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 ________________________________ 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 ____________________ 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 date to be shared between __________________________________ 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