CREATION Health Employees Health Check Form

CREATION HEALTH Employees is committed to making your health journey easy. That's why we have created a process for you to complete your biometric screening with your primary care provider. Please print and bring this form with you to your next physician visit.

CONSENT (PAGE 2) MUST BE INCLUDED OR RESULTS WILL NOT BE UPLOADED

All screenings must be completed and submitted between January 1, 2019 – October 30, 2019.

Complete Section A. Your Physician must complete Sections B and C below.

(Important that ALL information be filled out. Incomplete information will not count as a screening and you may not have completed all requirements for a reward with CREATION Health Employees.)

Section A – Employee Information

First Name:		Last Name:
FH OPID:	Date of Birth:	Phone Number:
Consent to Medical Screening and Release Medical Information I consent to release of my medical information as described below to Florida Hospital Centra Care and any other companies who offer wellness and associated services to me through Florida Hospital. A photocopy of this consent shall be as effective and valid as the original. This consent shall be considered valid for one year from the date signed. I also understand and agree that Florida Hospital Centra Care has the right to request, at any time, applicable screening tests.		
Employee Signature Date:		Email Address:

Section B: Physician Information

Physician & Practice Name:	Phone #:	Fax #:
Address:		Test Date:

Section C: Test Results

Blood Pressure		Body Measures	
Systolic:	Diastolic:	Height: inches	Weight: lbs.

Clinical Laboratory						
Fasting Blood Glucose: mg/dl	Total Cholesterol: mg/dl	LDL Cholesterol: mg/dl	HDL Cholesterol:	Total Cholesterol to HDL Ratio:	Triglycerides: mg/dl	HGBA1C %

Physician Signature: **FORM MUST BE SIGNED BY YOUR PHYSICAN**

Please send completed form and consent ***by October 30, 2019*** *to*

biometrics@flhosp.org

OR

Fax results to (407) 200-9231 Attn: Andrea Flanagan

AUTHORIZATION AND RELEASE
WELLNESS SCREENING

1. I understand that my employer ("Employer") is offering me the opportunity to participate in a wellness exam and that my participation in the wellness exam is voluntary. I hereby agree to participate in the wellness exam performed by Florida Hospital Centra Care ("FHCC") or such other party that FHCC engages to conduct wellness exams, including FHCC's parent companies, affiliates and subsidiaries (collectively, "Designees"). I understand that the wellness exam will include a health risk assessment and biometric screening, including urine and blood specimen collection and testing in a laboratory designated by FHCC, the Designees or my Employer.

2. I understand that the wellness exam is not a medical exam and is not meant to treat or diagnose any underlying medical problem or condition. I understand that it is my responsibility to contact a medical doctor for a complete medical exam and testing and to obtain medical advice on the results of my wellness exam. I hereby release FHCC; the Designees; my Employer; and all of their respective officers, directors, employees, attorneys, representatives, agents and affiliates from any and all liability and damages arising out of the wellness exam, including failure of the wellness exam to identify any medical condition.

3. I understand that FHCC, the Designees and the laboratory performing the testing and analysis **will *not* release the results of my wellness screening to my Employer**; however, I agree and consent to FHCC, the Designees and the laboratory **releasing non-identifiable, aggregated results** for evaluation, management and planning of my Employer's wellness program and health benefit program and for public and private reports, presentations and publications by FHCC, the Designees, laboratory and Employer. I agree that FHCC, the Designees and the laboratory may contact me to notify me that medical attention is recommended based upon my wellness exam results or to advise me of other health and wellness programs offered by my Employer, FHCC or the Designees. **I give FHCC, the Designees and laboratories permission to share the results of my wellness exam, health risk assessment and biometric screening with my health insurance provider and its parent companies, affiliates and subsidiaries.**

4. I authorize FHCC, the Designees, and the laboratory performing the testing and analysis to release the results, information and forms from my wellness exam, health risk assessment and biometric screening, which includes urine and bloods specimen collection and testing, in response to any proceeding commenced by me or on my behalf challenging the wellness exam, health risk assessment and biometric screening.

5. I hereby release FHCC; the Designees; the laboratory performing the testing and analysis; and all of their respective officers, directors, employees, attorneys, representatives, agents and affiliates from any and all liability and damages arising out of the wellness exam, health risk assessment and biometric screening and the communication of the results of the wellness exam, health risk assessment and biometric screening pursuant to this Authorization and Release ("Release").

6. I have voluntarily signed this Release. I understand that authorizing the disclosure of my health information as described in this Release is voluntary. I can refuse to sign this Release. I understand that FHCC will not condition treatment, payment, or enrollment in any health plans or my eligibility for benefits if I decide not to sign this Release. **If I do not sign this Release, I understand that FHCC will not perform the wellness exam offered by my Employer.**

7. I understand that I may revoke this Release at any time by notifying FHCC in writing, but if I do revoke this Release, my revocation will not have any effect on any actions FHCC took before FHCC received the revocation. I understand that there is potential for information disclosed based on this Release to be subject to re-disclosure by the recipient and to no longer be protected by the Privacy Rule.

Patient Name (Print):	Office Use Only Medical Record#:
Name of Legal Representative (Print):	
Signature of Patient (or Legal Representative):	
Telephone:	
Street Address:	Date of Birth:
City State Zip	Today's Date: