Biometric Measures & Physical Confirmation

B

Take this form with you to your scheduled annual physical to be **completed and signed by your Primary Care Physician**. It is the participant's responsibility to submit the Biometric Measures & Physical Confirmation form as part of the complete packet to be returned to Healthy Directions as outlined below.

Employer Name: Buchanan County BOS, Schools, PSA, DSS (Buchanan County Consolidated)

Participant Name: _____ Date of Birth: _____

Previous/Maiden Name (if changed in last 12 months): _____

Preferred Phone: ____-____-_____ Preferred Email: _____

PHYSICAL CONFIRMATION

Type of Service Provided: **Complete Annual Preventive Physical** Date of Service: ____/____/_____

_____ _____

*Signature of health care provider (required) Date Signed

- All testing must have been completed between **1/1/2016-12/31/2016.**
- Primary care physician needs to complete all information with an * in front of it. Return signed form to participant.
  - * Does your patient have a history of coronary artery disease (MI, CABG, PTCA)? ☐ YES ☐ NO
  - * Does your patient have a history of diabetes? ☐ YES ☐ NO
  - * If no, does your patient have pre-diabetes? ☐ YES ☐ NO
  - * Does your patient exercise weekly? If so, how often? _____ days/week _____ minutes/day

BIOMETRIC MEASURES	VALUE	TEST DATE (Month/Day/Year)
*Total Cholesterol		
*Triglyceride Level		
*Glucose (fasting)		
*HDL Cholesterol		
*LDL Cholesterol		
Hemoglobin A1c (if physician recommended)		
*Systolic Blood Pressure		
*Diastolic Blood Pressure		
*Height (in feet, inches)		
*Weight (in pounds)		
*Abdominal Circumference (in inches)		

Participant submit completed packet by 1/15/2017

Choose one:

- Scan and email to buchanancounty@trihealth.com
- Send to the secure fax 513 852 3911
- Mail to Healthy Directions, 11129 Kenwood Road, Cincinnati, OH 45242

A + B + C =

Eligible to receive the monthly discount

Questions? Please contact buchanancounty@trihealth.com or call 866 256 9007.

Healthy Directions Registration & Consent A

PLEASE PRINT CLEARLY

Complete the information below to register for participation in Healthy Directions. A separate form must be completed if both an employee and spouse participate. *Your signature is required at the bottom of the form to confirm you have read and understand what is involved in participating in Healthy Directions.

Employer: Buchanan County BOS, Schools, PSA, DSS (Buchanan County Consolidated)

First Name: _____ Last Name: _____

Previous/Maiden Name (if changed in last 12 months): _____

Date of Birth: __/__/____ Select One: ☐ Male ☐ Female

Select One:

☐ Employee: Do you have a spouse on your Buchanan County Consolidated medical plan?
If yes, provide name: _____

☐ Spouse of Employee: Provide name of Buchanan County employee: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Preferred Phone: _____-_____-_____

Preferred Email: _____

Healthy Directions Program Participation Acknowledgement

My participation in the TriHealth Healthy Directions program is voluntary. I understand that initiating a follow-up examination to confirm results of any physical screening and obtaining professional medical assistance is my responsibility alone and not that of my health plan, employer (or spouse's employer/health plan) or Bethesda Healthcare,Inc./TriHealth, Inc.

Bethesda Healthcare, Inc. /TriHealth, Inc. will disclose to my (or my spouse's) employer that I had a physical and underwent laboratory testing. Bethesda Healthcare, Inc. /TriHealth, Inc. will make this disclosure in order for my (or my spouse's) employer to determine eligibility for discounts on medical insurance premium.
My (or my spouse's) employer will not have access to any of my specific medical information provided through the Healthy Directions Program.

My employer and/or health plan - or my spouse's employer/health plan - will have access only to aggregate data to assess population trends. ("Aggregate data" does not personally identify me but combines my individually identifiable medical information with those of other participants in Healthy Directions for review.) Through my participation in the Healthy Directions program, I consent to all of the following:

- Receipt of aggregate data as described in the previous paragraph by my health plan's/employer's or my spouse's employer/health plan.
- Receipt of such aggregate data by my health plan/employer - or my spouse's health plan/employer - wellness advisor, USI Insurance Services LLC and USI Holdings Corporation ("USI").
- Disclosure of my personally identifiable biometric data/report by Bethesda Healthcare Inc. / TriHealth, Inc. to the third-party data analytic vendor specified by my health plan/employer -or my spouse's health plan/employer - in order for such vendor to determine my eligibility for medical insurance premium discounts and/or for data aggregation as described above in this form.

I affirm that I have read, understand and agree to the terms set forth above, and I wish to participate in the Healthy Directions Program on the terms specified.

SIGN _____ _____

*Signature of Participant (Required) *Date