HEALTH SCREENING PROGRAM
CONSENT AND AUTHORIZATION

Barcode

The purpose of this voluntary health screening program offered through your employer is to gather sufficient information about you so you can receive an informative Healics, Inc. Health Report. The report you will receive and the medical information shared among Bellin Health, Healics, Inc., and the lab will constitute protected health information as defined by the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule). Bellin Health and Healics, Inc. have executed confidentiality agreements and certifications as necessary to comply with the HIPAA Privacy Rule.

Name of Employer Sponsoring HRA: Foth & VanDyke, LLC

Last Four Digits of Your Social Security Number (SSN*): XXX-XX-_____ Have you participated in a Healics health screening before? ( ) Yes ( ) No
**SSNs are kept confidential and used by Healics and the lab for identification purposes only and will not be used for report scorecards or mailings.*

Name (please print): _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: ( )_____ ( ) Mobile ( ) Work ( ) Home

E-mail: _____ Best Way to Reach You: ( ) Phone Call ( ) Text ( ) E-mail

Gender assigned at birth: ( ) Male ( ) Female Gender you identify with: ( ) Male ( ) Female ( ) Other

Date of Birth (Month/Day/Year): _____/_____/_____ Age: _____

Regarding the sponsor employer, are you the: ( ) employee ( ) employee's spouse ( ) retiree ( ) retiree's spouse ( ) other

If you are a spouse, what is the employee's name? _____ Last 4 of Employee's SSN: XXX-XX-_____

CONSENT TO HEALTH SCREENING BLOOD TESTS: I wish to participate in a voluntary Health Screening program sponsored by my employer or by my spouse's employer (the sponsoring employer). As part of that program, I hereby provide my consent to Bellin Health (and any provider working with Bellin Health on the health screening program, including, but not limited to, Healics, Inc., and/or Clinical Reference Lab) to take measurements, including my blood pressure, to draw blood samples from my arm and to analyze the blood sample and test results. I understand there are possible risks associated with taking blood pressure or drawing blood from my arm including, but not limited to, the risk of infection, discomfort and bruising. I understand that other, more remote risks may be involved, however the information I have received is sufficient for me to consent to the blood sample, testing, and analysis. The screening vendor is not responsible for such conditions or effects (for example, the screening vendor will not pay for a physician to visit to treat bruising). I understand that 1) the results from my blood test are preliminary only and do not mean I have a particular diagnosis, 2) the health screening is not intended to replace a full examination by my own primary care provider, and 3) I am responsible, if I choose, for sending copies of my health screening results to my personal physician and arranging any follow-up examination(s) deemed necessary by my primary care provider. I understand that the blood test results will be entered into and available through the Bellin Health electronic medical record system. I have read/had read to me the above. I have had the chance to talk about any questions and concerns, which were answered to my satisfaction. I understand and agree with the above. Dr. Brad Wozny will be the ordering provider for health screening lab tests. I understand that Healics and its vendors generally are required by law to maintain the confidentiality of the medical information I provide through the health screening. The medical information includes my biometric results and other information about the manifestation of a disease or disorder. Healics uses this information to provide services to me and / or my spouse, such as an analysis of certain health risk factors. Healics is restricted by privacy law in how my or my spouse's medical information can be used or disclosed. For example, the Genetic Information Nondiscrimination Act generally prohibits Healics from disclosing to my employer my spouse's genetic information (which generally includes his or her health status). Such spousal information generally cannot be made available to managers, supervisors or others at the employer who make employment decisions, or anyone else in the workplace. Healics has established privacy and security policies and procedures that discuss how my medical information will be properly held, used and disclosed. I knowingly and voluntarily provide my Consent.

