WELLNESS FIRST
A Division of BHS

COLLECTION SITE INSTRUCTIONS FOR

Quincy Medical Group Occupational Health

1. Please call 217-222-6550 ext 3662 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 the Quest form with you. This provides the information the clinic needs, including billing details.

Quincy Medical Group Occupational Health

1025 Maine St
2nd Floor

Monday – Friday
8:00 am – 5:00 pm

Clinic Instructions:

Billing Information:
Ivy Creek Health
Attn: Sara Chandler
500 Hospital Dr, Wetumpka, AL 36092
FAX: 866-729-9740

1. Please make sure member included name on Quest form.
2. Record body measurements:

Height	Weight	Waist Circumference	Blood Pressure

Please fax form to Sara Chandler at 866-729-9740

ClinicContact James Gragg

Outside Alabama

EMPLOYER SOLUTIONS NATIONAL CLINICAL ACCOUNT

FOR QUEST DIAGNOSTICS USE ONLY – QUESTIONS PLEASE CALL 1.866.226.8046

Account Number	97518030
Account Name	Wellness First – US
Address	4081 Hwy 14
City	Millbrook
State	AL
Zip	36054

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)		
Patient ID#			
Patient Phone			
Street Address			
City			
State		**Zip**	

	Order Code	**Test Name**		**Order Code**	**Test Name**
	483	Glucose		91695	Weight
	7600	Lipid Panel		19689	Height
				91696	Blood Pressure
				16349	Waist Circumference

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize my health care providers, Wellness First and University Services staff and laboratories that run medical tests for me to use and disclose certain protected health information about me.

The protected health information will be used or disclosed for the sole purpose of complying with state and federal laws. These laws authorize a review and approve laboratory requisitions and review laboratory results.

I authorization my protected health information and laboratory test results to be mailed through the United States Postal Service in order for me, the patient , to receive results to allow me to make informed decisions about my health care.

I understand that I have to receive a copy of this authorization. I understand that I will not be able to receive laboratory testing unless I sign this authorization. I understand I have the right to refuse to sign this authorization. I understand that by signing this authorization I may not be continued to be protected under the HIPPA Privacy Rule. This authorization will expire one year after the date of this authorization.

I understand that this authorization is for my consent to participate in the AMGH Wellness performed by Wellness First and the parties listed above. I have received a copy of this authorization and consent to its terms and representations.

Name:

Signature:

Date:

This signed and dated authorization form must accompany your physician form and lab forms