PHYSICIAN SCREENING FORM INSTRUCTIONS

CHI Healthy SPIRIT

Catholic Health Initiatives

Screening Collection Period: 05/01/2016- 11/30/2017
Submission End Date: 11/30/2017

CATHOLIC HEALTH INITIATIVES WELLNESS PROGRAM

Get to know your health numbers and discover what your numbers say about your health by completing the attached form. Schedule your annual physical with your physician and bring these forms to your visit.

If you have completed an onsite health screening at any of Catholic Health Initiatives' locations, please DO NOT submit this PSF form.

If you are pregnant, you may opt out of this health screening process. Please note, you are still required to complete Section 1; physician must complete Section 3.

STEP 1:

Print this entire document. Complete and sign Section 1.

- **Use a black pen.** Incomplete or illegible forms will not be processed.
- **To obtain your wellness ID**, log into My Healthy Spirit and click the "Preferences" link in the "My Healthy Spirit DASHBOARD." Please include the full wellness ID including any letters before the "\" in the ID.
- Read the 'Wellness Program Notice and Consent.'

STEP 2:

Physician completes Section 2 and 3.

Note: Lab reports may ***ONLY*** be used in lieu of a physician signature and must accompany a completed Physician Screening Form with all required fields completed. Full name and DOB must also be printed on each page of the report.

STEP 3:

<u>Employee or Physician</u> submits page two, the Physician Screening Form (as well as lab reports if applicable). Please do not rely on your Physician's office to submit the form. Submit by April 28th, 2017, using one of the following options:

Upload: https://chihealthyspirit.preventure.com

Fax: 855-385-5453. Retain a fax confirmation for your records.

Mail: Preventure
Customer Solutions Department
2000 Nooseneck Hill Road

If you have provided an email address, you will receive a confirmation email from Customer Support within three business days.

You're on your way!

Don't forget, you must also complete your Personal Health Assessment by April 28th, 2017.

Visit the Healthy Spirit website at: https://chihealthyspirit.preventure.com to complete your PHA and review all your other opportunities for Wellness Rewards.

Questions? Contact Preventure Customer Support, Monday - Friday 8 a.m. - 8 p.m. ET, at (888) 321-4326.

Screening Collection Period: 05/01/2016 – 11/30/2017
Submission Deadline: 11/30/2017

Physician Screening Form

*** If you have attended an onsite screening, DO NOT submit this PSF form ***

Please print clearly. Items marked with asterisk * are required.

Incomplete or illegible forms will not be processed.

Choose only ONE of the following submission options: 1) Upload Online: https://chihealthyspirit.preventure.com 2) Fax: 855-385-5453
3) Mail to: Preventure | Customer Solutions Department | 2000 Nooseneck Hill Road | Coventry, RI 02816

SECTION 1 - Personal Information (Participant/Patient Completes)

Participant/Patient First Name * | M.I. | Participant/Patient Last Name *

Employee First Name (if different from Participant/Patient) * | M.I. | Employee Last Name*

Employee's Company Name: C H I

Username * (see form instruction sheet for your Username format)

Date of Birth * | Primary Phone * | Secondary Phone

Email Address *(Required to receive an email confirmation of receipt of your form)*

Gender * ☐ Male ☐ Female

If female, are you currently pregnant? * ☐ Yes ☐ No

Participant Status * ☐ I am the Employee ☐ I am Spouse

By signing below, I acknowledge the Wellness Program Notice and Consent.

Participant/Patient Signature * | Date *

SECTION 2 - Clinical Information (Physician or Health Care Provider's Office completes – report only the tests required)

Date of Lab Work * | Height (total in inches) * | Weight (pounds) *

Measurements Required Values Marked *	Patient Results	Check only if Medically Unreasonable to Comply with Healthy Target Range
Body Fat % (optional)		Not Required
Waist Circumference (optional)		Not Required
Body Mass Index-BMI *		☐ Yes
Blood Pressure (Systolic/Diastolic) *		☐ Yes
Glucose (mg/dl) *		☐ Yes
Total Cholesterol *		☐ Yes
HDL Cholesterol (mg/dl) *		☐ Yes
LDL Cholesterol (mg/dl) *		☐ Yes
Cholesterol/HDL Ratio *		☐ Yes
Triglycerides (mg/dl) *		☐ Yes

SECTION 3 – Physician Information (Physician or Health Care Provider's Office Completes)

Physician or Health Care Provider's Name (please print clearly) * | National Provider Identifier (NPI) if applicable

Office Phone Number * | Date * | Physician or Health Care Provider's Signature *

The information you are submitting may be shared with a third party for the sole purpose of administering additional wellness program services or to conduct other wellness programming activities as permitted by law and will comply with applicable law. Preventure will maintain the confidentiality of your personally identifiable information and will only release personal information as permitted by law for the sole purpose of wellness program administration.

Wellness Program Notice and Consent

I consent to participate in Preventure's Biometric Screening and Wellness Program (the "Program"), which may include providing biometric measurements such as weight and blood pressure, disclosing laboratory results from a recent blood test with my personal physician, and/or completing other health and wellness services and programs. I understand that my participation in the Program is voluntary and that I am not required to participate as a condition of employment or of enrollment in my health plan.

I understand and consent to my personal physician providing Preventure with the results from a blood draw and laboratory analysis performed by my physician for the tests listed on the Physician Screening Form. I agree to execute any authorization form required by my physician prior to disclosing my results to Preventure. Such results will include lipids (cholesterol and components) and blood glucose measurements.

I consent to Preventure providing me with an online report of my Program results and, if applicable, periodically providing me with follow-up educational materials and information relevant to my results. The laboratory results reflected in my report are for information purposes only and are NOT a medical diagnosis.

I understand that my employer or benefits provider sponsors the Program. If an incentive is implemented as part of the Program, I consent to Preventure informing my Sponsor only whether or not I qualify for such incentive based upon my participation in the Program. I understand that if I do not elect to provide such consent, I may not qualify for such incentive.

I understand that my individual health data will be used by Preventure and will be treated as confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individual health information will be shared between my physician or care provider and Preventure, however will not be shared with my employer. I understand that Preventure will not disclose my individual health information to my employer. Aggregated data (i.e., data with no individual identifiers) on all participants, however, may be shared with my employer.

I understand that my employer or benefits provider may from time to time offer enrollees other health and wellness services and programs (collectively, "Other Health/Wellness Programs"), such as employee assistance and/or disease management programs. I consent to the disclosure by Preventure of my wellness screening results and/or other personal health information that identifies me to Other Health/Wellness Program providers so that they may contact me for the purpose of addressing my particular health/wellness needs. I understand that Preventure and/or my employer or benefits provider will require such Other Health/Wellness Program providers to agree to maintain confidentiality of any wellness screening results and/or other personal health information provided to them by Preventure in accordance with the applicable regulations under HIPAA.

I understand that if I do not want Preventure to disclose my wellness screening results and/or other personal health information to Other Health/Wellness Program providers sponsored by my employer or benefits provider, I must notify Preventure in writing at: Preventure, Inc., 2000 Nooseneck Hill Road, Coventry, RI 02816.

I understand that this consent will remain in effect for as long as I participate in the Program, and that I am entitled to a copy of this consent. I may revoke this consent at any time by notifying Preventure in writing, to the extent Preventure has not already relied on this consent.

By signing and submitting your Physician Screening Form you acknowledge the Wellness Program Notice and Consent.