INSTRUCTIONS

Thank you for choosing to participate in ThriveOn's 2016 Biometric Screening Program. Please use this form if you are going to receive health screening services from your personal physician. *Alyfe Wellbeing Strategies* is the Biometric Health Screening vendor for Franklin County. Instructions for completing the health screening form are detailed below.

PLEASE NOTE: The Biometric Screening form (on the reverse side) must be completed in its entirety to receive credit.

Step 1: Make an appointment with your physician and request the following:

- full lipid panel(Total Cholesterol, HDL, LDL, TC/HDL ratio, Triglycerides, Glucose and/or A1C*)
- blood pressure reading
- height
- weight
- waist circumference

** A1C is to be done if it is determined that you meet the risk factors per American Diabetes Association.*

Step 2: Read the Screening Informed Consent/Authorization Release below and complete the Physician Health Screening Form in its entirety.

Step 3: Fax to the secured fax number below or mail the completed form to:

Alyfe Wellbeing Strategies
ATTN: Data Group at: 1-844-379-7494

OR

Alyfe Wellbeing Strategies
ATTN: Data Group - CONFIDENTIAL
171 Green Meadows Drive South
Lewis Center, OH 43035

PLEASE RETAIN A COPY FOR YOUR RECORDS ALONG WITH THE FAX CONFIRMATION, if applicable.

Completed forms must be post mark dated or faxed to *Alyfe* by September 1st 2016.

SCREENING & INFORMED CONSENT/AUTHORIZATION RELEASE FORM

1. I voluntarily agree to participate in this health screening activity coordinated by Franklin County Cooperative's ThriveOn program and Alyfe Wellbeing Strategies (Alyfe).
2. I hereby release Alyfe and/or their agents and staff from any and all liability arising from or in any way connected with my health screening.
3. I understand it is my responsibility to direct questions regarding testing to those administering the tests and to follow-up with my physician to discuss the results of these tests, when so advised.
4. I understand that any information collected as part of this health screening will be treated as confidential. **Individual health information will not be shared with my employer.**
5. I understand that my individual health data will be used by *Alyfe* to:
   - Evaluate the impact of the wellness program.
   - Provide my employer aggregate information as part of a group summary report (my individual data will not be disclosed).
   - If an incentive is implemented as part of the Program, I consent to Alyfe Wellbeing Strategies informing my benefits provider whether or not I qualify for such incentive based on my participation in this screening.
6. I authorize my physician or lab to perform the above listed tests and release information regarding these tests to *Alyfe Wellbeing Strategies.*
7. The results and a copy of the release form can be faxed directly to the Data Group at *Alyfe* at 844-379-7494.
8. I understand that I am responsible for any potential fees for my physician visit including, but not limited to co-pays, deductibles, and processing fees to complete necessary paperwork.

Alyfe complies with all HIPAA Privacy and Security Standards, and maintains the confidentiality of all information relating to employees that choose to participate – which means that individual results are never released unless the appropriate written consent is provided by the Franklin County team member. A high-level summary of the aggregate results will be provided to StayWell to better understand the impact their efforts are having on the overall health and well-being of the Franklin County Cooperative members. This information will assist in customizing future programs which will promote the specific health/prevention needs of the Franklin County Cooperative members.

By signing the Physician Biometric Health Screening Form, I agree to the terms outlined above.

ThriveOn Physician Health Screening Form

PARTICIPANT**:** Complete section 1 ***PROVIDER*****:** Complete section 2 and return a completed copy by 09/01/2016 to:

Alyfe Wellbeing Strategies
ATTN: Data Group at: 1-844-379-7494

OR

Alyfe Wellbeing Strategies
ATTN: Data Group
171 Green Meadows Drive South
Lewis Center, OH 43035

SECTION 1: PARTICIPANT INFORMATION (Completed by participant – PLEASE PRINT CLEARLY)

FIRST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ M/I ☐ LAST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

DATE OF BIRTH ☐☐/☐☐/☐☐☐☐ GENDER ☐ M ☐ F RELATIONSHIP ☐ EMPLOYEE ☐ SPOUSE/DEPENDENT PHONE ☐☐☐-☐☐☐-☐☐☐☐

County ☐☐☐☐☐☐☐☐☐☐☐☐

Last 4 of SSN ☐☐☐☐ EMAIL ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

By signing below, I understand that the purpose of my health screening is to evaluate my health status and any potential health risks. I hereby request and authorize ***ALYFE*** to transmit health information about me to the health management companies that provide services to my employer so that these companies may help me reduce, manage and/or control any such risks. I understand that ***ALYFE*** is not responsible for diagnosing, treating, or preventing any medical disease or condition that I currently have or may have in the future. I also understand that ***ALYFE*** will not give me medical advice and that I must seek such advice from my own physician. I understand that ***ALYFE*** will not provide my employer any health information that identifies me. I acknowledge and agree that ***ALYFE*** may provide my employer aggregate statistical health information which includes my health information. I understand that ***ALYFE*** may also use my health information for its own internal business purposes such as to develop future wellness programs. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. I voluntarily agree and consent to participate in the health screening and accept and assume all risks associated with such participation. I hereby release and forever discharge ***ALYFE,*** its owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney's fees and costs, arising out of or in any way related to my participation in the health screening.

Participant Signature: ______________________________ Date: ______________

SECTION 2: BODY MEASUREMENTS & BIOMETRIC RESULTS (Completed by provider)

DATE OF SERVICE: ☐☐/☐☐/☐☐☐☐

IS PATIENT PREGNANT? (Circle one) **YES** or **NO**
FASTING? (Circle one): **YES** **NO**

BODY COMPOSITION & BLOOD PRESSURE		BLOOD TEST RESULTS				
BLOOD PRESSURE	____ ____ ____ / ____ ____ ____ **mmHg**	TOTAL CHOLESTEROL				mg/dl
HEIGHT (w/o shoes)	____ ____ . ____ Total Inches (____ ft ____ in)	HDL CHOLESTEROL				mg/dl
WEIGHT (w/o shoes)	____ ____ ____ . ____ Pounds	TRIGLYCERIDES				mg/dl
WAIST	____ ____ . ____ Inches	GLUCOSE				mg/dl
BMI	____ ____ . ____	LDL CHOLESTEROL				mg/dl
Notes:		TC/HDL RATIO	.			
		A1C (optional)	____ . ____%			

Provider's Signature______________________________**Provider's Phone #**______________________________