_____ _____
Signature of health screening participant date/time Signature of Witness date/time

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH SCREENING INFORMATION: I understand that Bellin Health will be obtaining personal health information (PHI) from me as part of my voluntary participation in the Health Screening, including, but not limited to, the results of the measurements, blood pressure tests, and blood tests, and the information on my health questionnaire that I will be providing as part of the health screening process. I hereby authorize that all such information relating my Health Screening, including my PHI, may be used by Bellin Health (and the other health screening providers, such as Healics or Clinical Reference Lab, working with Bellin Health) to perform the health screening. I authorize such information to be disclosed by those parties to those vendors, including Healics, retained by Bellin Health or the sponsoring employer to process my Health Screening results and/or to provide health management services connected to the Health Screening Program. I understand that Bellin Health and all the vendors involved in the health screening process are required to maintain the privacy of my PHI except as I may specifically authorize**.** I authorize the release of my name as a health screening participant to the sponsoring employer for the purpose of creating a participant name list. In the event that the sponsoring employer offers an incentive or health management program related to the health screening lab values, scores, and/or nicotine results, I authorize the release of my lab values, scores, and/or nicotine results to the sponsoring employer or its designated agent to use in the incentive or health management program. I understand that no other PHI or other information resulting from the Health Screening will be shared with the sponsoring employer or with any other party not specifically authorized under this agreement. I understand the program including any possible consultation or follow-up is not a substitute for a full examination by my own physician. I accept responsibility for arranging any follow-up examinations that may be appropriate. I authorize Bellin Health to use my PHI for payment and health care operations and to send me targeted information, based upon my personal health profile, designed to assist me in lowering my health risks and accessing necessary health care services. I am agreeing that I have read, understand, and am voluntarily agreeing to all the terms outlined on this page and that no strikeouts or additional writing will be accepted on this authorization. I have had the opportunity to raise any questions or concerns with Bellin Health, or other health screening provider, which were answered to my satisfaction. I further agree, understand, and acknowledge the following:

- That this Authorization is meant to comply with all state and federal laws regulating the form and content of authorizations for disclosure of medical information, including but not limited to, the medical privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- That I have a right to request access to all my medical records that are used or disclosed pursuant to this Authorization
- That a photocopy of this Authorization will be as valid as the original.
- That I may request a copy of this Authorization.
- That I may refuse to sign this Authorization. Refusal to sign the authorization means that I am no longer eligible to participate in the assessment process.
- That this authorization will stay in effect until revoked or superceded by another agreement.
- That I may revoke this authorization at any time in writing, I understand that the revocation will not affect actions taken by parties in reliance on this Authorization.
- That my rights to revoke may also be limited by any Notice of Privacy Practices provided to me by my health care providers pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations.
- That I may contact the Bellin Health Privacy Offices at (920) 433-3595 for information on how to revoke my authorization,
- That disclosed PHI may be subject to redisclosure by the person receiving the PHI and privacy protections may be lost.
- That the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits (except as has been explained to me by the sponsoring employer) on my decision to sign this authorization.
- That I have been provided with a copy of Bellins Health's Notice of Privacy Practices.

I have read/had read to me the above. I have had the chance to talk about any questions and concerns, which were answered to my satisfaction. I understand and agree with the above.

_____ _____
Signature of health screening participant date/time Signature of Witness date/time

***Please answer the questions on the following pages. Bring the completed questionnaire to the health screening*. If your primary care provider has prescribed any medication, you must stay on that medication for the health screen. Screening facility: please scan the completed questionnaire to** screen_team@bellin.org Information will be stored on the Healics, Inc. Computer System Standard Form Version 4.01 6/2018 © Healics Inc.

1 Medical History

Condition	Have you ever been diagnosed or treated for any of the following conditions? (check box if yes)	Are you taking prescription medication for any of the following conditions? (check box if yes)
Allergies	❒	❒
Arthritis	❒	❒
Asthma	❒	❒
Back or neck pain	❒	❒
Blood pressure	❒	❒
Cancer	❒	❒
Cholesterol	❒	❒
Depression/anxiety	❒	❒
Prediabetes	❒	❒
Diabetes (Type 1)	❒	❒
Diabetes (Type 2)	❒	❒
Fibromyalgia	❒	❒
Heart attack	❒	❒
Heart conditions	❒	❒
Heartburn/acid reflux	❒	❒
Irritable Bowel Syndrome/Crohn's	❒	❒
Kidney disease	❒	❒
Liver disease	❒	❒
Lung disease	❒	❒
Lymes disease	❒	❒
Migraine headache	❒	❒
Obesity	❒	❒
Sleep disorder/trouble sleeping	❒	❒
Stroke	❒	❒
Thyroid disease	❒	❒
Other condition(s)	❒	❒
None of the conditions above	❒	NA
No prescription medications used	NA	❒

