HEALTHY MIAMI PREMIUM DISCOUNT PROGRAM
CONSENT FOR BIOMETRIC HEALTH SCREENING

I have been informed and I understand that my participation in the Healthy Miami Premium Discount Program (the "Program") is completely voluntary. I understand that TriHealth, Inc. on behalf of its affiliates including Bethesda Healthcare, Inc. ("TriHealth") performs biometric health screenings as part of the Program on behalf of the Miami University Health Plan (the "Plan").

If I choose to participate in the Program I must obtain a biometric health screening and I hereby consent to the performance of the following:

- Blood pressure screening
- Height and weight measure for purposes of calculating body mass index ("BMI")
- Complete a fasting blood draw for the purpose of performing the following screening tests:
  - *Comprehensive Metabolic Panel*
  - *Lipid Panel*
  - *Complete Blood Count (CBC panel)*
  - *Iron, thyroid stimulating hormone (TSH), and if applicable colon health kit*
  - *HemoglobinA1c for fasting glucose over 100*

The purpose of a biometric health screening is to evaluate selected physical measurements and lifestyle factors that help to identify risk for potential health problems. I understand that the data derived from this screening is to be considered preliminary only, does not constitute a diagnosis, and that this screening conducted under the Program is not a full medical exam. The information provided to me through this screening is not intended to be a substitute for professional medical advice.

I understand that risks of the screening may include discomfort such as soreness, bruising or adverse reactions. I also understand that it is my responsibility to disclose to the person conducting the screening any known allergies, medical conditions, and medications I am taking prior to the assessment or screening.

I understand that the responsibility for initiating a follow-up examination to confirm results of any screening and obtain professional medical assistance is mine alone, and not that of my employer, the Plan or TriHealth. If I display disease symptoms, fall into certain high risk categories, or receive abnormal results, I am solely responsible for consulting my physician before embarking on any course of action or lifestyle change.

I understand and agree that TriHealth is not liable for any health consequences resulting from my participation in the Program.

I affirm that I have read, understand, and agree to the terms set forth above and I wish to participate in the Program.

PRINTED NAME OF PARTICIPANT: _____

SIGNATURE OF PARTICIPANT: _____ **DATE:** _____

BIOMETRIC HEALTH SCREENING RESULTS **FASTING? Yes** ☐ **No** ☐

Participant Information (Please Print):

Date of Birth _____/_____/_____ **Age**_____ **Select One: Male** ☐ **Female** ☐

Select One: Employee ☐ **Spouse** ☐ **If Spouse, indicate Name of Employee** _____

Phone: _____ **Email:** _____ **Last 4 digits of SSN#:** _____

Colon Health Kit? Yes ☐ **No** ☐ (*applicable for those age 50+ as of Dec. 31, 2020*) ***Staff:*** *colon kit* ☐ *yes* ☐ *no* ☐ *waive*

IF NO LABEL - Complete this box

Last Name: _____

First Name: _____

Middle Initial _____ ☐ Male ☐ Female

Miami Unique ID: _____

Staff Use Only ☐ *All info complete* ☐ *Entered in to EMR*

BP _____/_____ **mmHg**

Height _____ **ft**_____**in** **Weight**_____**lb**

Optional:
Hip Cir _____ **in** **Waist Cir** _____ **in**

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION
HEALTHY MIAMI PREMIUM DISCOUNT PROGRAM

TriHealth has been engaged by Miami University Health Plan (the "Plan") to provide biometric health screenings as part of the Plan's Healthy Miami-Premium Discount Program (the "Program"). I authorize TriHealth, Inc. on behalf of its affiliates including Bethesda Healthcare, Inc. (referred to hereinafter collectively as "TriHealth") to use and/or disclose my individually identifiable health information as described below.

I understand it is a requirement of the Healthy Miami Premium Discount Program to have annual well visit with a primary care physician. By completing the "physician information" below I authorize the named physician to receive my biometric health screening results and the other information described on the health screening results form (*e.g.* blood test results) (collectively, the "Biometric Health Screening Results").

I further authorize TriHealth to disclose my Biometric Health Screening Results to the Plan's designated third party in order for such third party to: (1) make premium discount determinations for the Plan; and (2) create and report Aggregate Data to the Plan for the Plan to assess population trends. "Aggregate Data" means a combination of my data with the data of other participants in the Program that prevents the personal identification of me or any other participant. **I understand that my employer will not receive nor have access to my personally identifiable health information as part of the Program**. I further authorize TriHealth to release my Health Screening Results to Cerner Wellness and The Advisory Board for the purposes of providing in-person and on-line results to me, if I wish to do so.

TriHealth may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization TriHealth will not withhold treatment from you nor will your health plan enrollment or eligibility for benefits be affected. I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law.

I understand that I may revoke this Authorization at any time by notifying TriHealth in writing by sending a letter to: Bethesda Healthcare, Inc., 11129 Kenwood Road, Cincinnati, Ohio, 45242, attention of: Practice Administrator, Cynthia Traficant. I understand that if I revoke this Authorization, it will not affect any actions that TriHealth took before it received my revocation letter.

This Authorization will expire one year after the date below.

Physician Information

If you choose to participate in the Program in order to receive the full premium discount you must complete an annual well visit with a physician. Your health screening results will be sent to your designated physician below.

Name of Physician (first and last): _____

Physician's address (Street/City/ Zip Code:_____

Physician telephone number: _____

Physician FAX number: _____

PRINTED NAME OF PARTICIPANT: _____

SIGNATURE OF PARTICIPANT: _____**DATE:** _____

Are there other health concerns you would like to share with your biometrics team today?

_____

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