Onsite Biometric Screening Event Information

We are looking forward to seeing you at the biometric screening event. Please take a moment and review the information below so you are familiar with the screening process.

1. It is recommended that you fast for 9 hours before your screening event if possible. We encourage each participant to drink 8 ounces of water an hour before their scheduled screening time to help prevent dehydration.

2. Fasting is recommended but not required.

3. Please continue to take all of your medications at their scheduled times.

4. Please wear a short-sleeved or loose fitting shirt to provide proper access for measuring your blood pressure

5. Please review your scheduled screening appointment time and bring all of your completed paperwork with you to the screening event. You should have a copy of the Biometric Screening Form, Privacy Policy and the Consent Acknowledgement Form. If you are missing any of these documents please contact your HR Department.

6. If you have any additional questions or concerns about your screening, you may contact your HR Department or call Triad Care at (336) 541-6475 option 0.

Triad Care Onsite Biometric Screening Event Form

Participant completes the section below prior to the screening

Name:_____ Company:_____ Work Location:_____

Department: _____ Shift: _____ Employee or Spouse

Address:_____ City:_____ State:_____ Zip:_____

DOB:_____ Age:_____ Height:_____ Race:_____ Gender: M F Employee ID:_____

Email:_____ Home Phone:_____ Mobile:_____

Would you be interested in participating in a company sponsored health coaching program? ___No ___Yes

Do you have a primary care provider? __No __Yes Date of last visit: _____

Have you used any tobacco products in the past 30 days? __No __Yes Type: __Smoke __Chew

(This includes: electronic cigarettes, cigarettes, pipes, cigars, chewing tobacco, dip, snuff and any other product containing tobacco)

How many prescription medications do you take on a daily basis? _____

Do you take any medications for the following conditions?

Asthma/COPD: __No __Yes *Blood Pressure*: __No __Yes *Cholesterol:* __No __Yes *Diabetes:* __No __Yes

My submission of this form confirms that I agree to all of the terms and conditions of Triad Care's Consent and Privacy Practice Acknowledgement Form and attest to the accuracy of the information provided above.

Provider completes the section below

Height _____

BP (140/90) _____

Pulse _____

Manual BP (160/90)MD _____

Weight _____

Waist Circumference _____

Hip Circumference _____

Body Fat % _____

BMI (>35=MD) _____

COT Results ____Pos ____Neg

Patient Fasting (9 hrs) ____No ____Yes

Total Cholesterol _____

HDL _____

TRG (400+=MD) _____

Glucose (126/200) _____ if non DM

Glucose (2nd Test) _____

LDL (160+=MD) _____

TC:HDL (Ratio) _____

LDL = TC - HDL - (TRG X 0.2)

CardioChek Time _____

Provider Signature:_____ Date:_____

Additional follow-up needed: ____No ____Yes Follow Notes:

Consent and Privacy Practice Acknowledgement Form for Onsite Screening Event

Finger Stick Blood Glucose and Lipid Profile Testing

A capillary blood sample will be obtained from your fingertip. This blood sample will be used to determine the level of glucose (sugar), total cholesterol, LDL, HDL and triglycerides present in your blood.

Potential Risks Associated with Fingertip Blood Testing:

You may experience minor discomfort or bruising at the test site, or rarely, dizziness or fainting as a result of having blood taken from your fingertip.

Please notify the provider if you have ever experienced dizziness or fainting as a result of this type of blood testing, so that precautions can be taken to prevent any potential injury to you.

Body Fat Analysis

The OMRON Body Fat Analyzer estimates the body fat percentage by sending an extremely weak electrical current through your body to determine the amount of fat tissue. This electrical current is not felt while operating the Body Fat Analyzer.

Contraindications:

- This unit should not be used by any person with an implanted medical electronic device such as a pacemaker.
- If you are pregnant, you must consult with your personal physician and obtain a written approval prior to using this device.

