EMPLOYEE HEALTH AND WELLNESS
WE CERTIFY YOUR ANNUAL EMPLOYEE MEDICAL HEALTH AND ASSESSMENT/SCREENING FORM

I would like to sign up for the Preventive Health and Wellness Evaluation

Our program is a fully credentialed and approved In-Network medical provider with most health insurance carriers, Medicare, Medicaid, and Union Plans. You may receive a statement from your insurance company (Explanation of Benefits, EOB) itemizing what services were rendered, this is not a bill.

Appointment time: _____ **Date of event:**_____

Name: _____
First Name Middle Name Last Name

Address: _____
Street Apt. Number

_____
City State Zip Code

Date of Birth: _____/_____/_____ Telephone #: _____

Email Address: _____@_____

Medical Ins. Info: *Medical insurance card and Photo ID must be presented at time of testing.
Insurance Co: _____

Ins. Co. ID #: _____ Group #: _____

Signature:_____ Date:_____

Primary Care Doctor: _____ Tel:_____

PCP Address:_____

**** Please circle where would you like your test results mailed to.**

HOME PCP OFFICE OTHER

Other:_____

HIPAA RELEASE OF INFORMATION / AUTHORIZATION FORM

I authorize the release of medical information necessary to my Insurance carrier to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize the physician to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and accurate. I authorize the physician to treat me and / or my child.