Preventive Health Screening Form – Mennonite Village-MSNW

We are committed to your wellbeing and are providing an incentive to encourage you to complete your annual preventative health screening(s). Preventive health screenings are invaluable opportunities to identify any health concerns and ensure optimal health.

Participating is easy:

1. Schedule a preventive health screening visit with your health care provider. If you need help finding a health care provider, call DirectPath at 866-253-2273.
2. Bring this form to your screening and ask your provider to complete the bottom section and email the form to DirectPath at advocate@directpathhealth.com or Fax to 414-301-6963.
3. To receive any wellness incentives, **this completed form must be received by September 30th, 2021**

PATIENT NAME (First) **(Last)**			☐ **MALE** ☐ **FEMALE**
PATIENT E-MAIL		**PATIENT PHONE NUMBER**	
EMPLOYER NAME	**LAST 4 DIGITS OF SOCIAL SECUITY NUMBER**	**DATE OF BIRTH**	☐ **PRIMARY INSURED** ☐ **SPOUSE**

THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER: We are providing incentives for employees completing activities that promote optimal health. We are asking for physician verification of completion of an annual medical exam and key biometric screening measures. Please provide verification that the following biometric screening measures have been completed, **populate the values below**, sign to attest completion and email the form to DirectPath at advocate@directpathhealth.com . We sincerely appreciate your help in driving health awareness.

BLOOD PRESSURE	_____SYSTOLIC _____DIASTOLIC
HEIGHT	feet inches
WEIGHT	pounds (lbs)
GLUCOSE	
TRIGLCYERIDES	
TOTAL CHOLESTEROL	
LOW DENSITY LIPOPROTEIN (LDL)	
HIGH DENSITY LIPOPROTEIN (HDL)	
TOBACCO FREE (including e-cigarettes) for the past six (6) months	☐ Yes ☐ No
AGE & GENDER PREVENTIVE SCREENINGS UP TO DATE	☐ Yes ☐ No
VACCINATIONS UP TO DATE	☐ Yes ☐ No

Physician/Nurse/Technician Name (printed)	**Phone Number**
Physician/Nurse/Technician (signature)	**Date**

Employee: please read and sign page 2 prior to submitting this form!

We are committed to your wellbeing and are providing an incentive to encourage you to complete your annual preventative health screening(s). Preventive health screenings are invaluable opportunities to identify any health concerns and ensure optimal health.

PATIENT NAME (First) (Last)			☐ **MALE** ☐ **FEMALE**
PATIENT E-MAIL		**PATIENT PHONE NUMBER**	
EMPLOYER NAME	**LAST 4 DIGITS OF SOCIAL SECUITY NUMBER**	**DATE OF BIRTH**	☐ **PRIMARY INSURED** ☐ **SPOUSE**

***I, _____ (participant name), agree to release my personal health information obtained through the preventive health screening to DirectPath for outreach education for Wellness Incentive purposes. Additionally, I agree to release my personal health information to IMA Financial Group. This information will be used to provide de-identified aggregate group and program results to my employer. None of my personal health information will be shared with my employer.**

Authorized dates of services (select one):

____ All dates of services or Date Range: From _____ to _____

Expiration: This authorization will automatically expire when you are no longer eligible to receive DirectPath advocacy services through your employer.

Right to Revoke: You may revoke this authorization at any time, except to the extent that action or release has been taken in reliance on this authorization, by giving written notice to the address listed at the bottom of this page.

Release of Protected Personal Identifiable Information (PII)

To earn credit towards your wellness program incentive, DirectPath will notify your employer that you completed your wellness exam and/or completed Nurse Navigator health coaching calls. We will share only your first name, last name and the date of your exam/coaching call completion. **No personal health information will be shared.**

If you wish to be eligible for the wellness program incentive, please sign and date below. By doing so, you authorize DirectPath to release the above-mentioned information to your employer.

Signature: _____ Today's Date: _____

Authorized dates of services (select one):

____ All dates of services or Date Range: From _____ to _____

Expiration: This authorization will automatically expire when you are no longer eligible to receive DirectPath advocacy services through your employer.

Right to Revoke: You may revoke this authorization at any time, except to the extent that action or release has been taken in reliance on this authorization, by giving written notice to the address listed at the bottom of this page.