# Xavier University All For Wellbeing Program 2024 Primary Care Physician Consent

PLEASE PRINT CLEARLY

Complete the information below to register for participation in Xavier University's Know Your Numbers Campaign. ***Your signature is required at the bottom of this form** to confirm you have read and understand what is involved in participating.

First Name: _____ Last Name: _____

Previous/Maiden Name (if changed in last 12 months): _____

Date of Birth: _ _/_ _/_ _ _ _ Select One: ☐ Male ☐ Female ☐↑ Trans* ☐ Trans* Man ☐ Trans* Woman

Employer/Health Plan: Xavier University Select one: ☐ Employee ☐ Spouse

Home Address _____ City: _____

State: _____ Zip Code: _____ Preferred Phone: _____

Preferred Email: _____

## Wellness Program Participation Acknowledgement

My participation in the Know Your Numbers Campaign (the "Program") is voluntary. I understand that the responsibility for initiating a follow-up examination to confirm results of any physical screening or obtain professional medical assistance is mine alone, and not that of my Employer or Bethesda Healthcare, Inc./TriHealth, Inc ("TriHealth"). For purposes of this consent, "my Employer" means the entity (a health plan, as applicable) listed on the "Employer" line above.

I understand, agree and consent to the following:

- ✓ In order to be eligible for any medical insurance premium discounts /incentives offered under the Program by my Employer, I must have a physical, and undergo laboratory testing (blood work) ("Eligibility Requirements"). My physician will complete the "Biometric Measures & Physical Confirmation" form included in this packet and the biometric screening results and other medical information contained on form will be disclosed to TriHealth by my physician. TriHealth will use the information on the Biometric Data Form to inform my Employer or my health insurer whether I completed the Eligibility Requirements. If I fail to complete any of the forms required for the Program, TriHealth has the right to tell my Employer which forms I have not completed in order for my Employer to follow up with me directly if it so chooses.
- ✓ My Employer will have access to and will review aggregate data (my individually identifiable medical information combined with those of other participants in the Program that does not personally identify me) to assess population trends. Such aggregate data may also be received by my Employer's designated wellness advisor or broker.
- ✓ Questions about my manifestation of a disease or disorder (that is, my medical history) may be considered genetic information. I do not need to answer these questions. As long as I complete all the other requirements for participation in the Program, I will qualify for the Program reward/incentive even if I choose not to answer the questions which may be considered as requesting genetic information. In other words, I may choose not to answer the questions about my medical history and still qualify for the Program reward/incentive.
- ✓ Should I choose to answer the questions regarding my medical history, I am providing those answers voluntarily and I knowingly consent to the collection of that information. All of my personally identifiable health information collected as part of the Program, including any information that may be considered genetic information will be used for the purposes and in the manner described above and will be subject to the restrictions on its disclosure as described above.
- ✓ I understand that the cost of the physical and laboratory testing (blood work) is not covered by the Program. I may have cost sharing obligations (e.g. co-insurance; deductible) for the physical, the testing required for the Biometric Measures & Physical Confirmation Form and for any other tests ordered by my physician as a result of the physical.
- ✓ I received, read, and understand the "U.S. Equal Employment Opportunity Commission Notice Regarding Wellness Program" contained on pages 4 and 5 of this packet.
- ✓ **I read, understand and agree to the terms set forth above, have completed and signed the enclosed authorization and I wish to participate in the Program on the terms specified.**

SIGN _____ _____

* Signature of Participant (**Required**) * Date



TriHealth Corporate Health

# Xavier University All For Wellbeing Program 2024 Authorization of Use and Disclosure of Protected Health Information

PLEASE PRINT CLEARLY

Complete the information below to authorize participation in Xavier University's Know Your Numbers Campaign. ***Your signature is required at the bottom of this form** to confirm you have read and understand what is involved in participating.

First Name: _____ Last Name: _____

Previous/Maiden Name (if changed in last 12 months): _____

Date of Birth: _ _/_ _/_ _ _ _ Select One: ☐ Male ☐ Female↑ ☐ Trans* ☐ Trans* Man ☐ Trans* Woman

Employer/Health Plan: Xavier University Select one: ☐ Employee ☐ Spouse

Home Address _____ City: _____

State: _____ Zip Code: _____ Preferred Phone: _____

Preferred Email: _____

1. Authorization: I authorize TriHealth, Inc./Bethesda Healthcare, Inc. ("TriHealth") to use and/or disclose my individually identifiable health information as described below. TriHealth is engaged by my employer or employer sponsored health plan to provide services for the voluntary Xavier University's Know Your Numbers Campaign. (the "Program"). My employer or employer sponsored health plan, as applicable, is referred to in this authorization as "my employer."
2. Type of Information to be Released: I want the following information to be used and disclosed pursuant to this Authorization
   - ✓ Medical information that I provide directly to TriHealth, including results from a health risk assessment.
   - ✓ Medical Information contained on the Biometric Measures & Physical Confirmation form completed by my physician.

