Dear Main Line Health Employee:

Thank you for your interest in participating in this year's Making Life Healthy program!

Here are the instructions for **submitting your results from a biometric screening with your physician**:

Step 1: Fill out the form

- Complete the **Patient** section of the attached participation form.
- Sign the Authorization line.

Step 2: Complete a biometric screening with your physician

- Use results from a recent screening (no earlier than October 1, 2018), or schedule an appointment with your physician.
- Have your physician complete and sign the **Health Care Provider** section.

Step 3: Submit your completed form (either fax or mail)

- Fax: 610-350-3530
- Mail: Impact Health, 1009 W. Ninth Avenue, Suite A, King of Prussia, PA 19406

The deadline for submission is midnight on **September 30, 2019.**

Best of health!

Impact Health
Promoting Healthy Decisions

Physician Screening Form 2019

Patient: Please complete this section and sign the authorization below. (PRINT CLEARLY)

First Name: _____ Last Name: _____

Birth Date: ☐☐/☐☐/☐☐☐☐ Age: ☐☐

Employee ID #: _____ Gender: ☐ Male ☐ Female

Have you been diagnosed with diabetes or pre-diabetes? ☐ **Yes** ☐ **No**

Women only: Are you pregnant or nursing? ☐ **Yes** ☐ **No**

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Impact Health to use and disclose my test results and my responses to the health questions at the top of this form (the "Protected Health Information") to ***Active Health Management***, Main Line Health's wellness vendor, and the Delaware Valley Accountable Care Organization for the purpose of participation in Main Line Health's wellness program.

The Protected Health Information may be used by ***Active Health Management*** and/or the Delaware Valley Accountable Care Organization for the following purposes:

(1) to provide me with programs and materials that I may find useful; and
(2) to contact me regarding health and wellness services for which I am eligible

I understand that I have the right to revoke this authorization at any time by delivering written notice of my intent to revoke to: Impact Health, 1009 West Ninth Avenue, Suite A, King of Prussia, PA 19406 Attention: Privacy Practices. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the Protected Health Information have acted in reliance upon this authorization. I understand that if I do not consent to release this information to Active Health Management, I will not be eligible for the Rewards available.

This authorization is effective now and shall remain in effect for a period of one year, unless I revoke my authorization. I certify that I have received a copy of this authorization.

SIGN HERE → _____

Health Care Provider: Please complete and sign this section.

Your patient is participating in a wellness program and has elected to have their screening conducted by you. Please complete this section and return it to your patient for them to submit to the program.

Date of Screening ☐☐/☐☐/☐☐☐☐

Height ☐feet ☐☐.☐inches

Weight ☐☐☐.☐pounds

Waist ☐☐.☐inches

Blood Pressure ☐☐☐/☐☐☐mmHg

Total Cholesterol ☐☐☐mg/dL

HDL ☐☐☐mg/dL

TC/HDL Ratio ☐☐.☐

Glucose ☐☐☐mg/dL

Patient fasted for at least 8 hours prior to blood test? ☐yes ☐no

Health Care Provider Name: _____

Health Care Provider Signature: _____

Health Care Provider phone: ☐☐☐-☐☐☐-☐☐☐☐ NPI: _____

Please return this completed form to Impact Health by 09/30/19

Fax: **610-350-3530**
Mail: Impact Health, 1009 W. Ninth Avenue, Suite A, King of Prussia, PA 19406