR**
	❑ Current jurisdictional (city/county, etc.) license. **PLUS** either of the following:
	  ❑ Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage & Bodywork **OR**
	  ❑ Certificate of active professional AMTA or ABMP membership (requires 500 hrs training) **OR**
	  ❑ Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.)
	❑ Professional liability insurance of at least $200,000 / $500,000

Massage Therapy-Clinical	❑ Hold a valid unrestricted state massage license
	❑ Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBMTB) or an equivalent State licensing exam
	❑ Evidence of professional continuing education in massage totaling at least **60 hours** of course work in the past four years
	❑ Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more
	❑ Documentation of at least two calendar years in active clinic practice
	❑ **Two Letters** of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which must be from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner who has supervised your practice **PLUS:**
	❑ Documentation of **supervised contact hours** performing clinical massage:
	  ❑ 500 contact hours required for applicants with only a basic 500 hour massage education **OR**
	  ❑ 250 contact hours required for applicants with 1000 hour basic massage education that Includes clinical assessment, clinical pathology, and clinical charting **OR**

	❑ Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education
	❑ Professional liability insurance of $200,000/$600,000 or $500,000/$500,000
Mind-Body Skills Instructor	❑ Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" program **OR** ❑ Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington,DC O**R** ❑ Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley,CA **OR** ❑ Written Documentation of completion of training as a meditation Instructor in a formal or apprenticeship training program **PLUS** ❑ Attestation of a minimum of 200 hours or training and/or practice teaching
Mindfulness Based Stress Reduction Teachers	❑ MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA **OR** ❑ Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) **PLUS** ❑ Written Documentation of completion *of Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retrea*t offered by the Center for Mindfulness at University of Massachusetts Medical School **OR** ❑ Written Documentation of completion of *Practicum in MBSR* (formerly the *Internship Program*) and/or *Teacher Development Intensive in MBSR* and/or *Supervision in MBSR* conducted by CFM or a CFM affiliated training program **PLUS** ❑ Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or WholeHealth Networks, Inc. for list of approved professionals)
Music Therapy	❑ A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) **OR** ❑ A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry **PLUS** ❑ Current membership in the American Music Therapy Association (AMTA)
Naturopathic Physician	❑ Graduation from a naturopathic medical college with a minimum four-year graduate degree ❑ Hold a valid unrestricted state license If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license ❑ Professional liability insurance of at least $200,000/$500,000
Nutritional Counselor	❑ Hold a valid unrestricted state license as a nutritionist **OR (if non-licensed state)** ❑ Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board **OR** ❑ Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education ❑ Professional liability insurance limits of at least $200,000/$500,000
Occupational Therapist	❑ Graduation from an accredited college or formal training program ❑ Hold a valid unrestricted state license ❑ NBCOT certification (not required but recommended) ❑ Professional liability insurance limits of at least $200,000 / $500,000
Asian/Oriental Bodywork	❑ Hold a valid unrestricted state or local license **PLUS** ❑ Written documentation of Massage training program, Including Oriental body work, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification **OR** ❑ Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) ❑ Professional liability insurance of at least $200,000 / $500,000
Pain Practitioner	❑ Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate ❑ Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency ❑ Current professional liability insurance policy meeting primary specialty requirements, or at least $200,000 / $500,000 ❑ Certification as a Diplomat, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management **OR** ❑ Certified by the American Board of Pain Medicine **OR** ❑ Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
Personal Trainer/ Exercise Specialist	❑ Certification from the American College of Sports Medicine(ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA)or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education ❑ Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution **OR** an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: The Center for Exercise Physiology (CEP) **OR** Registered Clinical Exercise Physiologist by the American College of Sports Medicine ❑ Health Fitness Director or Program Director certification by the American College of Sports Medicine ❑ Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) **PLUS** ❑ Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
Physical Therapist	❑ Graduation from an accredited college or formal training program ❑ Hold a valid unrestricted state license ❑ Professional liability insurance limits of at least $200,000 / $500,000
Pilates Instructor	❑ Pilates Certified Teacher from the Pilates Method Alliance (PMA) **OR** ❑ Letter attesting current employment at Studio or Educational Organization that is registered with PMA **OR** ❑ Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance **OR** ❑ Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement ❑ Professional liability insurance limits of at least $200,000/$500,000
Post Birthing/ Lactation Counselor	A Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of: ❑ International Childbirth Education Association (ICEA) **OR** Childbirth and Postpartum Professional Association (CAPPA) **OR** La Leche League International accredited Leader program **OR** International Board of Lactation Consultant Examiners (IBLCE)
Qi Gong	❑ Certification from the National QiGong Association (NQA) or individual training program ❑ A minimum of 200 hours of formal training ❑ One year teaching experience
Reflexologist	❑ Credentialed with WholeHealth Networks, Inc. as a massage therapist ❑ Certification from the American Reflexology Certification Board ❑ Professional liability insurance limits of at least $200,000 / $500,000
Tai Chi	❑ Certification from the individual training program ❑ A minimum of 200 hours of training and/or practice teaching ❑ One year documented teaching experience
Yoga	❑ A Registered Yoga Teacher (RYT) **OR** a registered with Yoga Alliance (200/500 hour certifications) **OR** a nationally certified course or training program **OR** Certificate of completion of a comprehensive Yoga Teacher Training course **PLUS** ❑ One year in practice experience following completion of training or working under supervision in a Yoga facility

