Health Designs

BROOKS Rehabilitation

Brooks Rehabilitation
LabCorp Voucher - Instructions

Thank you for taking the time to participate in the wellness program. It was designed to help you see how your lifestyle affects your health and often serves as a motivator for behavior change. Below are the instructions for completing your screening via LabCorp. During the screening process you will complete a venous blood draw, blood pressure reading, and height and weight measurement. You will also need the LabCorp Voucher form, which you are required to take to your nearest patient care center for completion.

The steps below are required by you for participation:

1. Complete the Paper Health Questionnaire: Participant must complete and email the paper Health Questionnaire to coaching@healthdesigns.net. Please complete all 15 questions on the form. Including first name, last name, date of birth and Identifier. In the identifier section please add your Member ID. *Please contact your Wellness Team at brooks.wellness@brooksrehab.org for your assessment due date.*

2. Visit your nearest LabCorp patient care center to complete your health screening.
   - Print this cover sheet and voucher after you complete your health assessment. Fill-in your name, sex, and DOB. The other fields will be completed by LabCorp staff.
   - To locate a LabCorp patient care center offering biometric screenings, visit www.LabCorp.com and click: Labs & Appointments.
   - Enter your workplace address and select Employee Wellness with body measurement in the “Service” section and then click “Search”.
   - Select the location and click “Appointments” to choose the appointment time that works best for you, before your specified due date.
   - **Please bring the voucher and Driver’s License with you to your appointment.**

LabCorp will send your information directly to our office for processing.

To learn if we have received your paperwork and/or confirm the data we have recorded for you, you may contact Health Designs after the first business day of the next month at: 904–285-2014 or coaching@healthdesigns.net.

You may also contact Health Designs to schedule a personal telephonic health coaching appointment for a better understanding of your current risk factors and the opportunity to set realistic goals for your health.

***Please note – we are only able to discuss this personal health information directly with the participant, in accordance with HIPAA and other privacy regulations.**

To find the nearest patient service center, visit www.labcorp.com or call 888-LABCORP (888-522-2677)

☐ Fax ☐ Call ☐ Mail — Send additional copy of report to: Client Number/Physician's Name; Phone/Fax Number ( ); Physician's Address; City, State, Zip

0702.21

Brooks Rehabilitation c/o Health Designs
LABCORP WELLNESS VERIFIED
35 Executive Way, Suite 110
PONTE VEDRA BEACH FL 32082
866-827-8046

*****ENTER ONLY THE ACCOUNT NUMBER CIRCLED*****
LABCORP ACCOUNT NUMBER: 09008465

CIRCLE ONE:

1003837659 - Grable, Stephen

CHECK ONE:
03 [X] ACCOUNT BILL

Patient's Legal Name (Last, First, MI)	Sex	Date of Birth MO DAY YR	Collection Time : AM PM	Fasting ☐ Yes ☐ No	Collection Date MO DAY YR	Urine hrs/vol hrs____ vol____

NPI	UPIN	Physician's ID #	Patient's SS #	Patient's ID #

Physician's Name (Last, First) — Physician/Authorized Signature X

Hospital Patient Status: ☐ In-Patient ☐ Out-Patient ☐ Non-Patient

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service
Highest Specificity Required

PATIENT: Patient's Address; Phone; City; State; ZIP

RESP. PARTY: Name of Policy Holder (if different from patient); Address of Policy Holder; APT #; City; State; ZIP

PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
Insurance Carrier *	Insurance Carrier *
ID #	ID #
Group #	Group #
Insurance Address	Insurance Address
Name of Insured Person	Name of Insured Person
Relationship to Patient	Relationship to Patient
Employer Name	Employer Name
*If Medicaid State — Physician's Provider #	Workers Comp ☐ Yes ☐ No

I hereby authorize the release of medical information related to the service described herein and authorize payment directly to LabCorp. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

X Patient's Signature — Date

MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)
Refer to Determining Necessity of ABN Completion on reverse.

