TO: Health Screening Participant

FROM: Interactive Health

DATE: 2018

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. To use the website, on the home page in the "Labs & Appointments" box enter your address or ZIP code. Click your address or ZIP code from the Matching Places or Matching ZIP Codes that appear below the box. Make sure "Routine blood work" is selected from the "Select Service" drop down and click the blue "GO" button. The site search results will provide details on the hours of operation, phone numbers, and the ability to make appointments 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. 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).

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). THIS TEST IS A VENIPUNCTURE NOT A FINGERSTICK**

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: _____

Well onTarget℠

Diocese of Austin

Health Behavior Questionnaire

Group # ☐☐☐☐☐☐ **Date of Screening** ☐☐ / ☐☐ / ☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐ **First Name** ☐☐☐☐☐☐☐☐☐☐☐

DOB ☐☐ / ☐☐ / ☐☐☐☐ **Gender** ☐ **M** ☐ **F** **Employee ID#** ☐☐☐☐☐☐☐☐☐☐☐

Are you a Blue Cross and Blue Shield member? ☐ Yes ☐ No **Subscriber ID #** ☐☐☐☐☐☐☐☐☐

Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Street or PO Box

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐☐☐☐

City *State* *Zip Code*

Please include your phone number and choose which phone number you prefer to be used for contact:

☐ Home ☐☐☐ - ☐☐☐ - ☐☐☐☐ ☐ Work ☐☐☐ - ☐☐☐ - ☐☐☐☐

E-mail Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Height ___________ **ft.** ___________ **inches**

Weight _________________________ **pounds**

Waist Circumference _____________**inches**

To measure your waist circumference, use a tape measure.
Start at the top of the hip bone, then bring it all the way around – level with your navel.
Make sure it's not too tight and that it is parallel with the floor.

Blood Pressure, Top Number (Systolic)____________ **mm Hg**

Blood Pressure, Bottom Number (Diastolic)__________**mm Hg**

☐ **I do not know my Blood Pressure**

IMPORTANT:

DO NOT EAT OR DRINK (EXCEPT WATER) FOR 8 HOURS PRIOR TO THIS SCREENING.

Sign the consent and complete this Health Behavior Questionnaire and return them to Interactive Health by fax (410- 356-6205), mail (11409 Cronhill Drive, Suite M, Owings Mills, MD 21117) or e-mail (offsiteforms@interactivehealthinc.com).

Revised 1/12/15

(Continued on back)

Diocese of Austin

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

REQUESTED BY

1372240

LabCorp®

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

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

Significant Clinical Information
_____ Fasting _____ Non-Fasting

CUSTOMIZED REQUEST

(EMBOSSING AREA)

7040.25

1372240

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 #
I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION RELATED TO THE SERVICES DESCRIBED HEREIN AND AUTHORIZE PAYMENT DIRECTED TO LABCORP. I AGREE TO ASSUME RESPONSIBILITY FOR PAYMENT OF CHARGES FOR LABORATORY SERVICES THAT ARE NOT COVERED BY MY HEALTHCARE INSURER.	Responsible Party or Insured's Name (Last, First)		Patient's SS #
Patient's Signature Date	Address	City	State Zip Code
Resp. Party's Employer	Medicaid Number/HMO #	Medicare #	

Physician Name	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. _____

PLEASE PRINT

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**

PLEASE PRINT

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 #
	☐ 998074	☐ 998085	☐ 998239	☐ 998250	☐ 998261	☐ 998272	☐ 998283	

TRAVEL LOG ID		
PST HR#	DATE	LOG#

[X] 303544 - LP+Glucose

EXPIRES 12/31/2018

ORIGINAL-LABORATORY / COPY-LABORATORY / COPY-CLIENT

CONTAINERS RECEIVED	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 TRNSPT	O & P KIT	PROBE TRNSPT	URN CUL TRNSPT	STERIL TRNSPT	FECAL TRNSPT	VIRAL TRNSPT

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.