Primary Care Provider - Biometric Screening Incentive

Premise Health.

PARTICIPANT INSTRUCTIONS:

When utilizing your Primary Care Provider for the [2027] incentive, this form must be completed to receive credit for your biometric screening and/or review appointment.

- Wellness Incentive steps must be completed between [1/1/26] [10/31/26].
- To be eligible for the incentive, please fax this completed form and a copy of your lab results to the [Butler Advantage (Hamilton) Center] Health Center at [5138962399] by [10/31/26]
  You may also send to: Sharonville (fax): 513-612-5499 or Beavercreek (fax): 937-912-3321.
  **Please call the wellness center to confirm receipt of your outside provider form.

Note: You will need to FAST (no food or beverage) for 8 hours prior to the biometric screening. It is recommended that you drink plenty of water before the blood draw. You may also have black coffee. Take any medication as prescribed.

Premise Health personnel will not be responsible for contacting an outside provider or patients to correct an incomplete or incorrect form. Please confirm all information is completed and correct before faxing.

If not already completed, please sign the *CONSENT-Incentive Program Employee Notice and Authorization* (attached) and return to the Health Center along with this form.

PROVIDER INSTRUCTIONS:

Your patient is participating in a voluntary incentive program. To earn the incentive, your patient must complete the following:

- Annual blood work to include the labs listed below

Please print clearly in CAPITAL LETTERS and fill out each blank space area using an ink pen (*required). Please complete the below information as noted, attach a copy of the lab results, and return to the patient for submission for their annual incentive program by [10/31/26].

PATIENT INFORMATION:

*Patient's Last Name: _____ *Patient's First Name: _____

*Patient's Phone #: ( )_____-_____ *Patient's DOB:____/____/_____ *Date of Visit:____/____/____

REQUIRED VALUES:

*Height:_____feet_____inches *Weight:_____pounds

*Blood Pressure:_____/_____ *Waist Circumference (at navel level):_____inches

***Blood Panel** – must include the following and a copy of blood work must be included with this form to be eligible for the incentive.

Total Cholesterol	LDL Cholesterol	HDL Cholesterol	T. Chol/HDL Ratio
Triglycerides	Glucose, Serum	HbA1c (if glucose over 100 or known Diabetic)	

PROVIDER INFORMATION:

Provider's Name: (print) _____

Provider's Signature: _____

Provider's Office Phone Number: _____

Provider's UPIN/NPI: _____

Incentive Program Employee Notice and Authorization

Your employer has contracted with Premise Health Employer Solutions, LLC, along with its professional affiliates ("Premise Health") to provide certain health and/or wellness services in connection with your employer's voluntary incentive program.

If applicable, by participating in the Incentive Program, you consent to the collection of a blood specimen and/or bodily fluids. You understand and acknowledge that the collection of blood through a needle or fingerstick may cause pain, a bruise or, rarely, an infection. You also consent to the collection of additional biometrics (height, weight, blood pressure, waist circumference, and perhaps other measurements, as per the design of the program), health history, physical exam, health coaching and other services based on your employer's incentive program. You understand that a biometric screening and other screenings are not meant to replace the care of a medical professional and that Premise Health may recommend that you seek additional medical care based on the screening.

If applicable, by participating in the incentive program, you may be asked to complete a voluntary health risk assessment ("HRA") that presents a series of questions about your health-related activities and behaviors and whether you had or have certain medical conditions (e.g., cancer, diabetes, or heart disease).

If applicable, by participating in the Flu vaccination program, you may be asked to answer a series of questions about certain medical conditions.

Protection of Your Health Information: Premise Health agrees to abide by all applicable laws and regulations governing the privacy and security of your personal health information. To the extent, the information is subject to the Health Insurance Portability and Accountability Act and its implementing regulations ("HIPAA"), Premise Health will abide by HIPAA and maintain the privacy and security of your Protected Health Information ("PHI") in accordance with its Notice of Privacy Practices ("Notice"), which Premise Health has provided to you. This Notice is also available at Health Center and on the Premise Health website. You may also request a copy of this Notice from Premise Health at any time.

Authorization: I understand that my participation in the incentive program is strictly voluntary, but in order to determine my eligibility for health and/or wellness incentives, the administrator(s) of the health and wellness program must receive a record of my participation. By signing below, I authorize Premise Health to disclose information regarding my participation in the program with the administrator(s) of the program. If the incentive program includes by design a review of my results (e.g., measurement, test or blood specimen results) so that I can be provided recommendations in furtherance of my health, I authorize Premise Health to disclose my results to my employer, Premise Client or any third party who has contracted with my employer to review and analyze those results in connection with the program.

I understand that this information may be disclosed through electronic means. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Effective Date: This consent and authorization will expire five (5) years from the date of signature.

Right to Revoke Authorization to Release PHI: I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to the Health Center, or to Premise Health, Compliance Department, 5500 Maryland Way, Suite 120, Brentwood, TN 37027. I understand that my revocation of this authorization does not affect any actions taken prior to receipt of my revocation. I further understand that my revocation of this authorization may impact my ability to participate in the incentive program and/or receive the incentives.

Signature and Copy: I have read and understand this form in its entirety and voluntarily authorize the consent to treat and uses and disclosures of the information described above. I acknowledge that the person executing this form is the person participating in or receiving services, or such participant's legal representative who is authorized to act on such person's behalf to sign this form. I further acknowledge I am at least 18 years old. I understand that I have the right to receive a copy of this authorization upon request.

Participant

First Name:_____ Last Name:_____ Date of Birth:_____

Participant or Legal Representative Signature:_____ Date:_____