TRAVEL LOG ID
PST HR# — DATE — LOG#

[X] 262204 LP+Glu

[X] 101300 - Biometrics

PLEASE PRINT

REQUESTED BY 1A 1B 1C

ITEM # 0000000000053663 FORM # 0702 (UNIVERSAL FREEFORM 07)

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NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT. LISTED ABOVE ARE THE CUSTOMIZED PROFILES YOU HAVE SPECIFICALLY REQUESTED FROM LABCORP. THE INDIVIDUAL COMPONENTS HAVE BEEN DISCLOSED TO YOU AND THEY MAY ALSO BE ORDERED INDIVIDUALLY IN THE SPACE ABOVE. COMPONENTS AND BILLING CODES FOR NON CUSTOMIZED TEST PROFILES ARE LISTED ON REVERSE. COMPONENTS MAY BE BILLED SEPARATELY IN ACCORDANCE WITH CARRIER POLICIES.

Health Designs

www.HealthDesigns.net (904)-285-2019

HEALTH QUESTIONNAIRE

This Health Questionnaire will ask you about your health lifestyle habits and is not intended to diagnose illness. The information obtained will be stored in a secure manner, consistent with HIPAA requirements.

Correct ***Incorrect*** ***Use blue or black pen, bubble in completely, print neatly in the text boxes.***

1. Are you an employee of this company or a spouse?
◯ Employee ◯ Spouse

2. Gender: ◯ Male ◯ Female

3. Do you currently have or been diagnosed with (bubble in all that apply):
◯ High blood pressure ◯ High cholesterol ◯ Diabetes

4. Do you currently take medication for (bubble in all that apply):
◯ Blood pressure ◯ Cholesterol ◯ Diabetes

5. Rate your current state of health?
◯ Great ◯ Good ◯ Average ◯ Below Average ◯ Poor

6. Do you use any tobacco products?
Examples: Cigarettes, pipes, cigars or smokeless.
◯ Yes ◯ No

7. How often is too much stress a problem for you?
◯ Never or rarely ◯ Sometimes ◯ Often ◯ Always

8. How many days a week do you get at least 30 minutes of continuous physical activity?
◯ 4 or more ◯ 3 ◯ 1 - 2 ◯ Never

9. In an average week, how many alcoholic drinks do you consume?
◯ None ◯ 1 - 2 ◯ 3 - 7 ◯ 8 - 14 ◯ 15 or more

10. During a typical day, how many servings of high-fiber foods do you eat?
Examples: 1 slice whole grain bread, ¾ cup whole grain cereal, fresh fruit/vegetables, beans.
◯ 0 - 1 ◯ 2 - 4 ◯ 5 or more

11. During a typical day, how much of what you eat is high-fat versus low-fat foods?
Examples: High-fat foods include processed foods, fatty meats, creamy foods/sauces, whole milk, and fried foods.
◯ Mostly high-fat ◯ About half high-fat & half low-fat ◯ Mostly low-fat

12. During a typical day, how many sugared beverages do you drink?
Examples: 8-12 oz of soda, sweet tea, sports drink, fruit drinks, or sweetened coffee.
◯ None ◯ 1 ◯ 2 - 3 ◯ 4 or more

13. In the next six months, are you planning to make any changes to any of the following areas (bubble in all that apply):
◯ Nutrition ◯ Blood Pressure
◯ Stress ◯ Diabetes Mgt
◯ Exercise ◯ Cholesterol
◯ Tobacco ◯ Weight

14. Have you been fasting for the past 2 hours?
Nothing to eat or drink except water and unsweetened/black coffee/tea.
◯ Yes ◯ No

15. Is this your first time taking this assessment?
◯ Yes ◯ No

LAB INFORMATION

SBP **DBP** **TC** **HDL** **LDL**

Triglycerides **RATIO** . **Glucose** **A1C** . **Cotinine**

Height feet inches **Weight** **BMI** . **Waist Circumference** .

First Name (Please Print Legal Name) **Date of Birth** / /

Last Name (Please Print Legal Name)

Identifier (Internal Use Only)

53302

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