Please notify the provider if you have a medical electronic implant or if you are pregnant. These individuals should refrain from using the Body Fat Analyzer in order to prevent any potential injury.

If the measurement is made after drinking a large amount of water or within 1 to 2 hours after a meal, results could be inaccurate due to the change of the water content in the body.

Do you have a history of dizziness, light-headedness, or fainting with blood finger sticks? ___NO ___YES

Do you have an implanted medical electronic device such as a pacemaker? ___NO ___YES

Are you currently pregnant or suspect that you could be pregnant? ___NO ___YES

I hereby request and authorize Triad Care, Inc. to obtain a blood sample from me for the following tests:

- Blood Glucose Testing
- Lipid Profile Testing (total cholesterol, HDL, LDL and triglycerides) ___NO___YES

I have read the information above and consent to the use of the OMRON Body Fat Analyzer to determine my body fat percentage and body mass index.

___NO___YES

I authorize Triad Care, Inc. to provide my screening results to my insurance company or a health risk assessment (HRA) company designated by my company for data analysis. In the event that Triad Care, Inc. services are transitioned to another service provider, Triad Care, Inc. may deliver my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any incentives, Triad Care, Inc. may provide my name, employee ID number and date of birth to a designated representative of my company to notify them of the fact that I am eligible for the incentive.

___NO___YES

By signing this form, I authorize Triad Care, Inc. to collect personal identifiable information about me, including, but not limited to, my name, my employee ID number, my date of birth, and my screening results (my "Personal Information"). My Personal Information is used by Triad Care, Inc. to provide health management services to me, which includes using the Personal Information to inform me of relevant health related risks and health education programs offered by Triad Care, Inc. In addition to any Personal Information disclosed as set forth above, aggregate results, without any identifiable Personal Information, may be made available to my company 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 _____

Triad Care, Inc.

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your identifiable health information
- Your privacy rights in your identifiable health information
- Our obligations concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. A copy of our current Notice will always be maintained in our office. You will also be able to obtain your own copy by calling 1-866-885-7931 and requesting a copy.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Compliance Officer 1-866-885-7931

C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your identifiable health information.

1. Treatment. Our organization may use your identifiable health information to treat you. Many of the people who work for our organization may use or disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your physician, therapists, spouse, children or parents.

2. Payment. Our organization may use and disclose your identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.

3. Health Care Operations. Our organization may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

OPTIONAL:
4. Appointment Reminders. Our organization may use and disclose your identifiable health information to contact you and remind you of visits/deliveries.

OPTIONAL:
5. Health-Related Benefits and Services. Our organization may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

6. Release of Information to Family/Friends. Our organization may release your identifiable health information to a friend or family member that is helping you pay for your health care, or who assists in taking care of you.

7. Disclosures Required By Law. Our organization will use and disclose your identifiable health information when we are required to do so by federal, state or local law.

D. YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

1. Confidential Communications. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Compliance Officer,Triad Care, Inc., 302 Pomona Drive, Suite L, Greensboro, NC 27407. Specifying the requested method of contact, or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat to you. In order to request a restriction in our use or disclosure of your identifiable health information, you must make your request in writing to Compliance Officer,Triad Care, Inc., 302 Pomona Drive, Suite L, Greensboro, NC 27407. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Compliance Officer,Triad Care, Inc., 302 Pomona Drive, Suite L, Greensboro, NC 27407 in order to inspect and/or obtain a copy of your identifiable health information. Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to Compliance Officer,Triad Care, Inc., 302 Pomona Drive, Suite L, Greensboro, NC 27407. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the organization; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to Compliance Officer,Triad Care, Inc., 302 Pomona Drive, Suite L, Greensboro, NC 27407. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Triad Care, Inc., (866) 885-7931.

7. Right to File a Compliant. If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, contact Compliance Officer,Triad Care, Inc., 302 Pomona Drive, Suite L, Greensboro, NC 27407.All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note we are required to retain records of your care.