AMENDMENT TO
PARTICIPATING PRACTITIONER AGREEMENT

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between **WholeHealth Networks, Inc.** ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

WITNESSETH

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

NOW THEREFORE, in consideration of the mutual covenants, conditions, and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties hereto agree as follows:

1. Practitioner agrees to participate in the Health and Fitness Product ("Health and Fitness Product") network being arranged by WHN, in accordance with the terms and conditions set forth in the group summary document attached as Attachment 1 to this Amendment. The Practitioner agrees to participate in this Health and Fitness Product throughout the duration of the Agreement.

2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

PRACTITIONER

Signature: _____ Date: _____

Printed Name: _____

NPI Number:_____ Email Address: _____

WHOLEHEALTH NETWORKS, INC.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY

Network Status: Open

Product Type: The Health and Fitness Product

Eligible Practitioners: WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists

Program Design:

Notwithstanding any provision of the Agreement, the following additional provisions shall be applicable to Practitioners providing services to Participants who elect to participate in a new health and fitness product being jointly developed by WholeHealth Networks, Inc. and a large, nationally known brand in the older adult wellness space (the "Health and Fitness Product").

The Health and Fitness Product shall provide Participants with Twenty and No/100 Dollars ($20.00) vouchers (each, a "Voucher") to be utilized for complementary health services (e.g., acupuncture, massage therapy, chiropractic). Depending on the Participant's election, this Voucher shall either only be provided to the Participant as a one-time benefit for enrolling, or may be a recurring monthly Voucher for as long as the Participant is enrolled in the Health and Fitness Product. In addition to the agreed upon discount set forth in Practitioner's Agreement, the Practitioner agrees to accept the voucher from the Participant in accordance with the following provisions:

1. The Practitioner agrees to accept the Voucher as a cash equivalent for services provided to the Participant. For the initial presentation of a Voucher from a Participant, the Practitioner agrees to accept the voucher with no reimbursement from WHN. For any additional Vouchers (the monthly recurring Vouchers), the Practitioner shall submit the Voucher to WHN for reimbursement of the listed amount on the Voucher.

2. The Practitioner must adhere to the following requirements in order to be reimbursed by WHN:

    a) Notify and submit the Voucher to WHN in the manner agreed upon by the Parties (e.g., web, mail or fax) within forty-five (45) days after acceptance of the Voucher from a Participant. This notification must include the date the Voucher was submitted and the name (and any other requested identifying information) of the Participant who submitted the Voucher.
    b) Ensure that the submitted Voucher was not accepted beyond the listed expiration date on the Voucher.
    c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.

3. WHN shall remit payment to Practitioner for all eligible and submitted Vouchers within forty-five (45) days after WHN receives the Voucher and validation from Practitioner.

4. Participants agree to pay remaining balance of Practitioners cash charges at time of service.

Questions:

- Customer Service: 1-800-274-7526
- Address Changes: provider.updates@tivityhealth.com

- Voucher redemption: Tivity Health WholeHealth Networks
  1445 S. Spectrum Blvd., Suite 100
  Chandler, AZ 85286
  Attn: Voucher Redemption

- For more information about WHN visit our provider website https://www.WholeHealthPro.com