2021 Physician Biometric Screening Form

HbD International

THIS PAGE DOES NOT NEED TO BE FAXED TO HBD. THIS IS FOR PARTICIPANT INFORMATION ONLY.

To be eligible for Preferred Premiums in 2022, the following criteria will apply to complete a biometric screening AND the online Member Health Assessment (MHA) during 2021:

- All associates hired on or before 9/30/2021 must complete & submit both items by **11/30/2021**

Instructions:

- Please ensure all items for the biometric screening are completed. You may use results from 9/1/2020 or later. *For any result which cannot be completed, please provide a reason or note, otherwise the participant's screening may show as incomplete*
- Ensure the participant has been shown and understands the ***Consent and Disclosure***, and that they sign that section on the results page
- Only the results page needs to be faxed to HBD at 844-206-1533
- Keep a record or copy of the date this screening is completed and a copy of the fax confirmation page
- **Remind the participant that to qualify for the incentive they must also complete the MHA.**
  If they have not already completed the MHA, please ask them to complete the MHA by either:
  - Logging in to DENSOHealthyHorizons.com (if they do not know how to log in, click "Contact" and ask for help)
  - Complete the MHA on-site with any of the Healthy Horizons health coaches
  - If they cannot do either of the above, then they can call HBD at 866-996-2155

PARTICIPANT MUST READ & UNDERSTAND THIS SECTION AND SIGN ON NEXT PAGE.

Consent for Voluntary Participation and Authorization of Disclosure:

I hereby consent to voluntarily participate in a health screening by a physician of my choice in order to participate in my employer's wellness program which will include a measurement of my Cholesterol and lipid panels, blood glucose, blood pressure, waist, height, and weight.

I understand it is my responsibility to ask questions or follow up results directly with my practitioner and in no way hold HBD (including affiliates, employees, agents, and contractors) or my employer liable for any grievance which may arise as a result of my participation in this screening.

I understand that the information collected during this screening will be treated as confidential. **I authorize my physician to release the information obtained in this screening to HBD.** While individual health information will not be shared with my employer, I understand that my health information may be used to evaluate the impact of wellness programs or be included in aggregate information or group summary data provided to my employer.

My health information may be shared within HBD in order to provide more personalized programming or coaching as a part of my participation within the wellness program. I authorize HBD to use and disclose my protected health information, including to my employer in the minimum amount of detail as necessary for incentive eligibility. This authorization relates to any information collected as part of my participation in this screening as well as data collected through other aspects of the wellness program.

I understand I have the right to revoke this authorization, or to review and dispute my health information at any time by contacting HBD, in writing, by addressing correspondence with Attention to: Data and Privacy Officer, PO Box 382, Enola PA 17025. I understand that if I revoke this authorization I may no longer be eligible for certain incentives, however I am still able to participate in the wellness program.

Complete your MHA and view your screening data at DENSOHealthyHorizons.com or speak with a Healthy Horizons Health Coach to check your data is complete.

Healthy HORIZONS
kaizen your life

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PARTICIPANT: I have read and understand the "Consent for Voluntary Participation and Authorization of Disclosure" which accompanied this results page. I know that if I have questions or wish to revoke my consent I can do so by contacting HBD in writing at HBD International, LLC, PO Box 382, Enola PA 17025.

Participant Name (please print): _____ Date of Birth: _____

Signature: **Today's Date:**

DENSO location or affiliate where I am employed (Circle): DIAM DMMI DMTN DMAT DMAR DPAM DMNC

If "other", please write your location here: _____ I was hired after 1/1/21: Y / N

PROVIDER TO COMPLETE

Please print clearly and complete ALL sections.

Date of screening:	Total Cholesterol (mg/DL):	HDL (mg/DL):
Triglycerides (mg/DL):	Blood Glucose (mg/DL): ☐ Fasting ☐ Non fasting	Blood Pressure: /
Height: (Inches)	Waist measurement: (Inches)	Weight: (Pounds)
Provider Name (print):		
Medical practice name:		
Address:		Phone:
State of license:		

Provider Signature: **Date:**

Notes or additional information: _____

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