



TO: Health Screening Participant

FROM: Interactive Health

DATE: 2017

RE: Health & Wellness Screening Voucher Service

Enclosed is information regarding the Health & Wellness Screening Voucher Service. **Diocese of Austin** is providing these screenings at no cost to you. The screening will provide information on your current health status and help you identify any potential health risks and opportunities for improvement.

To assist you in obtaining your free screening, we have outlined the steps for you as follows:

**Step 1:** LabCorp is the approved lab you must use for your free health screening. To find a LabCorp in your area you can use your local telephone book or visit [www.labcorp.com](http://www.labcorp.com). To use the website click the "Find a Lab" link in the "I Am a Patient" section. On the page that comes up enter your location information and a search radius. Make sure "Routine clinical laboratory collections" is selected and click the blue "Search" button. The site search results will provide details on the hours of operation and phone numbers for each LabCorp location. **You must take the LabCorp requisition (included in this packet) with you to your visit with your name (last name, first name), date of birth, gender, and telephone number filled out.**

**IMPORTANT NOTE: You must use only LabCorp locations. Depending on your location, your site search may include LabCorp contracted labs (DynaCare, Concentra, etc.) These are not LabCorp Patient Service Centers and should not be used. If you use a non-LabCorp lab your results may not be reported to Interactive Health and you may be financially responsible for the entire cost of all lab tests.**

**Step 2:** **Before** your appointment, please complete the Consent Form and Health Behavior Questionnaire and return it to Interactive Health by fax (410-356-6205) or mail (11409 Cronhill Dr, Suite M, Owings Mills, MD 21117) or e-mail ([offsiteforms@interactivehealthinc.com](mailto:offsiteforms@interactivehealthinc.com)).

**Step 3:** You must take the completed requisition form to your visit.

**Step 4: FASTING IS REQUIRED FOR THIS TEST (Fasting = 8hrs with only water and medications).**

**Step 5:** Your lab results will be sent to Interactive Health. The results will be mailed to you in a confidential envelope to the address that you provided.

Your results are confidential and will not be shared with your employer. In order to help your employer determine the success of this program, aggregate data will be provided to **Diocese of Austin**.

**Note: Your Requisition Voucher has an expiration date.  
Please note the expiration date stamped on the bottom of your form.  
This voucher will expire and no longer be valid if not used before the expiration date.**

**Health Screening Release of Liability  
and Informed Consent**

I, the undersigned, hereby consent to health screening services and collection of screening results offered by Health Solutions (HSSI), a subsidiary of Interactive Health (IH), my Employer, or Blue Cross and Blue Shield of Texas ("BCBSTX"), a division of Health Care Service Corporation, a Mutual Legal Reserve Company through my participation in a wellness program or health fair.

I hereby release Health Solutions (HSSI), a subsidiary of Interactive Health (IH), my Employer, my Employer Sponsored Group Health Plan, BCBSTX, any third party vendor selected by my Group Health Plan, or any other organization(s) associated with a wellness program and/or health fair screening including their affiliates, directors, officers, employees, assigns and successors from any liability arising from or in any way connected with my participation in these activities or from any data derived therefrom.

I, the undersigned understand that:

- my participation in the wellness program or health fair screening is voluntary.
- the data derived from any health or wellness screening test(s) are considered to be preliminary and do not constitute a diagnosis of any particular disease or condition.
- a health screening is not a substitute for the medical advice of my health care provider. If I have any questions or concerns regarding any of the results from the screening, I understand that I should discuss them with my health care provider. The responsibility for initiating a follow-up examination to discuss or confirm the results of this screening and obtain professional medical assistance is mine alone, and not that of any organization(s) associated with this screening, wellness program or health fair.
- results of any screening test(s) can give false positive or negative results for a variety of reasons. I acknowledge that my health care provider is best able to interpret the results of these tests based on their understanding of my medical history.

I, the undersigned further understand that:

- my employer is the Plan Sponsor of my Group Health Plan, as the Plan Sponsor, my Employer may receive a list of all participants for administrative purposes, including but not limited to, billing and attendance.
- my Group Health Plan may be administered and/or insured by my Employer or an insurance company such as BCBSTX, one of these entities or their selected vendor may have access to my individually identifiable information for condition management and lifestyle management purposes, or to appropriately operate or administer my Group Health Plan.

The organizations involved in this wellness activity and/or health fair recognize the importance of safeguarding individually identifiable health information and are obligated to take reasonable steps to protect such information from unauthorized access or use.

