Biometric Screening Form

The City of Greeley Wellness Program is a participatory incentive-based wellness program compliant with federal regulations and guidelines. Participation is not mandatory and will not impact ability for individuals to obtain insurance plans offered through their employer.

Participant Instructions

You must complete an annual biometric screening with a provider through the City of Greeley Health Clinic or with your primary care provider by **September 30, 2024,** to earn the available points for the 2024 Wellness Program.

When completing your labs and biometric screening with a provider outside the City of Greeley Clinic, **ensure your provider's office, or you directly, return this completed form (pages 1-3) to the City of Greeley Employee Wellness Clinic by fax to (970) 351-5096 with a copy of your lab work by September 30, 2024** to receive credit for completion of the incentive requirements. Member to complete Incentive Program Employee Notice and Authorization. Provider to complete entire Provider Section on page 2.

Authorization for release of health information

The authorization form on page 3, titled "Incentive Program Employee Notice and Authorization" must be signed and received at the City of Greeley Wellness Clinic if you have your biometric screening completed at the City of Greeley Wellness Clinic or an outside provider. The authorization form authorized Premise Health to disclose information regarding your participation in the program with the administrator(s) of the program.

Provider Section:

Your patient is participating in a participatory wellness program offered through their employer, or spouse's employer, City of Greeley. To demonstrate completion of the required actions, the patient, or your office, must return this completed form. Following receipt of the required lab work, complete all the sections below. Fill out each blank space, print clearly in CAPITAL LETTERS using an ink pen. Please send completed form to the secure fax @ **970-351-5096**.

Patient Information

*Patient's Last Name: _____ *Patient's First Name: _____ *Gender: _____

*Patient's Phone #: ( ) - *Patient's DOB: / / *Date of Annual Labs: / /

Follow-up: / /

Labs and Biometrics:

***Blood work results must include at least 21 of the 28 HRA labs (see listing below).**
***All fields below with an asterisk (*) must be completed to be eligible for the incentive.**
***All biometric measurements must be completed.**

Biometrics – All Required

*Height: _____ feet_____inches

*Weight: _____pounds

*Blood Pressure: _____/_____

*Waist Circumference (at navel level): _____inches

*Patient cleared for exercise? _____YES _____NO

*Annual labs Ordered MUST INCLUDE full cholesterol panel, chemistry panel and fasting blood sugar. A copy of labs must be included with this form to be eligible for the incentive.

Provider's Name: (print) _____ Provider's Signature: _____

Practice Name: _____ Phone/Fax: _____

Address, City, State, Zip: _____

- ☐ ***Total Cholesterol**
- ☐ LDL Cholesterol
- ☐ ***HDL Cholesterol**
- ☐ T. Chol/HDL Ratio
- ☐ Triglycerides
- ☐ Sodium, Serum
- ☐ Potassium, Serum
- ☐ Chloride (CI)
- ☐ Carbon Dioxide (CO2)
- ☐ Blood Urea Nitrogen (BUN)
- ☐ Creatinine (Creat)
- ☐ BUN/Creatinine Ratio
- ☐ ***Glucose, Serum**
- ☐ Calcium (Ca)
- ☐ Phosphorus, Serum
- ☐ Magnesium, Serum
- ☐ Aspartate Aminotransferase Enzyme
- ☐ Alanine Aminotransferase Enzyme
- ☐ Gamma Glutamyl Transferase Enzyme
- ☐
- ☐ Bilirubin, Total
- ☐ Alkaline Phosphatase, Serum
- ☐ Lactate Dehydrogenase Enzyme
- ☐ Albumin, Serum
- ☐ Protein, Total, Serum
- ☐ Globulin, Total
- ☐ Prostate Specific Antigen, Serum
- ☐ Iron, Serum
- ☐ Uric Acid, Serum
- ☐

Incentive Program Employee Notice and Authorization

Your employer has contracted with Premise Health Employer Solutions, LLC, along with its professional affiliates ("Premise Health") to provide certain health and/or wellness services in connection with your employer's voluntary incentive program.

If applicable, by participating in the biometric screening, you consent to the collection of a blood specimen and/or bodily fluids. You understand and acknowledge that the collection of blood through a needle or fingerstick may cause pain, a bruise or, rarely, an infection. You also consent to the collection of additional biometrics (height, weight, blood pressure, waist circumference, and perhaps other measurements, as per the design of the program). You understand that a biometric screening is not meant to replace the care of a medical professional and that Premise Health may recommend that you seek additional medical care based on the screening.

If applicable, by participating in the HRA, you may be asked to complete a voluntary health risk assessment ("HRA") that presents a series of questions about your health-related activities and behaviors and whether you had or have certain medical conditions (e.g., cancer, diabetes, or heart disease).

Protection of Your Health Information: Premise Health agrees to abide by all applicable laws and regulations governing the privacy and security of your personal health information. To the extent, the information is subject to the Health Insurance Portability and Accountability Act and its implementing regulations ("HIPAA"), Premise Health will abide by HIPAA and maintain the privacy and security of your Protected Health Information ("PHI") in accordance with its Notice of Privacy Practices ("Notice"), which Premise Health has provided to you. This Notice is also available at Health Center and on the Premise Health website. You may also request a copy of this Notice from Premise Health at any time.

Authorization: I understand that my participation in the incentive program is strictly voluntary, but in order to determine my eligibility for health and/or wellness incentives, the administrator(s) of the health and wellness program must receive a record of my participation. By signing below, I authorize Premise Health to disclose information regarding my participation in the program with the administrator(s) of the program. If the incentive program includes by design a review of my results (e.g., measurement, test or blood specimen results) so that I can be provided recommendations in furtherance of my health, I authorize Premise Health to disclose my results to any third party who has contracted with my employer to review and analyze those results in connection with the program. I understand that no information obtained or created as a result of my participation in this incentive program will be used to make any employment decision about me, but the information may be used by Premise Health, the administrator(s) of the health and wellness program and/or any third party entity that has contracted with your employer for purposes of administering the program.

I understand that this information may be disclosed through electronic means. I also understand that the 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.

Effective Date: This consent and authorization will expire five (5) years from the date of signature.

Right to Revoke Authorization to Release PHI: I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to the Health Center, or to Premise Health, Compliance Department, 5500 Maryland Way, Suite 120, Brentwood, TN 37027. I understand that my revocation of this authorization does not affect any actions taken prior to receipt of my revocation. I further understand that my revocation of this authorization may impact my ability to participate in the incentive program and/or receive the incentives.

Signature and Copy: I have read and understand this form in its entirety and voluntarily authorize the consent to treat and uses and disclosures of the information described above. I acknowledge that the person executing this form is the person participating in or receiving services, or such participant's legal representative who is authorized to act on such person's behalf to sign this form. I further acknowledge I am at least 18 years old. I understand that I have the right to receive a copy of this authorization upon request.

Participant

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

Participant or Legal Representative Signature:_____ Date:_____