EMPOWER HEALTH SERVICES

AUTOMATIC SPRINKLER LOCAL 281, U.A. WELFARE FUND

INDIVIDUAL PROGRAM INFORMED CONSENT/REGISTRATION

CLIENT CODE
sprinkler281

THIS IS NOT A REQUISITION FOR LAB WORK

Please PRINT LEGIBLY

DAYTIME AREA CODE & PHONE NUMBER

LAST NAME

FIRST NAME

MAILING ADDRESS

APT #

CITY

ST

ZIP

EMAIL ADDRESS

PROVIDE THE LAST 4 OF YOUR SOCIAL SECURITY #

BIRTH DATE

AGE

Male

Female

VALUES LEFT BLANK WILL BE RECORDED AS DECLINED

Self Reported HEIGHT FT

IN

Self Reported WEIGHT LBS

Self Reported BLOOD PRESSURE

/

Informed Consent for Administration of Wellness Screening Tests:
I hereby consent to have Empower Health Services, LLC (EHS), and its assigned screening partners, complete and obtain the following items that may be included in the Wellness Screening Program: a blood sample; blood pressure; height and weight; BMI and/or body composition calculation.

I consent to have a sample of my blood taken via venipuncture and I understand that there are possible risks associated with taking a blood sample by venipuncture including, but not limited to, the risk of discomfort, bruising, fainting, or infection. I consent to and authorize the drawing of my blood for lab analysis as indicated above.

I authorize EHS and its assigned screening partners to disclose my screening results to my employer's group health plan for the purpose of administering any incentive awards, or for payment, treatment, or health care operations as permitted by applicable law. I understand that my participation in this Wellness Screening Program is voluntary.

EHS's Notice of Privacy Practices (NPP) has been made available to me in connection with this Wellness Screening Program. A current copy of the NPP is also available at www.empowerhealthservices.com/privacypolicy. My signature below acknowledges receipt and acceptance of the NPP.

I understand the information provided in this Wellness Screening Program is not intended as a substitute for the professional advice and care of my personal physician and in no way provides a medical diagnosis. If I have any questions or concerns about my results, or obtain an abnormal screening result, I will consult my physician.

I release and discharge EHS and any other organization(s) associated with this Wellness Screening Program and their respective shareholders, parents, subsidiaries, officers, directors, employees, affiliates, successors, or assigns, and the program sponsors, the owners/operators of this facility, my insurer, and/or administrative service provider/wellness program provider associated with this program from any and all liability, damages, claims or causes of action that may arise from or are in any way connected with my participation in this Wellness Screening Program. This release shall be binding upon my heirs, assigns, executors, administrators, and representatives.

Signature: _____ **Date:** _____

- [x] **247252** Panel C + Reflex to Hemoglobin A1c
- [x] **010322** PSA - Prostate Specific Antigen (men age 50+ only)
- [x] **224576** Advanced Thyroid Profile (women age 40+ only)

Registration Options

Upload completed form to **ehsupload.com**

Fax completed form to **630.385.0156** • Attn: Individual Program

Mail completed form to: EHS Individual Program • 4205 Westbrook Dr., Aurora, IL 60504

REGISTRATION DEADLINE: 12/01/21 **SCREENING DEADLINE: 12/15/21**

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