Appalachian Regional Healthcare

ARH Health Plan Biometric Screening Form

*** ALL INFORMATION IS REQUIRED TO PROCESS YOUR SCREENING FORM ***
(Incomplete or Illegible forms are at risk for not being processed)
Deliver Completed Form to Your Local Human Resources Department by December 31

Section 1: Patient Information *(To be completed by patient)*
(Please include name of employee cardholder if this form is being completed for an ARH employee's spouse)

Patient Name:		Street Address:
Patient Date of Birth:		City:
Last 4 digits of SSN:		State:
Gender: ❒ Female ❒ Male		Zip:
Cardholder name *(if patient is a spouse)*:		Phone:
Do you use Tobacco?	❒ No	❒ Yes: ❒ Cigarettes ❒ Smokeless Tobacco ❒ Both
Have you obtained this season's Flu Vaccine?	❒ No	❒ Yes: Date: _____ Location (indicate clinic/pharmacy name or if received at work):_____

Section 2: Physical Exam and Review of Labs (*To be completed by health care provider*)
***Patient Should Have Required Labs Drawn Before Appointment with Healthcare Provider**

Lab Panel Completed? ____Yes (Date: _____) ____No

Wellness Exam Completed? ____Yes (Date: _____) ____No

_____ _____
Health Care Provider's Name (Please Print) Date/Time

_____ _____
Health Care Provider's Signature Provider's Office Phone Number

Section 3: Patient Signature (Required)
By signing below, I give my medical provider listed above permission to provide me with a copy of this form. I acknowledge full understanding that it is my responsibility to submit a valid copy of this form to the ARH Human Resource office as proof of meeting the requirements of the Wellness Plan.
In the course of your participation in the biometric screening, ARH, its partners and its affiliates will collect information from your health provider, on behalf of your health plan. Some of the information you submit may be protected health information (for example, information such as your name, address, and information on your health). ARH and its affiliates use that information to provide you with the health plan benefits associated with your biometric screening, such as administering and providing wellness programming to you, and to conduct other health plan activities as permitted by law. By signing this form, you consent to the release of your biometric screening health records, including sample, by your provider to ARH, its partners, its affiliates and clinical diagnostic laboratories for the purposes of interpretation and analysis, and providing you with additional information about your health status. You also consent to the release of your health records to your health plan and plan sponsor in order to administer your wellness benefit and conduct other health plan activities as permitted by law. The provision of the last 4 digits of your social security number is optional and is used for internal tracking purposes only. ARH and its affiliates will maintain the confidentiality of your protected health information and will only release protected health information as described in your health plan's Notice of Privacy Practices.

Patient Signature and Date Required: _____