

Physician Health Screening Form

Patient to Complete Form to Red Line - PLEASE PRINT – Form Must Be Completed in Full

Patient Last Name: _____ First Name: _____

Employer Providing Program: _____

Choose one: Employee Spouse Domestic Partner

Phone: _____ Email Address: _____

DOB: ____/____/____ Last 4 SS# (optional): _____ Gender: Male Female
(Month) (Day) (Year)

I authorize my healthcare provider to release the requested information to Health Advocate. I acknowledge that I have read, signed and submitted to Health Advocate the Notice and Authorization Form as provided on the reverse of this form.

Signature: _____ Date: _____

If you are a spouse or domestic partner, please complete the section below:

Employee Name: _____

DOB: ____/____/____ EE's last 4 SSN# (optional) : _____

To Be Completed by Physician Office

Please enter the results of the physical below. All measurements are required or the processing of this form may be rejected.

Height: _____ FEET _____ INCHES	Trig: _____ LDL: _____
Weight: _____ POUNDS	Ratio: _____
Waist: _____ INCHES	Glucose Fasting: _____
Total Chol: _____	OR Glucose Non-Fasting: _____
HDL: _____	OR HbA1c: _____
	Blood Pressure: _____/_____
Physician Comment: _____	

_____/_____/_____ DATE OF EXAM

Patient Pregnant: Yes No

Healthcare Provider Signature

Office Telephone Number

Signature Date

After providing any needed counseling on values obtained, please email or fax this completed form to Health Advocate. Email: Specialtyforms@healthadvocate.com Fax: 610.397.7898 MUST BE EMAILED OR FAXED FROM PHYSICIAN'S OFFICE. If you have any questions, please call the Screening Assistance Line at 800.970.1263.

Results may be verified with physician's office.

Dear BrandSafway Member,

You have elected to have your health screening results sent to Health Advocate by your personal physician. We must receive your results by **November, 15 2021** and the form must be completed in its entirety. If all metrics are not completed your form will be rejected. Only exams performed from January 1, 2021 – November 15, 2021 will be accepted.

Please complete and sign the top portion of the Health Screening Form, and give the form and the attached Physician Results Release letter to your doctor. If you are a spouse of a BrandSafway employee who is not on the BrandSafway medical plan today you must indicate the employee who works at BrandSafway on the top of the form to ensure you receive the incentive credit if choosing the CHDP plan. (Please note: your employer **will not** receive a copy of your results; they will only receive notification that we have received your results from your physician.)

If you would like us to send you a confirmation when we receive your results, please make sure your email address is printed clearly on the Health Screening Form. If you do not hear from us within two weeks of requesting your results from your physician, please feel free to call or send us an email.

Sincerely,

Health Advocate

Phone: 877-650-9027

Email: Specialtyforms@healthadvocate.com

Fax: 610-397-7898

Dear Physician:

Your patient, _____, a BrandSafway member has elected to participate in the company's Wellness program, provided by Health Advocate, Inc.

One feature of the program, a wellness incentive, requires that participants undergo certain biometric screenings (at their healthcare provider's office or through LabCorp) and have the results transmitted to Health Advocate.

Your patient has elected to have the required screenings (listed below) performed at your office.

Once you have completed the screenings and reviewed the results with and/or counseled your patient on the values obtained, **please fax the completed health screening form to Health Advocate at 610-397-7898.**

(Please note, Health Advocate is in full compliance with all federal HIPAA guidelines, and keeps all personal health information strictly confidential. Results **will not** be shared with BrandSafway.)

Your patient's Wellness program requires the following biometric screening results

- **Height**
- **Weight**
- **Blood pressure**
- **Waist circumference**
- **Glucose and/or HbA1c**
- **All cholesterol readings**

Thank you in advance for your assistance.

Sincerely,

Health Advocate

Phone: 877-650-9027

Email: Specialtyforms@healthadvocate.com

Fax: 610-397-7898

Important Information

The purpose of this Notice and Authorization Form relates to screening for cholesterol, glucose (or HbA1c), blood pressure and/or body composition measurements as part of an employee wellness program. By participating, you hereby release the administrators of the screenings, Health Advocate, the employer and/or its group health plan, from any and all claims, demands, actions, and causes of action which may result from participation in this program.

