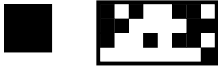

50070

PRIMARY CARE PROVIDER BIOMETRIC SCREENING FORM

Company______________________

Employee/Member ID

First Name **Middle Initial**

Last Name

Email Address

Street Address

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

DOB (MM/DD/YYYY) / /

Phone - -

Gender

☐ Male ☐ Female

I will participate in the screening program being offered. By signing this consent form, I understand that I am requesting and agree to allow this company to perform the screening. • I understand that a screening does not replace a consultation, physical examination, or evaluation from my physician or other appropriate healthcare provider. • I understand that this screening may generate an inaccurate result. I will discuss my screening results with my physician and will not use my results as an indicator for medication dosing. • I understand that the recommendation to contact my physician about the result of the screening is not a medical diagnosis or assessment of good health as only my own physician can make such a judgment and more information would be needed to establish or rule out a diagnosis or assessment of good health. • I understand that participation in this screening will not protect me from disease. • I understand that regardless of the results of this screening and consultation, my overall health is affected by cigarette smoking, family history of disease, hypertension and excess weight, and that I should discuss these risk factors with my own physician. • I understand that I am responsible for any follow-up examinations with my physician that may be indicated from the results of this screening.
I hereby release this company, their directors, officers, employees, agents and contractors, and any and all other organizations involved in the program, and their affiliates and subsidiaries, and all of their past and present officers, employees and agents, and the successors of each, from any liability and responsibility for any and all manner of actions, causes of action, (individual and class), claims or demands of any kind whatsoever, whether known, suspected or unknown, in law or in equity including, but not limited to, all claims or potential claims arising out of my voluntary participation in or any injury, loss or death sustained from or arising as a result of, this screening program, and any claim that this screening failed to identify or incorrectly identified any health condition. By signing below, I acknowledge that I have read, understand, and accept all of the statements on this consent form. Authorization for Release of Information: By signing this form, I authorize this company to disclose my health screening results to my health plan for the purpose of administering my wellness benefits and incentive awards, as applicable, and conducting other health plan activities as permitted by law. To the extent I am covered under an employer group policy which provides incentive awards related to a health screening program, I further authorize this company to disclose information regarding my participation in this health screening event and eligibility for various incentive awards to the plan sponsor of my employer group health plan for the purpose of administering my incentive awards. • I understand that I am not obligated to participate in this health screening program and that this authorization is voluntary. However, I understand that there may be certain wellness benefits (including incentive awards) under my health plan that I will not be eligible for as a result of either not participating in this program or not providing my health screening results to my health plan. • I understand that my wellness information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by the Federal privacy regulations. • I understand that I may revoke this authorization at any time by notifying this company in writing at the address below. However, the revocation will not have an effect on any actions this company took before it received my written revocation. Written revocation may be made to: 118 West First St., Suite 300, Dayton, OH 45402. If you have any questions regarding this form, please contact the Director of Healthy Living at 937-223-5201. By signing below, I agree to the consent for screening, the release of liability and release of my screening results to my health plan as set forth above.

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

FOR PROVIDER OR OFFICE STAFF USE ONLY BELOW THIS LINE

Hours Fasted		Blood Pressure - Systolic	mm Hg	HDL	mg/dl
Height	inches	Blood Pressure - Diastolic	mm Hg	LDL	mg/dl
Weight	pounds	Total Cholesterol	mg/dl	Total Cholesterol : HDL Ratio	.
Waist	inches	Triglycerides	mg/dl	Glucose	mg/dl
BMI	.				

Physician Stamp

☐ I certify these values are correct

Provider's Signature **Date of Exam (MM/DD/YYYY)** / /

Completed forms can be uploaded to your wellness portal by taking a picture on your phone or scanning to your computer, saving to your device, and uploading to the portal. If you have questions uploading this form, contact support at YWellnessSupport@daytonymca.org or 937-531-4444.