   The information described in this Section includes medical information for both the current Program year as well as prior Program years.
3. Your Refusal to Sign this Authorization: TriHealth may not condition treatment or health plan enrollment or eligibility for benefits on whether or not I sign this Authorization. If I refuse to sign this Authorization TriHealth will not withhold treatment from me nor will the Employer or Insurance Company condition health plan enrollment or eligibility for benefits.
4. Purpose for the Use or Disclosure: The purpose for the use or disclosure is for:
   - ✓ My employer or for the health insurance company with whom my employer has coverage, to make individualized medical insurance premium discounts determinations or other incentive eligibility determinations.
   - ✓ TriHealth to create and report aggregate information (i.e. my data combined with those of other participants that does not personally identify me) back to my employer or my employer's designated wellness advisor/broker for population trending and program planning purposes.
   - ✓ A data analytics vendor specified by my employer to create and report aggregate data (i.e. my data combined with those of other participants that does not personally identify me) back to employer for population trending and program planning purposes.
   - ✓ For a successor wellness vendor engaged by my employer to continue the ongoing administration of the wellness program offered by my employer if TriHealth is no longer engaged by my employer.

   No biometric measures/individually identifiable medical information (e.g. results of blood work) created or received by TriHealth in connection with the Program will be shared with my employer.
5. Re-disclosure: 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.
6. Revocation: I understand that I may revoke this Authorization at any time by notifying TriHealth in writing by sending a letter to the address of TriHealth, Inc., Fountain Pointe 1 –Suite 350, 4665 Cornell Rd. Cincinnati, OH 45241 addressed to the Coordinator of the Wellness Education Program. I understand that if I revoke this Authorization, it will not affect any actions that TriHealth took before it received my revocation letter.
7. Expiration: This Authorization will expire upon the earlier of: (i) 3 years after the date of my signature below; or (ii) the date upon which my employer no longer receives Program services.

SIGN _____ _____

* Signature of Participant (**Required**) *Date



TriHealth Corporate Health

# Xavier University Know Your Numbers Campaign Physical Confirmation

Take this form to your scheduled annual preventive physical to be **completed and signed by your Primary Care Physician**. It is your responsibility to submit the Biometric Measures & Physical Confirmation form to TriHealth as outlined below.

Select one: ☐ Employee ☐ Spouse Participant Name:_____

Previous/Maiden Name (if changed in last 12 months): _____

Date of Birth:_____ Select One: ☐ Male ☐ Female ☐ Trans* ☐ Trans* Man ☐ Trans* Woman

Preferred Phone:_____-_____-_____ Preferred Email: _____

## PHYSICAL CONFIRMATION

Type of Service Provided: Complete Annual Preventive Physical Date of Service: ____/____/_____

_____ _____

*Signature of health care provider (required) Date Signed

- All testing must be completed AND SUBMITTED between 9/15/2022-9/14/2023. SUBMISSIONS RECEIVED AFTER 9/14/2023 WILL NOT BE CONSIDERED, DESPITE THE DATE OF SERVICE.

Participant: Submit completed packet by 9/14/2023 in one of the following ways

- Scan and email to xavierwellbeing@trihealth.com
- Send to the secure fax 513 487 5698
- Mail to TriHealth Corporate Health,
  Attn: Xavier University Coordinator
  4665 Cornell Road, Suite 350, Cincinnati, OH 45241

- Primary care physician: Complete ALL required information below; return signed form to participant.
- Does the Patient:
  - * have a history of coronary artery disease (MI, CABG, PTCA)? ☐ YES ☐ NO
  - * have a history of diabetes? ☐ YES ☐ NO
  - * have a history of pre-diabetes? ☐ YES ☐ NO
  - * exercise weekly? If so, how often? _____days/week _____minutes/day

| BIOMETRIC MEASURES (* required) | VALUE | TEST DATE (Month/Day/Year) |
|---|---|---|
| *Total Cholesterol | | |
| *Triglyceride Level | | |
| *Glucose (fasting) | | |
| *HDL Cholesterol | | |
| *LDL Cholesterol | | |
| Hemoglobin A1c (if physician recommended) | | |
| *Systolic Blood Pressure | | |
| *Diastolic Blood Pressure | | |
| *Height (in feet, inches) | Ft. In. | |
| *Weight (in pounds) | | |
| *Abdominal Circumference (in inches) | | |



TriHealth Corporate Health

U.S. Equal Employment Opportunity Commission

NOTICE REGARDING ALL FOR WELLBEING PROGRAM 2024

Xavier Wellbeing is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a physical exam and a biometric screening, which will include a blood test for total cholesterol, HDLs, LDLs, Triglycerides, and glucose. You are not required to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will earn a premium wellness rate for the 2024 plan year. Although you are not required to participate in the physical exam or biometric screening, only employees who do so will receive this rate.

If you are unable to participate in any of the health-related activities required to earn the wellness rate, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Office of Human Resources at 513 745 3638. The information from your physical exam and biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Xavier Wellbeing and Xavier University may use aggregate information it collects to design a program based on identified health risks in the workplace, Xavier Wellbeing will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in Xavier Wellbeing, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with Xavier Wellbeing will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to Xavier Wellbeing, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in Xavier Wellbeing or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of Xavier Wellbeing will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the individuals who provide you with services under Xavier Wellbeing.

In addition, all medical information obtained through Xavier Wellbeing will be maintained separate from your personnel records. Information stored electronically will be encrypted, and no information you provide as part of Xavier Wellbeing will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with Xavier Wellbeing, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in Xavier Wellbeing, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Office of Human Resources at 513 745 3638.