847

PARTNERS FOR HEALTH

PRIMARY CARE PHYSICIAN BIOMETRIC SCREENING FORM

ONSITE HEALTH DIAGNOSTICS
Employee Health Intelligence

Employee/Member ID **MRN** -

UPPERCASE ONLY and stay within the lines

First Name **Middle Initial**

Last Name

Email Address

Street Address

City **State** **Zip Code**

DOB (MM/DD/YYYY) / /

Phone - -

Gender ☐ Male ☐ Female

SAMPLE

I consent to participate in Healthways' Health Risk Screening and Support Program (the "Program"), which may include providing biometric measurements such as weight and blood pressure, disclosing laboratory results from a recent blood test with my personal physician, and/or completing an on-line or written Well Being Assessment. I understand that my participation in the Program is voluntary and that I am not required to participate as a condition of employment or of enrollment in my health plan. I understand and consent to my personal physician providing to Onsite Health Diagnostics, LLC on behalf of Healthways results from a blood draw and laboratory analysis performed by my physician within the past twelve (12) months for the tests listed below. I agree to execute any authorization form required by my physician prior to disclosing my results to Healthways. Such results will include lipids (cholesterol and components) and blood glucose measurements in addition to blood pressure, height, weight and waist.

I consent to Healthways providing me with a report (either on-line or in writing) of my Program results and, if applicable, periodically providing me with follow-up educational materials and information relevant to my Program results. The laboratory results reflected in my report are for informational purposes only and are NOT a medical diagnosis. I understand that the Program is sponsored by my employer or benefits provider. If an incentive is implemented as part of the Program, I consent to Healthways informing my Sponsor only whether or not I qualify for such incentive based upon my participation in the Program. I understand that if I do not elect to provide such consent, I may not qualify for such incentive. I understand that my individual health data will be used by Healthways and will be treated as confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individual health information will be shared between my physician or care provider and Healthways however not be shared with my employer. I understand that Healthways will not disclose my individual health information to my employer. Aggregated data (i.e., data with no individual identifiers) on all participants, however, may be shared with employer. I understand that my employer or benefits provider may from time to time offer enrollees other health and wellness services and programs (collectively, "Other Health/Wellness Programs"), such as employee assistance and/or disease management programs.

I consent to the disclosure by Healthways of my wellness screening results and/or other personal health information that identifies me to Healthways' other Health/Wellness Programs so that they may contact me for the purpose of addressing my particular health/wellness needs. I understand that Healthways and/or my employer or benefits provider will require such Other Health/Wellness Program providers to agree to maintain the confidentiality of any wellness screening results and/or other personal health information provided to them by Healthways in accordance with the applicable regulations under HIPAA. I understand that if I do not want Healthways to disclose my wellness screening results and/or other personal health information to Other Health/Wellness Program providers sponsored by my employer or benefits provider, I must notify Healthways in writing at: Healthways, Inc., 701 Cool Springs Blvd., Franklin, TN 37067, Attn: Screening Operations.

I understand that this consent will remain in effect for as long as I participate in the Program, and that I am entitled to a copy of this consent. I may revoke this consent at any time by notifying Healthways in writing, to the extent Healthways has not already relied on this consent.

Participant's Signature **Today's Date (MM/DD/YYYY)** / /

FOR PHYSICIAN OR OFFICE STAFF USE ONLY BELOW THIS LINE

Hours Fasted

Height inches

Weight pounds

Waist inches

BMI .

Blood Pressure - Systolic mm Hg

Blood Pressure - Diastolic mm Hg

Total Cholesterol mg/dl

Triglycerides mg/dl

HDL mg/dl

LDL mg/dl

Glucose mg/dl

Facility Stamp

☐ I certify these values are correct

Physician's Signature

Date of Exam (MM/DD/YYYY) / /

Please fax this form to (214) 203-0395. If you have any questions regarding this form, please call (877) 366-7483.