WELLNESS FIRST
A Division of BHS

Biometric Reporting Form for

AMGH Collection Site Screening

COLLECTION SITE INSTRUCTIONS FOR:

Firelands Corporate Health
5420 Milan Road, Sandusky, OH 44870
(419) 557-5550 / Mon-Fri: 7:00am-5:00pm

1. Please call 419-557-5052 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 LabCorp form with you. This provides the information the clinic needs, including billing details.
3. **Print the date, your name, date of birth, and employee ID # on this page. Print name, date of birth, sex, patient ID # (Your EMPLOYEE ID), complete mailing address and phone number on the LabCorp form.**

First Name

Last Name

Date of Birth

Employee ID (REQUIRED)

Clinic Instructions:

1. Please make sure member included name and employee number (as Patient ID) on LabCorp form.
2. Record body measurements.
3. Package specimen and send to LabCorp.
4. Invoice: ******PLEASE NOTE CHANGE IN THE BILLING ADDRESS******

Wellness First
P. O. Box 830724
Birmingham, AL 35283

5. **Please fax form to Wellness First at 205-879-1178 or email to wellness@behavioralhealthsystems.com.**

Date

Height (Inches)

Weight (Lbs.)

Blood Pressure

Waist Circumference

REQUESTED BY

LabCorp
Laboratory Corporation of America

To find the nearest patient service center, visit www.labcorp.com or call 888-LABCORP (888-522-2677)

****PAPER REQUISITION****

☐ Fax
☐ Call
☐ Mail

Send additional copy of report to:
Client Number/Physician's Name
( )
Phone/Fax Number
Physician's Address
City, State, Zip

0702.21

BHS/AMGH
LABCORP WELLNESS VERIFIED
2 Metroplex Drive, Suite 500
Birmingham, AL 35209
205-879-1150

****PLEASE NOTE: This is a PAPER Requisition. It needs to be entered into the system MANUALLY.****

****Please use EMPLOYEE COMPANY ID # for the Patient's ID #.****

ENTER ONLY THE ACCOUNT NUMBER CIRCLED
LABCORP ACCOUNT NUMBER: 01385590

CIRCLE ONE:

1841315298-
Szabo, Cheryl

CHECK ONE:

03 [✓] ACCOUNT BILL

Patient's Legal Name (Last, First, MI)	Sex	Date of Birth MO DAY YR	Collection Time : AM PM	Fasting ☐ Yes ☐ No	Collection Date MO DAY YR	Urine hrs/vol hrs ____ vol ____

NPI	UPIN	Physician's ID #	Patient's SS #	Patient's ID #

Physician's Name (Last, First) | Physician/Authorized Signature X

Hospital Patient Status: ☐ In-Patient ☐ Out-Patient ☐ Non-Patient

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service
Highest Specificity Required

PATIENT
Patient's Address | Phone
City | State | ZIP

RESP. PARTY
Name of Policy Holder (if different from patient)
Address of Policy Holder | APT #
City | State | ZIP

I hereby authorize the release of medical information related to the service described herein and authorize payment directly to LabCorp. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

X _____ _____
Patient's Signature | Date

PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
Insurance Carrier *	Insurance Carrier *
ID #	ID #
Group #	Group #
Insurance Address	Insurance Address
Name of Insured Person	Name of Insured Person
Relationship to Patient	Relationship to Patient
Employer Name	Employer Name

*If Medicaid State | Physician's Provider # | Workers Comp ☐ Yes ☐ No

MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Refer to Determining Necessity of ABN Completion on reverse.

TRAVEL LOG ID

PST HR# | DATE | LOG#

PLEASE PRINT

[✓] **303756 Lipid Panel**

[✓] **001032 Glucose, Serum**

[✓] **[illegible]**

PLEASE PRINT

ORIGINAL-LABORATORY / COPY-CLIENT

ITEM # 00000000000053663 FORM # 0702 (UNIVERSAL FREEFORM 07)

(REV 06/25/2015)

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT. LISTED ABOVE ARE THE CUSTOMIZED PROFILES YOU HAVE SPECIFICALLY REQUESTED FROM LABCORP. THE INDIVIDUAL COMPONENTS HAVE BEEN DISCLOSED TO YOU AND THEY MAY ALSO BE ORDERED INDIVIDUALLY IN THE SPACE ABOVE. COMPONENTS AND BILLING CODES FOR NON CUSTOMIZED TEST PROFILES ARE LISTED ON REVERSE. COMPONENTS MAY BE BILLED SEPARATELY IN ACCORDANCE WITH CARRIER POLICIES.

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: _____