Name	Wellness #
Address	
City, State Zip Code	

Telephone (work)	Telephone (home)	

Social Security Number (Last 4 digits) XXX-XX-	AGE	Birth Date	Gender ○ FEMALE ○ MALE
Have a personal medical provider? ◻ NO ◻ YES			

PLEASE CHOOSE ONE OF THE FOLLOWING HEALTH SCREEN PROFILES

( ) Wellness Profile $10.00

Glucose and good/bad breakdown of cholesterol, and GFR (these are included in the Health Screen Profile)

( ) Health Screen Profile $50.00

Glucose, cholesterol/lipid panel, BUN, Creat, Lytes, Ca, Total Protein, Albumin, AST, Alk Phosphate, Total Bili, ALT, CBC, Hgb, Hct, GFR, and TSH

( ) Health Screen Profile and PSA $70.00

Same as the Health Screen Profile plus addition of the PSA Screening for Prostate Cancer for Men

( ) Blood Typing $2.00

Find out your blood type (will receive card with it listed)

( ) PSA Screening $20.00

Prostate Cancer test for men

Advance Beneficiary Notice and Release of Information:
Hamilton Memorial Hospital District

Because your physician did not order these specific Laboratory tests, they are not covered under Medicare or Private Insurance. Thus it cannot be turned in to any agency for payment coverage.
By signing below you are agreeing to the statements and agree that you will not turn these in to your insurance carrier.
You may list your personal care physician as indicated below so that a copy of your lab results can be faxed to their office.
If your physician's office is not in McLeansboro – you need to provide the listed information so we can fax to their office.

To receive a copy of your own results, an Authorization for Release of Information has to be signed. This is accomplished by signing below.

I hereby authorize to release to my primary care physician and myself the following information:
Wellness Health Screen Profile and Laboratory Results.
This authorization expires 120 days from date signed.

I understand this screening is not performed by a physician and is not intended to be diagnostic of any medical condition.

I further understand it is my sole responsibility to follow up with my/a physician regarding any screening results or other information I obtain from my participation in the Wellness Screening Fair.

I agree to release and hold harmless Hamilton Memorial Hospital, including any of its employees or independent staff physicians, from any and all claims, of any nature whatsoever, related to my participation in the Wellness Screening Fair.

Signature: ______________________________ Date: __________

My Primary Care Physician in McLeansboro, IL is: ***please circle below***

Alec B. Hood, MD	K. Murugappan, MD
Jodi Pelegrin, DO	R. Brad Ringhofer, M.D.
Mike Davenport, FNP	Laura Devous, FNP
Wes Henson, FNP	Heather Johnson, AGACNP
Diana Mugge-Vaughn, FNP	Kathy Taylor, FNP

OTHER PROVIDER:

Name: ______________________________

Address: ______________________________

City /State /Zip Code: ______________________________

Phone Number: ( ) ______________ Fax Number: ( ) ______________

TOTAL COST:

[ ] cash
[ ] check

Payable to: Hamilton Memorial Hospital