CAROLINA OCCUPATIONAL HEALTH SCREENING GROUP

PO Box 606
Travelers Rest, SC 29690

The following is a questionnaire about your personal information that will help us calculate your risk for Coronary Artery Disease. Please answer all questions to the best of your knowledge. Also, please be assured that all information given is strictly CONFIDENTIAL.

Date of Screening__/___/___ Screening Location:_____ Email:_____

Name:_____ Insurance ID #_____

Male/Female:___ Age:____ D.O.B.:___/___/___ Phone Number:_____

Mailing Address: City State Zip Code

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1. Do you take any medications to treat/control the following conditions?
   High Blood Pressure Yes / No **Diabetes** Yes / No **Kidney** Yes / No
   Thyroid Yes / No **High Cholesterol** Yes / No **Liver** Yes / No **Gout** Yes / No
2. How often do you consume alcoholic beverages?
3. Daily_____ Weekly_____ Socially_____ Rarely_____ Never_____
4. Have you been diagnosed with Heart Disease? **Yes / No** Diabetes? **Yes / No**
5. Do you have a family history of Heart Disease? **Yes / No / ?** Diabetes? **Yes / No / ?**
6. How often do you engage in aerobic exercise (swimming, jogging, biking, walking)?
   Select most accurate: Rarely/Never_____ Regular (3+ times a week)_____
7. What is your smoking habit? I Don't Smoke_____ Current Smoker_____ Former Smoker_____
   # Years a Smoker_____ Average # Per Day_____ # Years Since you Quit_____
8. Have you previously suffered a heart attack or stroke? **Yes / No** If yes, which one?_____
9. Have you been treated for breast cancer and had lymph nodes removed? Yes / No
   If yes, please circle which side. **Left / Right**

Office Use Only

Height:_____in. Weight:_____lbs. SBP:_____ DBP:_____

Cholesterol:_____ HDL:_____ LDL:_____

Triglycerides:_____ Glucose:_____ Chol/HDL Ratio:_____

Carolina Occupational Health Screening Group (COHSG)

P.O. Box 606
Travelers Rest, South Carolina 29690-0606
Federal ID# 57-0707536

Director:
CHARLES F. TURNER, R.N.

Phone: *864-834-9078*
Toll Free: *888-348-8911*
Fax: *864-834-7891*

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (HIPAA AUTHORIZATION FORM)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal regulations.

Print Name:_____

SS #:_____XXX – XX – _____

BCBS ID #:_____

Providers and holders of your medical information:
Carolina Occupational Health Screening Group (COHSG)
PO Box 606 * 907 North Main Street
Travelers Rest, SC 29690

Persons/organizations who could receive the information include:
-our physicians (for further review and evaluation)
-your physician ***(only upon your request)***
-insurance companies for life ins. applications, etc. ***(only upon your request)***
-you (for your personal records)
-your employer ***(only upon your request)***

Specific description of information being disclosed:
-blood work results
-pulmonary function results
-blood pressure results
-stress test results, including copies of the EKG
-any records relating to the health screening

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS:

1. I understand that this authorization form will expire one (1) year from the date of the screening, unless revoked or terminated by the participant or the participant's representative. ***Initial:***_____

2. I understand that I may revoke this authorization at any time by notifying COHSG, in writing. I realize that if I do revoke this authorization, it will not have any effect on any actions taken by COHSG before receiving the revocation. ***Initial:***_____

3. I understand that information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations. ***Initial:***_____

_____ _____
Signature of Health Screening Participant Date

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YOU MAY REFUSE THIS AUTHORIZATION

I ***DO NOT*** authorize Carolina Occupational Health Screening Group (COHSG) to disclose my medical information to any physician, organization, health care provider, or any person, including having copies of specific results faxed or mailed to myself.

_____ _____
Signature ***(Refusal)*** of Participant Date

Wellness Screening Notice and Consent

- I consent to participate in the Wellness/Health Risk Screening Program (the "Program"), which may include but is not limited to: a health risk appraisal, obtaining a blood specimen for laboratory testing and taking biometric measurements such as weight and blood pressure.

- I authorize Carolina Occupational Health Screening Group (COHSG) to perform a finger-stick test and/or venipuncture for the purpose of measuring certain metrics, including but not limited to, blood cholesterol, blood glucose, and hemoglobin as part of my health screening.

- I acknowledge that participation in this program is voluntary. I understand that my individual health data will be treated as confidential.

  _____ (initials) **I consent** for my individual health data to be shared between COHSG and BlueCross BlueShield of South Carolina ("BlueCross"); however, it will not be shared with my employer. Aggregate data on all participants may be shared with the South Carolina Public Employee Benefit Authority ("PEBA").

  _____ (initials) **I do not consent** for my individual health data to be shared between COHSG and BlueCross.

- I understand that the feedback provided by the health educator is intended to be lifestyle recommendations, not medical advice. I should direct specific medical questions to my physician.

- I understand that the data derived from these tests are to be considered preliminary or informational only and do not constitute a diagnosis. The results of the health screenings are for my benefit only and do not take the place of, and are not intended to be substitutes for professional medical advice, diagnosis of any disease, nor any other illness, health condition or treatment from my doctor.

- I agree that the responsibility for initiating a follow-up exam to confirm the results of this screening and obtaining professional medical assistance is mine alone and not that of any organization(s) associated with this screening.

- I understand that the Program is offered by my health plan. If my health plan implements an incentive as part of the Program, I consent to BlueCross informing my health plan whether or not I qualify for such incentive based on my participation in the Program. I understand that if I do not elect to provide such consent, I may not qualify for such incentive.

- I understand that my health plan may from time to time offer enrollees other health and wellness services and programs, such as employee assistance and disease management programs.

- I understand that this Consent will remain in effect for as long as I participate in the Program or such shorter period permitted by law. I may revoke this consent at any time by notifying BlueCross in writing, to the extent BlueCross has not already relied on this consent.

- I understand I am entitled to a copy of this Consent.

_____ _____

Participant Signature Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Complete Only Highlighted Sections:
1a, 2, 3, 5, 6, 8, 12 and 13

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. Z00.00
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1														NPI	
2														NPI	
3								96160		1	$47.00			NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒ 57-0707536

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ $47.00

29. AMOUNT PAID $ $0.00

30. BALANCE DUE $ $47.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Abby Holmes DATE

32. SERVICE FACILITY LOCATION INFORMATION

North Greenville Fitness
907 N Main St
Travelers Rest, SC 29690

a. NPI b.

33. BILLING PROVIDER INFO & PH # (864) 834-9078

North Greenville Fitness
P.O.Box 606
Travelers Rest, SC 29690

a. 1679661144 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION