



Biometric Screening Consent Form

Biometric screening equipment is calibrated at the beginning of each screening event to ensure accurate results.

Finger Stick Blood Testing:

A fingertip capillary blood sample will be obtained. This sample will be used to determine the level of glucose (sugar), average glucose (A1C), total cholesterol, LDL, HDL, and triglycerides present in your blood. You may experience minor discomfort or bruising at the test site. Rarely, dizziness or fainting may result from a finger stick.

Please notify the provider if you have ever experienced dizziness or fainting because of a finger stick blood test.

Body Composition Analysis:

A body fat analyzer estimates body fat percentage by sending a weak, unfelt electrical current through the body. If the measurement is made after drinking a large amount of water or within 1 to 2 hours after a meal, changes to water content in the body may lead to an inaccurate result.

To prevent potential injury, use of the body fat analyzer is contraindicated in the following individuals:

- Those with an implanted medical electronic device, such as a pacemaker.
- Those who are pregnant. A physician consultation, with written approval, is required prior to using this device.

Please notify the provider if you have a medical electronic implant or if you are, or could be, pregnant.

Please respond to the following questions and statements.

I do not have a history of dizziness, light-headedness, or fainting with blood finger sticks. __AGREE __DISAGREE

I do not have an implanted medical electronic device, such as a pacemaker. __AGREE __DISAGREE

I am not currently pregnant and do not suspect that I could be pregnant. __AGREE __DISAGREE

I hereby request and authorize Triad Care, Inc. to obtain a blood sample from me. __AGREE __DISAGREE

I hereby request and authorize Triad Care, Inc. to use a body fat analyzer on me. __AGREE __DISAGREE

I authorize Triad Care, Inc. to provide screening results to my insurance company or the employer's health risk assessment (HRA) company for data analysis. To maintain continuity of care, Triad Care, Inc. may deliver my personal information to a successor provider should wellness services be transitioned to a different provider. To signal my eligibility for any available incentives, Triad Care, Inc. may provide my name, employee identifier, and date of birth to a designated representative of the employer. __AGREE __DISAGREE

By signing this form, I authorize Triad Care, Inc. to collect identifiable personal information about me, including, but not limited to, name, employee ID number, date of birth, and screening results (my "personal information"). My personal information is used by Triad Care, Inc. to provide me health management services, which includes using my personal information to notify me of relevant health-related risks and health education programs offered by Triad Care, Inc. In addition to personal information disclosures set forth above, aggregate results, without any identifiable personal information, may be made available to the employer for program reporting purposes. I acknowledge the risks outlined above and have been given a copy of Triad Care Inc.'s "Notice of Privacy Practices." I authorize Triad Care, Inc. to identify me as a participant in the health screening for payment purposes.

Employee (Print): _____

(Sign): _____

Date: _____