

PHYSICIAN SCREENING FORM – ONE HOPE UNITED

Your discounted medical plan rate will be applied upon receiving your screening results. Employees who have completed their biometric screening on or after September 1, 2019 WILL NOT need to complete another screening to receive lower medical premiums. If you have not participated in a biometric screening, or if you completed your screening before September 1, 2019, then you WILL have to complete a biometric screening in order to receive the lower medical premiums. Please scan and upload the completed form to <https://onehopeunited.uswellness.com> or fax to (240) 477-1528. Receipt of this form will be confirmed by US Wellness within two business days to the email provided below (please print clearly and allow emails from uswellness.com). Your medical plan allocation will be updated with 2 weeks of receiving this form.

STEP 1: To be completed by employee

<input type="text"/> First Name	<input type="text"/> Last Name	
<input type="text"/> Street Address		
<input type="text"/> City	<input type="text"/> State	<input type="text"/> Zip
Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> (Month) (Date) (Year)	Gender: <input type="checkbox"/> <input type="checkbox"/> Female Male	Phone Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/> E-mail address (to receive e-mail verification that form was received by US Wellness)		

STEP 2: To be completed by employee

I understand that any individually identifiable health information about me obtained in the course of this screening may be released to and maintained by US Wellness. I authorize US Wellness to share my individually identifiable health information with Strateben, Inc. and Deerwalk for the purpose of aggregate population health analysis. I understand that my information will not be shared with my employer. I authorize that US Wellness, Strateben, Inc. and Deerwalk may contact me and that my information will be managed in accordance with the uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule.

X

Employee Signature (SIGNATURE REQUIRED)

Date

STEP 3: To be completed by physician office

PREGNANT Yes No

<p>Cholesterol</p> <p>Total Cholesterol: <input type="text"/></p> <p>HDL Cholesterol: <input type="text"/></p> <p>LDL Cholesterol: <input type="text"/></p> <p>Triglycerides: <input type="text"/></p> <p>Was patient fasting for more than 8 hours prior to this test? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Date of Test: <input type="text"/> <input type="text"/> <input type="text"/> (Month) (Day) (Year)</p>	<p>Glucose (Blood Sugar)</p> <p><input type="text"/></p> <p>Was patient fasting for more than 8 hours prior to this test? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Date of Test: <input type="text"/> <input type="text"/> <input type="text"/> (Month) (Day) (Year)</p> <p>Waist Circumference</p> <p><input type="text"/> inches</p> <p>Date of Measurement: <input type="text"/> <input type="text"/> <input type="text"/> (Month) (Day) (Year)</p>	<p>Blood Pressure</p> <p>Systolic: <input type="text"/> / <input type="text"/></p> <p>Diastolic: <input type="text"/></p> <p>Date of Test: <input type="text"/> <input type="text"/> <input type="text"/> (Month) (Day) (Year)</p> <p>Height: <input type="text"/> (Feet) <input type="text"/> (Inches)</p> <p>Weight (lbs): <input type="text"/></p> <p>Date of Measurement: <input type="text"/> <input type="text"/> <input type="text"/> (Month) (Day) (Year)</p>
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Health Care Provider Name

Health Care Provider Signature

Phone Number

Date

STEP 4: To be completed by employee (recommended) or physician office. Scan and upload your completed form to <https://onehopeunited.uswellness.com> or fax to (240) 477-1528. Please note, if you choose to have your physician's office fax the screening form, follow up with your physician's office to ensure it has been sent. Email confirmation will be sent to the email address provided above within two business days of US Wellness' receipt of this form