AGC Health Benefit Trust

Health Care Provider Biometric Screening Form

INSTRUCTIONS:

- PARTICIPANT - complete section 1
- HEALTH CARE PROVIDER - complete section 2

Please fax completed form to Quest Diagnostics Health & Wellness Services at **(248) 864-4409**

SECTION 1 - PARTICIPANT INFORMATION - Print clearly. If the form is illegible it will not be processed.

Participant's Date of Birth (MM/DD/YYYY) ___ / ___ / ___

Gender: M F

Unique ID#

Participant's First Name

MI

Participant's Last Name

Address

Unit/Apt

City

State

Zip Code

Email Address

Phone Number ___ – ___ – ___

Are you: Employee Spouse Dependent

Please read the following disclosure statement. I understand that my health screening data will be released to health plans associated with my company for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information will not be shared with my Employer: however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to vendors engaged by my Employer or Employer-sponsored group health plan for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA). The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Participant's Signature: ______________________

Date: (Month) (Day) (Year)

PATIENTS: Biometric Screening must be completed by (09/30/2016) to receive completion credit or incentive (if applicable). This form must also be completed in its entirety, accurately and legible in order to be deemed complete.

SECTION 2 - BODY MEASUREMENTS / BIOMETRICS RESULTS - For physician or office staff use only below this line.

FOR HEALTH CARE PROVIDER: ***Client*** is offering a voluntary wellness program to encourage participants to understand their health risk.

Blood Panel

Total Cholesterol:

HDL:

TC/HDL Ratio:

Triglycerides:

LDL:

Glucose:

Fasting Status (Check one)

Fasting

Non-Fasting

Blood Pressure

Systolic

Diastolic

Body Composition

Height ft in

BMI

Waist

Weight lbs

Body Fat%

Hip

Pulse

Tobacco Use

Yes

No

For Females Only:

Currently Pregnant or Pregnant within the last 12 months

Yes No

I certify the listed biometric values are correct

Facility Name: ______________________

Phone Number: ______________________

Date of Service/Test: ______________________

Health Care Provider's Name: ______________________

Physician's Signature: ______________________

Date: ______________________

Please fax completed form to Quest Diagnostics Health & Wellness Services at

(248) 864-4409 by Deadline 09/30/2016

Date Faxed: ______________________

NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid

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