Employee Health Fair

AT MEMORIAL REGIONAL HEALTH

Last Name: _____ First Name: _____ MI: _____

☐ Male ☐ Female Date of Birth (MM/DD/YYYY): _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Day Time Phone: _____ Alternate Phone: _____

Email: _____

X	Select "X" to Request Testing	Amount	Total
	GROUP A TESTS		
☐	Blood Chemistry Screening (GLD)	$0	$
☐	Blood Cell Count Screening (LAV)	$0	$
☐	Vitamin D Screening (GLD)	$40	$
☐	Hemoglobin A1C (LAV)	$20	$
☐	$10 discount for All Group A Tests (no deadline)	$50	$
	GROUP B TESTS		
☐	PSA Screening **MEN ONLY** (GLD)*	$10	$
		TOTAL	$

Payment Method

☐ Cash

☐ Check

Note: Results will NOT be posted in the MyChart Patient Portal

** The PSA test has been widely used to screen men ages 50-69 for prostate cancer. It is also used to monitor men who have been diagnosed with prostate cancer to see if their cancer has come back after initial treatment or is responding to therapy. Some advisory groups now recommend against the use of the PSA test to screen for prostate cancer because the benefits, if any, are small and the harms can be substantial. None recommend its use without a detailed discussion of the pros and cons of using the test.*

# of Hours Fasting: _____ *A 12 hour fast is recommended. Diabetics should not fast.*

CONSENT & RELEASE

I request and grant ***permission*** to Memorial Regional Health and volunteers and organizations participating in Craig's Community Health Fair to perform certain health screenings for me. I understand that my personal identifying information and test results will be confidential.

In the event of an accidental needle puncture or other biohazard exposure, I authorize additional precautionary testing of the sample.

I understand that ***health screenings*** will be performed at no charge to me, except for the optional blood analysis, and /or any other special screenings for which a fee is charged. Third party payers will not be billed. I also understand that health screenings can provide only certain preliminary measurements, and cannot be relied upon to diagnose the existence or absence of any medical condition. I understand that my participation in Craig's Community Health Fair is not a substitute for examination by a healthcare professional/provider, and that I alone am responsible for obtaining, from a doctor or other qualified healthcare professional/provider, medical information or services concerning: (1) any aspect of my health, and (2) any information I may receive from Craig's Community Health Fair.

In return for being given free or low-cost health screenings, I ***release*** Memorial Regional Health, corporations and organizations sponsoring or participating in Craig's Community Health Fair and all of their employees, officers, directors, trustees, volunteers and agents (the "Released Parties") from any and all claims, demands or assertions of liabilities which I or my representatives might make, including claims of **NEGLIGENCE**, arising from, or based in whole or in part on, my participation in Craig's Community Health Fair, results of Craig's Community Health Fair screenings, any statements made to me by any health fair agent, employee or volunteer, nondisclosure to me of any information, my receipt or non-receipt of any information from Craig's Community Health Fair, any event or circumstance that may occur while I am present at the Craig's Community Health Fair site, or any other act or omission of any of the Released Parties.

I am 18 years of age or older, and I have read, understand, and agree to the foregoing consent and release.
If you'd like to keep a copy of your form, please make a duplicate before coming to the Health Fair.

Participant Signature _____ Date _____ Witness Signature _____ Date _____

NOTICE TO ALL MEDICARE PART B BENEFICIARIES: I understand that should I go to my physician and/or healthcare provider, Medicare allows a screening occult blood test every twelve (12) months; screening cholesterol, triglycerides and HDL tests once every five (5) years; screening glucose tests under certain conditions once every twelve (12) months; and a screening Prostate Specific Antigen test (PSA) once every twelve (12) months for males who are over fifty (50) years of age.

MEDICARE WAIVER: I have been informed and understand fully, that NO claim will be filed on behalf, NOR will I file a claim with Medicare or my Supplemental Insurance. I voluntarily take full financial responsibility for the screening(s) I have ordered, even if Medicare would have paid for any or all of these tests, had I gone to my physician or healthcare provider. I therefore, of my own will, refuse to authorize the Memorial Regional Health to submit a claim to Medicare on my behalf.

Participant Signature _____ Date _____

EMPLOYEE