Name	**Wellness #**
Address	
City, State Zip Code	
Telephone (work) / **Telephone (home)**	

Social Security Number	**AGE**	**Birth Date**	Gender
___ ___ ___ - ___ ___ - ___ ___ ___			o FEMALE o MALE

Email Address -

PLEASE CHOOSE ONE OF THE FOLLOWING HEALTH SCREEN PROFILES

() **Health Screen Profile and PSA** **$70.00**

Includes same testing as $50 Health Screen profile with the addition of PSA screening for prostate cancer in men

() **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

( ) **Vitamin D** **$35.00**

() **A1C Screening** **$25.00**

Diabetic three-month sugar check

() **PSA Screening** **$20.00**

Prostate Cancer test for men

() **Wellness Profile** **$10.00**

Includes glucose and good/bad breakdown of cholesterol.

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 above 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.
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 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 and Family Clinics, 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 Provider (PCP) in McLeansboro or Carmi is: _____

Please Circle One *(results can only be sent to one provider)*

A. Hood, MD

M. Warren, NP

I. Chernysh, DO

L. DeVous, FNP

H. Johnson, AGACNP/FNP

J. Jacobs, FNP

K. Wirth, NP

OTHER PROVIDER:

Name: _____

Address: _____

TOTAL COST:

[ ] cash

[ ] check

Payable to Hamilton Memorial Hospital