WELLNESS FIRST
A Division of BHS

COLLECTION SITE INSTRUCTIONS FOR:

Sanford Health Occupational Medicine Clinic

1. Please call (701) 225-7575 to schedule your appointment for venipuncture lab draw for lipid panel with glucose and body measurements (height, weight, waist circumference and blood pressure).
2. Take this form and the Quest form with you. This provides the information the clinic needs, including billing details.
3. Print your name and date of birth on this page. Fill out the Quest form according to the instructions.

Sanford Health Occupational Medicine Clinic
1531 W Villard Street
Dickinson, ND 58601
(701) 225-7575
Mon-Fri: 8:00am-5:00pm

DATE: _____

Name: _____ Date of Birth: _____

Clinic Instructions:

Billing Information:
Ivy Creek Health
Attn: Sara Chandler
P.O. Box 688
Millbrook, AL 36054
FAX: 866-729-9740

1. Please make sure all the member is included on Quest form.
2. Record body measurements.
3. Package specimen and Fed Ex to Quest. (Supplies have been sent to your location.)
4. Fax this form to the number at the bottom of this page.

Height	Weight	Waist Circumference	Blood Pressure

Please fax form to Sara Chandler at 205-979-1178.

Clinic Contact: Dale Larson, Amanda Hanson, Judith Krueger, Hannah Chandler, Casey Naastad, Kayleen Thorstenson

THIS IS A PAPER REQUSITION – ORDER NEEDS TO BE ENTERED BY PSC STAFF INTO QUANUM

Quest Diagnostics™

EMPLOYER SOLUTIONS NATIONAL CLINICAL ACCOUNT

FOR QUEST DIAGNOSTICS USE ONLY – QUESTIONS PLEASE CALL 1.866.226.8046

Account Number	97518619
Account Name	BHS/AMGH
Address	Two Metroplex Drive. # 500
City	Birmingham
State	AL
Zip	35209

SPECIMENS MUST BE TESTED IN A QLS LABORATORY

Collection Date	
Collection Time	

Ordering Physician and/or Payors		**Physician Name**	Chandra Matadeen-Ali
UPIN		**NPI**	1811197619

CLIENT BILL ONLY NO PATIENT OR THIRD PARTY BILLING ON THIS ACCOUNT

Patient Information			
Patient Name (first, last, middle)			
Date of Birth	(MM/DD/YYYY)	**Gender**	
EMPLOYEE ID#			
Patient Phone			
Street Address			
City			
State		**Zip**	

	Order Code	**Test Name**		**Order Code**	**Test Name**
	483	Glucose			
	7600	Lipid Panel			

AIR MEDICAL GROUP HOLDINGS, INC. HEALTH SCREENING NOTICE AND CONSENT FORM
NOTICE REGARDING WELLNESS PROGRAM

First Name: _____ Last Name: _____ Date of Birth _____

Email: _____ Phone Number: _____

Air Medical Group Holdings, Inc. health screening is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Participating: By participating in the screening, the participant consents to the collection of blood sample(s) (total cholesterol, HDL, LDL, triglycerides, glucose, and similar information) and receipt of information for these test(s). This health information will be gathered by testing a blood sample obtained from the participant. The participant understands that the collection of blood through a needle or fingerstick may cause a little pain, and that there is a small chance the needle or lancet could cause bleeding, a bruise or (rarely) an infection. The participant understands that the health screening performed will require a technician to draw his/her blood with a needle or fingerstick, and the participant hereby consents to the technician drawing his/her blood with a needle or fingerstick with a lancet. The participant also consents to the collection of additional biometrics (height, weight, blood pressure, waist circumference). The participant hereby releases Wellness First/BHS, Air Medical Group Holdings, Inc., Lockton Companies and any other organizations associated with this testing, parent and affiliate companies, successors and assigns, officers, directors, and employees from any and all liability arising from or in any way connected with collection of biometrics, including blood drawing for the indicated test(s) measurement(s), or from the data delivered there from. The information from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You are also encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information: We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Air Medical Group Holdings, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellness First health screening program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Consent for Health Screening: By participating in this health screening, the participant understands that certain health issues may be identified, such as high blood glucose and high cholesterol; however, this screening cannot and should not be considered a substitute for a thorough examination by, or testing recommended by, the participant's personal physician. The screening data received by the participant is for informational use only and should not be considered diagnostic or conclusive.

