PRIMARY CARE PHYSICIAN BLOOD WORK & BIOMETRIC SCREENING FORM

WHEN COMPLETE, PLEASE SCAN & EMAIL THIS FORM TO HELP@MYACCWELL.COM

PARTICIPANT MUST COMPLETE TOP SECTION:

ACC ID NUMBER

LAST NAME

FIRST NAME

MIDDLE INITIAL

DATE OF BIRTH (MM/DD/YY) ___ / ___ / ___

PHONE ___ – ___ – ___

GENDER (CHECK A BOX) ☐ MALE ☐ FEMALE

Have you been diagnosed with diabetes? NO ☐ YES ☐

Are you pregnant? NO ☐ YES ☐

I am voluntarily participating in the biometric screening performed by ACC Wellness. I understand my participation has no impact on my employment. I release ACC Wellness from all liability associated with any aspect of these services. This biometric screening may provide a better understanding of my health and lifestyle. This biometric screening is only educational and not meant to diagnose illness or replace any health care. I will direct questions about a specific illness or condition to my personal physician. ACC Wellness may collect or have access to my Protected Health Information (PHI) e.g., name, date of birth, screening results, etc.) derived from, or related to my biometric screening. I authorize ACC Wellness to disclose my Protected Health Information to Unified Government of Athens-Clarke County designated partners for the administration, development, and evaluation of Wellness initiatives. Otherwise, ACC Wellness will not disclose my PHI except as allowed by Federal and State laws without my express authorization. This authorization is valid until revoked in writing by me, sent to Attn: ACC Wellness, 375 Satula Avenue, Athens, GA 30601. Such revocation is effective upon receipt. My "Acceptance" below confirms I read this form and agree to its terms. Refusing to grant authorization does not affect disclosure of my information otherwise permitted by law. 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. Except for unlawful uses or disclosure of my PHI, I release and hold harmless my employer, ACC Wellness, and the vendors involved in providing the biometric services described above from liability that may arise from my participation in this biometric screening, except for injuries arising from their respective gross negligence or willful misconduct.

Participant's Signature

Today's Date (MM/DD/YY) ___ / ___ / ___

FOR PHYSICIAN OR OFFICE STAFF USE ONLY BELOW THIS LINE. *Blood work results may be written in below or sent separately.*

Weight	lbs.	**Blood Pressure Systolic**	mmHg	**Total Cholesterol**	mg/dl
Waist (around navel)	inches	**Blood Pressure Diastolic**	mmHg	**HDL Cholesterol**	mg/dl
Glucose	mg/dl	**Triglycerides**	mg/dl	**LDL Cholesterol**	mg/dl

Physician's Signature

Date of Exam (MM/DD/YY) ___ / ___ / ___

Physician's Name

Office Phone ___ – ___ – ___