What information we collect and how we protect that information:

The information collected and the results of your screening contain health information, such as your height, weight, body mass index, cholesterol levels, glucose levels and blood pressure. This health information may constitute "genetic information" if gathered from an employee's family members. The health information we collect from you will be stored using state-of-the-art secure technology to ensure security and confidentiality. Health Advocate follows the HIPAA Security Rule and secures your health information on computer servers in a controlled, secure environment, protected from unauthorized access, use or disclosure. When personal information is transmitted to other websites, it is protected through the use of encryption, such as the Secure Socket Layer (SSL) protocol. In the event of a breach of your Personal Health Information, Health Advocate will notify your employer sponsored health plan pursuant to its business associate agreement with that plan.

How we may use or disclose your information:

Health Advocate will use and disclose your Personal Health Information only as permitted by our business associate agreements with your employer sponsored health plans, as required to by law, or where required by the of U.S. Department of Health and Human Services (HHS) to investigate or determine Health Advocate's compliance with the HIPAA Rules. Under no circumstances will genetic information be used for underwriting purposes.

You are not required to provide your health information. The employer may not retaliate against employees who refuse to provide their health information. However, employees who do provide this information may receive an incentive from the wellness program. The employer will not receive any health information that will identify you as an individual unless the employer needs individually identifiable health information for limited purposes of administering parts of the wellness programs. In that case, the employer must agree to implement reasonable safeguards to adequately separate plan administration functions from other employment activities, and to otherwise protect the confidentiality, integrity and availability of the Personal Health Information they utilize on behalf of a group health plan. Minimally identifiable health information will be shared for those administrative purposes. The employer will not receive any individually identifiable genetic information, only genetic information on the aggregate. Your data may be stripped of all identifying information and combined with others in a large statistical database for aggregate reporting back to your employer and used for the development and implementation of preventive health programs and resources. Employees may not be discriminated against in employment because of the health information you provide. Employers may not use the health information to make any employment decisions about employees. Employer plan sponsors are also required to implement reasonable safeguards to adequately separate plan administration functions from other employer activities.

Your individual data may be shared with a third party such as disease management vendors who must abide by strict confidentiality and privacy guidelines, and with your written authorization on the previous page, will assist you with chronic condition management and other wellness program services. Your information will not be sold or transferred to, or exchanged or shared with, any third party except if needed to carry out specific activities related to the wellness program. The only other persons who will receive your individually identifiable health information are you and the professionals who need the information to deliver health and wellness services to you.

Authorization

By my signature on the previous page, I hereby authorize Health Advocate or the employer, if necessary, to use or disclose my health information collected during today's screening pursuant to the terms of this Notice and Authorization for the purposes of my continued Health Education or Care Management over the duration of my participation in the wellness program. These services may include care coordination, locating providers, claims/appeals assistance, health coaching, healthy reminders and other wellness services. This Authorization expires upon termination of my enrollment in the wellness program unless another date is indicated.

I further agree, understand, and acknowledge my rights in relation to the following:

- I may refuse to sign this Notice and Authorization. But if I do refuse to provide my authorization, I may not participate in the health screening that is the subject of this authorization.
- A photocopy of this Notice and Authorization will be as valid as the original.
- Health Advocate will ensure my rights of access, amendment and accounting of disclosures with respect to the Personal Health Information it maintains about me on behalf of HIPAA covered entities.
- I have received a copy of this Notice and Authorization, and that I am entitled to a copy of this authorization upon request.
- I may ask questions about the health information collected about me or make requests about this Notice and Authorization by contacting Health Advocate's Privacy Officer at 1-866-385-8033.
- I may also complain to Health Advocate, my employer or group health plan, or the Secretary HHS if I believe my privacy rights have been violated, and no retaliatory actions will be taken against me for filing a complaint.
- I understand that this authorization may be revoked in writing if delivered to Health Advocate although revocation will not be effective as to the disclosure of any information whose release I have previously authorized, or where other action has been taken in reliance on my authorization.