2 Pregnancy (Females only)

Are you pregnant? No ❒ Yes ❒ | Trimester 1st ❒ 2nd ❒ 3rd ❒ | Pre-pregnancy weight _____

Are you postpartum (0-12 months)? No ❒ Yes ❒ | Delivery date (mm|dd|yyyy) | | | | | | | | |

Lower of pre-pregnancy or postpartum weight _____

3 Weekly Exercise

On average, how many minutes per week do you exercise (excluding work activity), in which your rate of breathing and heart rate increases for a total of 10 minutes or longer?	150 mins or greater ❒	75-149 mins ❒	74 mins or less ❒

4 Ergonomics

On average, how many hours per day do you spend:	9+ hrs	7-9 hrs	3-6 hrs	Less than 3 hrs
Sitting	❒	❒	❒	❒
Standing	❒	❒	❒	❒
Performing repetitive motions	❒	❒	❒	❒

5 Sleep

On average, how many hours a day do you sleep?	9+ hrs ❒	7-9 hrs ❒	3-6 hrs ❒	Less than 3 hrs ❒

Do you experience interrupted sleep, sleep apnea, difficulty with quality sleep? No ❒ Yes ❒

6 Nicotine

Have you ever used products containing nicotine?

No ❒

I did, but I quit ❒ Quit date (mm|dd|yyyy) | | | | | | | | |

Current nicotine user ❒

I currently use nicotine in the following way(s):

Cigarettes ❒	Electronic cigarettes (vaping) ❒
Cigars ❒	Nicotine Replacement Therapy (gum/patch/lozenge) ❒
Pipe ❒	Chew/dip/pouches ❒

7 Alcohol

How often do you have a drink containing alcohol?

Never ❒ One time per month or less ❒ 2-4 times a month ❒ 2-3 times a week ❒ 4 or more times a week ❒

How many drinks containing alcohol do you have on a typical day?

0 ❒ 1-2 ❒ 3-4 ❒ 5-6 ❒ 7+ ❒

How often do you have six or more drinks on one occasion?

Never ❒ Less than once per month ❒ Monthly ❒
Weekly ❒ Daily or almost daily ❒

8 Safety

In the last 30 days, how often have you read/written texts or emails, viewed/responded to social media or watched videos on a phone or electronic device while driving?

Every time I drive ❒ Most of the times I drive ❒ Some of the times I drive ❒ Rarely ❒ Never ❒

In the last 30 days, how often have you been drowsy, dozed while driving or fallen asleep while driving?

Every time I drive ❒ Most of the times I drive ❒ Some of the times I drive ❒ Rarely ❒ Never ❒

9 Stress

Indicate how often the following apply to you:	Always	Usually	Sometimes	Never
I feel stress from work issues	❒	❒	❒	❒
I feel stress from family/personal relationships	❒	❒	❒	❒
I feel stress from financial concerns/issues	❒	❒	❒	❒
I feel stress from health concerns/issues	❒	❒	❒	❒

10 Emotional Health

Over the past two weeks, have you been bothered by thoughts that you want to hurt yourself or have you attempted suicide?	No ❒	Yes ❒
Do you currently suffer with or have you ever suffered in the past with an eating disorder?	No ❒	Yes ❒
Have you ever been in a relationship where you were threatened, hurt, or afraid?	No ❒	Yes ❒

National Suicide Hotline: https://suicidepreventionlifeline.org or 1-800-273-8255
National Depression Hotline, Substance Abuse and Mental Health Administration (SAMHSA) Helpline: 1-800-662-4357
National Domestic Violence Hotline: 1-800-799-SAFE (7233) or 1-800-787-3224 (TTY)

11 Readiness to Change

How would you like to enhance or improve your quality of life? Please rate your readiness to change using the key below:

Nicotine use	1	2	3	4	5	NA
Alcohol use	1	2	3	4	5	NA
Exercise habits	1	2	3	4	5	
Eating habits	1	2	3	4	5	
Stress management	1	2	3	4	5	
Weight management	1	2	3	4	5	
Sleep habits	1	2	3	4	5	
Financial management	1	2	3	4	5	

Readiness to Change key:
1 = I don't have a concern, I'm doing well in this area.
2 = I've begun making a positive change in the area, but need to maintain.
3 = I'm ready to start and want more information (may be used for program planning by your employer).
4 = I would like to start, but concerns are holding me back.
5 = I have a problem but I am not ready to make a positive change.
NA = Not Applicable

12 Interest Survey

Identify topics of interest to you (this may be used for program planning by your employer).

Personal health coaching ❒	Back/neck health ❒	Blood pressure ❒
Stretching ❒	Fitness ❒	Cholesterol ❒
Financial health ❒	First aid/CPR ❒	Wellness Workshops/Presentations ❒
Sleep health information❒	Men's health ❒	Nutrition ❒
Nicotine cessation ❒	Stress management ❒	Weight management❒
Women's health ❒	Emotional well-being program ❒	Employee Assistance Programs ❒
I am already engaging in activities of interest to me outside of my employer ❒		I'm not interested in any guidance or resources ❒

What would be your preferred method of receiving well-being information (if used for program planning by your employer)?

Email ❒ Printed Material ❒ Online ❒ Onsite activities ❒

13 Primary Care Provider

Do you have a Primary Care Provider? No ❒ Yes ❒

Have you had an annual physical with your Primary Care Provider in the last 12 months?	No ❒	Yes ❒
Do you share your health screening results with your Primary Care Provider?	No ❒	Yes ❒

14 Dental Care

Do you have at least one routine dental exam visit per year? No ❒ Yes ❒

15 Perceived Health

In general, how would you rate your physical health? Excellent ❒ Very Good ❒ Good ❒ Fair ❒ Poor ❒

16 Self-Reported Health Measurements

Height: ☐☐ feet ☐☐ inches Weight: ☐☐☐ pounds

Thank you for completing the Health Assessment!

The following is to be completed by a health screener at your health screening event.

Biometrics Record

Fill check boxes completely ○●○✍ with BLACK PEN ONLY

Please print, using numbers and UPPERCASE LETTERS ONLY A B C 7 8 9

Screening Date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
month day year

Participant Name

Last [ ] First [ ] Mid Init [ ]

DOB [ ] month day year

Was a blood sample taken? YES ○ NO ○

If yes, hrs. fasted? [ ]

If no, reason? [ ]

Gender: Male ○ Female ○

Females: Are you pregnant? YES ○ NO ○ | Are you postpartum (0-12 months)? YES ○ NO ○ | Delivery date: ____________

(Instruction to Screener: if pregnant/postpartum (0-12 months), do not measure weight or waist, but record pre-pregnancy weight below.)

Height (without shoes) [ ] feet [ ] inches

Weight (fully clothed without shoes)
(Pregnant: pre-pregnancy weight)
(Postpartum: actual or pre-pregnancy weight) [ ]

Males/Females: Inches around waist at navel (over clothes, to nearest ¼”) [ ] . [ ] Inches

Blood Pressure [ ] / [ ]

Repeat blood pressure if 130/80 or higher [ ] / [ ]

Repeat blood pressure if 160/100 or higher [ ] / [ ]

Optional [ ] / [ ]

Screening Participant: I indicate that the height, weight, waist and blood pressure measurements recorded by the screener are accurate – please initial here: [ ]

Screener Name: [ ]

Screener Location / Screener Notes: [ ]

Instructions to Screener:

Following the health screening, send completed questionnaires with cover sheet in a TRACKABLE method to Healics, Inc., 8919 W. Heather Avenue, Milwaukee, WI 53224.

Healics
With you for life