Instructions for Receiving Your Biometric Health Screening From Your Personal Physician

We are pleased you are participating in the biometric health screenings this year. Participation in the biometric health screening is confidential. Please review these instructions to ensure your information is complete and sent to the correct location.

See your primary care physician

1. Call your physician to schedule an appointment for your screening, OR if you already have lab results from your physician visit dated on or after September 3, 2014 you may ask your physician to submit those results with the data form on page two.
2. Fill out the Participant Information section of the Data Form provided with this package and bring it to the screening.
3. Leave the Data Form with your doctor.
4. Let the clinic/doctor know the completed form must be faxed by February 15, 2015, to:

   Wellness Corporate Solutions
   Attn: Information Management
   
   SECURE FAX: 888-972-5572

Please ask the office/physician to fax the completed data form to Wellness Corporate Solutions on or before February 15, 2015*.

Results from your biometric screening will be uploaded to the wellness portal within 2-4 weeks of submission. Please provide an email address on the data form to ensure you receive a submission confirmation email. You will receive this email within 10 business days of submitting your PCP form. If you do not receive a confirmation email or if you have any questions, please contact LiveHealthier Customer Service at 1-888-471-8851 or WKU@livehealthier.com.

Spouses/Partners should use their WKU employed spouses/partners employee ID followed by “S.” For example, if the employee ID is 800456789 the corresponding spouse ID would be 800456789S.
DATA FORM FOR HEALTH SCREENING WITH YOUR PERSONAL PHYSICIAN

PARTICIPANT: Complete participant information, bring form to provider for completion. Retain a signed copy for your records.

PROVIDER: Complete Body Measurements & Biometric Results and sign the form. FAX completed form to Wellness Corporate Solutions at 888-972-5572 by February 15, 2015

I understand that the purpose of my health screening is to evaluate my health status and any potential health risks. I hereby request and authorize Wellness Corporate Solutions, LLC to transmit health information about me to the health management companies that provide services to my employer so that these companies may help me reduce, manage and/or control any such risks. I understand that Wellness Corporate Solutions, LLC is not responsible for diagnosing, treating, or preventing any medical disease or condition that I currently have or may have in the future. I also understand that Wellness Corporate Solutions, LLC will not give me medical advice and that I must seek such advice from my own physician. I understand that Wellness Corporate Solutions, LLC will not provide my employer any health information that identifies me. I acknowledge and agree that Wellness Corporate Solutions, LLC may provide my employer aggregate statistical health information which includes my health information. I understand that Wellness Corporate Solutions, LLC may also use my health information for its own internal business purposes such as to develop future wellness programs. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. I voluntarily agree and consent to participate in the health screening and accept and assume all risks associated with such participation. I hereby release and forever discharge Wellness Corporate Solutions, LLC, its owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney’s fees and costs, arising out of or in any way related to my participation in the health screening.

PARTICIPANT INFORMATION (TO BE COMPLETED BY THE PARTICIPANT)

FIRST NAME

LAST NAME

DATE OF BIRTH (MM/DD/YYYY)

GENDER: Male Female

RELATIONSHIP: Employee Spouse

PHONE NUMBER

HOME STREET ADDRESS

CITY

STATE

ZIP CODE

EMAIL ADDRESS

SCREENING DATE

FASTING STATUS: Yes No

BODY COMPOSITION & BLOOD PRESSURE

HEIGHT (without shoes) feet inches

WEIGHT (without shoes) Pounds

BMI kg/m²

WAIST Inches

BLOOD PRESSURE mmHg

TOTAL CHOLESTEROL mg/dL

HDL CHOLESTEROL mg/dL

LDL CHOLESTEROL mg/dL

TRIGLYCERIDES mg/dL

GLUCOSE mg/dL

NOTES:

PHYSICIAN SIGNATURE (REQUIRED)

PHONE NUMBER (Provider/Clinic)

PLEASE FAX COMPLETED DATA FORM TO: WELLNESS CORPORATE SOLUTIONS, SECURE FAX: 888-972-5572