The participant also understands and agrees that:

- It is recommended that the participant share the test results with his/her personal physician.
- The participant assumes responsibility for consulting with his/her personal physician regarding the test results and/or symptoms. Unless the participant shares the results with his/her personal physician, no physician will interpret the results of the participant's health screening.
- Neither Air Medical Group Holdings, Inc., Lockton Companies nor the screening provider are responsible for interpreting the findings of the health screening and will not follow-up with the participant concerning diagnosis or care.
- The participant understands and agrees that self-diagnosis or self-adjustment of medication is dangerous and that only a physician is qualified to interpret the significance of the blood tests and any other screening tests conducted as part of the participant's health screening.
- THE PARTICIPANT HAS READ THIS NOTICE AND CONSENT IN ITS ENTIRETY, OR HAD IT READ TO HIM/HER, AND AGREES TO ITS TERMS.
- THE PARTICIPANT AGREES THAT S/HE HAS BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT THIS NOTICE AND CONSENT AND THE HEALTH SCREENING PROCEDURES THAT THE PARTICIPANT WILL BE RECEIVING.
- THE PARTICIPANT BELIEVES THAT S/HE HAS SUFFICIENT INFORMATION TO PROVIDE INFORMED CONSENT FOR THE HEALTH SCREENING. THE PARTICIPANT UNDERSTANDS THAT S/HE HAS THE RIGHT TO REFUSE TO RECEIVE THE HEALTH SCREENING PROCEDURES, but may not be eligible to participate in a program for which the screening is a prerequisite or may not be eligible to receive program rewards. The participant signs this agreement truthfully, knowingly, freely and voluntarily. Participant acknowledges that the person executing this agreement is the person receiving the health screening, or the legal representative of the person receiving the health screening and is authorized to act on such person's behalf to sign this agreement. The participant is at least 18 years old.

Signature: _____ Date: _____

AIR MEDICAL GROUP HOLDINGS, INC.HIPAA AUTHORIZATION

Participation in employer-sponsored wellness program is strictly voluntary, but if you do not agree to this authorization, you may not participate in the health screening:

Authorization. Upon ACCEPTANCE, I authorize Wellness First/BHS, its affiliates, authorized vendors and representatives to collect, use, disclose and/or receive Health Screening Information about me for purposes of performing my personal health screening, and/or related services. I understand and agree that my Health Screening Information includes but is not limited to general information collected (ex: name, address, age, DOB, etc.), family medical history, biometric measurements collected (ex: height, weight, blood pressure, waist circumference), and blood specimens collected (ex: cholesterol, HDL, LDL, triglycerides, glucose, etc). My results may be disclosed in detail to Lockton Companies and may also be disclosed in aggregate form to the employer sponsoring this program. By aggregate form, Wellness First means that my data will be combined with those of other participants in a manner, which does not personally identify me. I may be identified to the sponsoring employer by name as a participant, but my name will not be associated with any specific screening results. BHS does not share identifiable information with employers or unaffiliated third parties without the express permission of the participant, unless required to do so by law.

Effective Time Period. This authorization is valid until the earlier of the occurrence of my death or the authorization is revoked.

Right to Revoke Authorization. I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to BHS, Attention: Compliance, Two Metroplex Drive, Suite 275, Birmingham, AL 35209. Though my individual results can be deleted, BHS cannot guarantee that my information in aggregate form will be completely removed from the BHS system. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization. I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: _____ Date: _____