Good4U Wellness Club – *Primary Care Well Visit & Biometrics Authorization Form*

Name: _____ Date of Birth: _____ Age: _____ Female □ Male □
First name MI Last name

Note: If you are a covered SPOUSE under the Ancira medical plan, provide the employee' ID# and Ins. Member ID

Company Name: Ancira Good4Wellness Program Site Code: _____ EEID# 99__ __ __ __ Member ID: _____
Ex. "AWC, AMC, BRV, GMC, FLO, etc.

Address: _____ Cell #: _____ Email: _____
Street/P.O. Box City State Zip

Participant's CONSENT AND RELEASE – Participant, please READ this and sign below before giving it to your Doctor! By signing, I hereby consent to participate in the Ancira Good4 Wellness Program (hereafter "Program") and authorize my biometric screening results to be utilized for purposes of the Program. I understand that that a nurse, Health Coach, and/or similar healthcare personnel may review my results and contact me regarding how the health plan can assist with a medical condition in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA).

My personal results are NOT shared with Ancira, however they are aggregated and sourced by the selected provider/s in order to manage the Program and provide the most optimum benefit to the group. I acknowledge any specific medical questions or advice I seek should be directed to my physician. The results of any on-site health screenings are for basic knowledge only and do not take the place of, nor are intended to be substitutes for professional medical advice and do not replace the need for an annual well-visit with my Primary Care Physician (PCP). I agree that the responsibility for initiating a follow-up exam to confirm the results of any screening and obtaining professional medical assistance is mine alone and not that of any organization(s) associated with this screening, Ancira, or the Program. **I HEREBY WAIVE AND RELEASE AND HOLD HARMLESS ANCIRA, THE PLAN, THE PROGRAM, AND ANY ORGANIZATION(S) ASSOCIATED WITH THIS WELLNESS PROGRAM,** their affiliates, subsidiaries, directors, trustees, officers, employees, successors, and assignees from all liability, claims or causes of action for damages arising from or in any way connected with the Program and its administration.

I acknowledge that participation in the Program is voluntary. I acknowledge that the Program is intended to promote my health and well-being, but that I can withdraw at any time. Incentives may be offered in connection with the Program. **I acknowledge that if I choose to withdraw from participation in the Program, I will forfeit incentives offered by my employer in conjunction with Program participation. Program participation includes but is not necessarily limited to the successful completion of the Biometric Screening, establishment of a Medical Home, utilization of the Program's wellness coaching or other resources, obtaining routine care, and ongoing engagement with the Program.** "Participation" does not mean the meeting of specific biometrics; it means engaging with the Program resources. **Other eligibility requirements must also be satisfied. Participation is not a guarantee of future incentives. Program changes or discontinuation may be made at any time.** Program withdrawal includes, but is not limited to, voluntary withdrawal, involuntary withdrawal, noncompliance, covered spouse's non-participation, and similar. Final approval and effective date shall be the sole discretion of the Program representatives.

By signing this form below, you CONSENT to the terms and conditions contained in this form and to participate in the Program and authorize your provider to COMPLETE THE BELOW INFORMATION & submit this completed form to the fax # shown. Your personally identifiable information will remain confidential and will only be used to administer the wellness program or comply with applicable law or respond to valid legal process. **This information is only needed on primary insured & covered spouse.**

Insured's Signature:_____ **Date:**_____

****THE ABOVE MUST BE READ & SIGNED BEFORE SUBMITTAL TO YOUR DOCTOR. IT AUTHORIZES THEM TO DO THE NEXT SECTION****

May only be completed by Physician's office

Recommended Labs & Screenings (as applicable to Gender, Age, & per **Physician's judgment**)
Minimum 8 hours FASTING required (water/black coffee only) for labs unless Diabetic!
The following must be conducted in an in-network facility

		Biometric Data **Date of this Screening:** _____	
□ CBC & BMP (annually)	□ Skin Cancer Screening (annually)	Hours Fasted:	Total Cholesterol:
□ Thyroid & Hormone	□ Pelvic/Pap (annually)	Weight:	HDL:
□ Mammogram (40+) □ DEXA	□ Clinical Breast Exam (annually)	Height:	LDL:
□ PSA (40+ males)	□ Clinical Prostate Exam (annually)	Triglycerides:	Body Fat:
□ Fecal Occult □ Sig/DCB Enema/Colonoscopy or □Virtual Colonoscopy Imaging □ Coronary Artery Calcium Scoring — **Age 50+ every 5-10 years / Physician's judgment**	□ Vaccines/Booster Updates Tetanus Polio Hep Flu _____ [ ]N/A or declined	Glucose:	A1c:
		Urine Alb:	GFR:
30+ Min. Aerobic Activity □ 3x/wk or More □ Less than 3x/week or None If"<less than 3x/wk", is patient willing & able to add walking 20 min.3x/wk/60 days*? □Y □ N *If A1c, BP, or Cholesterol levels are elevated, please schedule re-check 60 days post walking regimen(w or w/o meds)		Neck Circumf:	Waist Circumf:
		Resting Heart Rate:	BP: _____/_____

Tobacco Use in past 6 months? □ Never □ No □ Yes Smoking exposure in household? □Never □When growing up □Current/Family member
If YES: Any interest in quitting? Patient may consult 90 Degree Benefits @ 888-267-4445 for a variety of cessation benefits including no cost RX and EAP services.

Physician/PCP Name	**NPI#**	**FEIN**
Address, City/Zip	**Physician's Signature:**	**Date:**
Office Phone #:	**Fax this completed form to 90 Degree fax # 806-698-5844 or return it to the patient to do so.**	