eHealthScreenings
screenings made simple

Physician Submission Form
Screening Key: BBH63

SCREENING NAME

Averett University 2017 Health Screenings

CRITERIA AND INSTRUCTIONS

The following testing criteria must be met for the Employee to be eligible for the wellness program incentive.

1. The required fasting laboratory tests include: Lipid Panel, Fasting Glucose.
2. The required biometrics include: Blood Pressure, Height, Weight and Waist Circumference.
3. The blood sample must be drawn by **venipuncture or finger stick.** Urine tests and mouth swabs will not be accepted.
4. Blood results must be provided on this form.
5. All of the information included on this form is required. Any missing information will prevent your results from being entered and will disqualify you from participating in the wellness program.
6. Do not provide a copy of this form to other Employees. Each Employee must request their own form.
7. Tests should be administered no earlier than: **1/17/2017** and no later than: **1/8/2018.**
8. Screening results must be received by eHealthScreenings no later than: **1/15/2018.**
9. Completed Manual Submission Form should be faxed to 210-767-2245 **or** scanned and sent using our mobile application **or** emailed to **ehsmanual@ehealthscreenings.com**.

Section A | EMPLOYEE INFORMATION (employee to complete)

First Name:	Last Name:
Sex: Last 4 SSN: _____ _____ _____ _____	DOB: (mm/dd/yyyy): _____ / _____ / _____
Phone:	Email:
Employee Signature:	**Date:**

Section B | PHYSICIAN AND/OR TESTING FACILITY INFORMATION (physician / nurse to complete)

Physician & Practice / Facility Name:	
Address:	Phone#:
National Provider ID # or CLIA certification #:	Test Date: _____ / _____ / _____
Physician Signature:	**Date:**

Section C | BIOMETRIC TEST RESULTS AND FASTING STATUS (physician to complete)

Blood Pressure

Systolic: (mmHg)	Diastolic: (mmHg)

Body Measurements BMI is a calculated value and will be available in your final report from eHealthScreenings.

Height: (inches)	Weight: (lbs)	Waist: (inches)

Fasting Status

- ☐ Yes, I fasted 9 or more hours
- ☐ No, I did not fast 9 or more hours

Section D | LAB TEST RESULTS (physician to complete)

Blood Testing Results

Total Cholesterol: (mg/dl)	LDL Cholesterol: (mg/dl)	HDL Cholesterol: (mg/dl)	Triglycerides: (mg/dl)	Glucose: (mg/dl)			

To contact **eHealthScreenings** with any questions or to confirm receipt, email us at **help@ehealthscreenings.com** or call **(888)708-8807**.

Thank you for selecting the option to submit physician lab results. **Note: If you do choose this option regular co-pays and deductibles may apply for the physician and lab visit.** You will be emailed the Manual Submission Form which you must have completed and then fax back to us by the deadline below.

Criteria and Instructions:

1. The required fasting laboratory tests include: **Lipid Panel and Fasting Glucose.**
2. The required biometrics include: **Blood Pressure, Height, Weight, and Waist Circumference.**
3. The blood sample must be drawn by finger stick or **venipuncture**. Urine tests and mouth swabs will not be accepted.
4. Blood results must be provided on the attached Manual Submission Form.
5. All of the information included on the Manual Submission Form is required. Any missing information will prevent your results from being entered and will disqualify you from participating in the wellness program.
6. Do not provide a copy of the Manual Submission Form to other Employees. Each Employee must request his or her own form.
7. Tests should be administered no earlier than: **1/17/2017** and no later than: **1/8/2018.**
8. Screening results must be received by eHealthScreenings no later than: **1/15/2018.**
9. Completed Manual Submission Form **and** supporting official laboratory form can be faxed to 210-767-2245 or scanned and sent using our mobile application or emailed to **ehsmanual@ehealthscreenings.com.**

If you have any questions or to confirm receipt, please contact eHealthScreenings by email at **help@ehealthscreenings.com** or by phone at 1-888-708-8807.

AVERETT UNIVERSITY HEALTH SCREENING NOTICE AND CONSENT FORM
NOTICE REGARDING WELLNESS PROGRAM

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

Email: _____ Phone Number: _____

Averett University health screening is a voluntary wellness program available to all employees and may be made available to employee spouses. 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: If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). 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 eHealthScreenings, Averett University, 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 HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are 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 Averett University may use aggregate information it collects to design a program based on identified health risks in the workplace, Averett University's 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 Averett University, 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 by this facility 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: _____

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 EHS (eHealthScreenings), its affiliates, authorized vendors and representatives to collect, use, disclose and/or receive Health Screening Information about me for purposes of performing my spouse's and/or my own 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 my Health and Wellness Program Administrator, beBetter Health, and may also be disclosed in aggregate form to the employer sponsoring this program. . By aggregate form, EHS 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. EHS 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 EHS, Attention: Compliance, 12000 Starcrest, Suite 108, San Antonio, TX, 78247. Though my individual results can be deleted, EHS cannot guarantee that my information in aggregate form will be completely removed from the EHS 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: _____