Signature of participant, parent or legal guardian of participant: \_\_\_\_\_

Printed Name/Relationship to participant: \_\_\_\_\_

Date: \_\_\_\_\_



**Name:** \_\_\_\_\_

1. **In the average week, how many times do you engage in a physical activity for at least 20 minutes?**  
 Less than 1 time per week       1 or 2 times per week       3 or more times per week
2. **How many servings of food do you eat that are high in fiber?**  
 Rarely/never       1 or 2 servings per day       3 or more servings per day
3. **How many servings of food do you eat that are high in cholesterol or fat?**  
 Rarely/never       1 or 2 servings per day       3 or more servings per day
4. **How many alcoholic beverages do you have in a typical week?**  
 Less than 6       6 or more
5. **How often do you feel tense, anxious or depressed?**  
 Rarely/never       Sometimes       Often
6. **Considering your age, how would you describe your overall physical health?**  
 Poor       Fair       Good       Excellent
7. **Do you use tobacco in any form?**  
 Do not use tobacco       Use tobacco
8. **I recognize that the way I live my life impacts my health and well-being. My plan for changing my behavior is:**  
 I don't feel that my lifestyle is a problem and have no plans to change the way I live my life.  
 I plan to make changes within the next six months.  
 I plan to make changes within the month.  
 I have made changes to the way I live my life within the last six months.  
 I have made changes to the way I live my life more than six months ago.
9. **My number one health improvement need is: (PLEASE SELECT ONE)**  
 Weight Mgmt/Nutrition       Blood Pressure       Weight Mgmt/Exercise       Cholesterol Mgmt.  
 Stress Mgmt.       Smoking Cessation       Diabetes Mgmt.       Back care
10. **Do you have any of the following conditions: (PLEASE CHECK ALL THAT APPLY)**  
 Asthma       COPD/Emphysema       Heart Failure       Migraine Headaches       Low Back Pain  
 Acid Reflux       Hypertension       Diabetes       Heart Disease       None
11. **Do you have a Primary Care Physician?**  
 Yes       No
12. **When was the last time that you saw your Primary Care Physician?**  
 Less than 1 Year       1-2 Years       3 or More Years       N/A
13. **Are you currently pregnant or planning on becoming pregnant in the next 6 months?**  
 Not applicable       Yes       No
14. **WOMEN OVER 40: When was the last time that you had a mammogram?**  
 2 Years or Less       More Than 2 Years       Never
15. **WOMEN OVER 21: When was the last time that you had a Pap smear?**  
 3 Years or Less       More Than 3 Years       Never
16. **PARTICIPANTS OVER 50:**
  - a. **When was the last time you had a colorectal screening?**  
 Less than 5 Years       5-10 Years       10 or More Years       Never
  - b. **If you have had a colorectal screening what test(s) have you had completed?**  
 Colonoscopy       Sigmoidoscopy       Fecal Occult Blood



Health Solutions: Diocese of Austin  
LABCORP WELLNESS VERIFIED  
11409 Cronhill Drive, Suite M  
OWINGS MILLS, MD 21117  
800-833-3934

Significant Clinical Information  
\_\_\_\_\_ Fasting \_\_\_\_\_ Non-Fasting  
**CUSTOMIZED REQUEST**  
(EMBOSSING AREA)



**\*\*WELLNESS-ENTER ONLY THE ACCOUNT NUMBER CIRCLED\*\***

Account No. **19572920**

Submit Separate Specimens (Not Request Forms) for each Frozen Test Requested.

Specimen Date Mo Day Yr	Specimen Time Hr Min	Patient Name (Last)	(First, MI)	Sex	Date of Birth Mo Day Yr	Age Yrs Mos	
Patient I.D. #		Physician I.D.		Patient/Resp. Party's Phone #			
Responsible Party or Insured's Name (Last, First)		Patient's SS #					
Address		City		State Zip Code			
Patient's Signature Date		Medicaid Number/HMO #		Medicare #			
Resp. Party's Employer		NPI #		UPIN #		Physician's Signature	Provider #
Diagnosis Code (ICD-9)		Insurance Code or Company Name and Address			Insurance I.D. #		Workers Comp. Yes No
Group # or Name		Relationship to Insured (Circle One) 1-Self 2-Spouse 3-Other		Urine Total 24hr. Vol. _____		Patient's Ht. _____ Wt. _____	

CHECK ONE:  
**03 [X] ACCOUNT BILL**

CIRCLE ONE:  
**Dr. Lidia Nelkovski**  
**1396766598**

**MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)**

**Use a separate ABN when ordering tests which require an ABN.** Refer to the back of this form for more information.

- @ = Subject to Medicare medical necessity guidelines
- % = Subject to Medicare frequency guidelines
- # = Medicare deems investigational

INDIVIDUAL COMPONENTS OF TEST COMBINATIONS / PROFILES LISTED IN THE SECTION ABOVE CAN BE ORDERED BELOW

LABCORP USE ONLY	STAT	VENIPUNCTURE	NON LABCORP	VERBAL ORDER	CHART ORDER	HANDWRITTEN	24 HR TUV	PST/PSC #
	<input type="checkbox"/> 998074	<input type="checkbox"/> 998085	<input type="checkbox"/> 998239	<input type="checkbox"/> 998250	<input type="checkbox"/> 998261	<input type="checkbox"/> 998272	<input type="checkbox"/> 998283	

TRAVEL LOG ID		
PST HR#	DATE	LOG#

**[ X ] 303544 - LP+Glucose**

**EXPIRES 12/31/2017**

GEL SPUN	USST UNSPUN	SER SERUM TRNSPT	FRZ FRZ TRNS	RED RED	LAV LAVENDER	SLD SLIDE	BLU LT. BLUE	GRY GREY	GRN GREEN	RYB RYL BLU	YEL ACD	PLS PLASMA	URN URINE	24U 24 HR URINE	TA-U TART. ACID	FL FLUID	OT OTHER	BACT BACT TRNSPT	O & P KIT	PROBE PROBE TRNSPT	URN CUL URN CUL TRNSPT	STERIL STERIL TRNSPT	FECAL FECAL TRNSPT	VIRAL VIRAL TRNSPT
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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. COMPONENTS OF THE ORGAN OR DISEASE PANELS AND COMMON TEST COMBINATIONS ARE SHOWN ON THE REVERSE SIDE, AND ANY COMPONENT MAY BE ORDERED INDIVIDUALLY. COMPONENTS MAY BE BILLED SEPARATELY PER CARRIER POLICY. THE INDIVIDUAL COMPONENTS OF ANY CUSTOMIZED PROFILES HAVE BEEN DISCLOSED TO YOU AND THEY MAY ALSO BE ORDERED INDIVIDUALLY.

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