TRIAD CARE
Health Care That Saves

Biometric Screening Process
When Using a Lab Voucher

We are looking forward to working with you as your health and wellness provider. Please take a moment and review the information below so you are familiar with the process of receiving your lab voucher.

1. Please complete the top portion of the Lab Voucher Request Form
2. Verify the form is complete and accurate
3. Sign and date the form
4. Send the form to Triad Care via email, fax or mail
5. Triad Care will send you a lab voucher based on your selected delivery preference. This will include the address of the closest lab and contact information.
6. You may schedule an appointment with the lab by contacting them directly or simply walk-in for an unscheduled appointment.
7. It is recommended that you fast for 9 hours before your lab appointment if possible. We encourage each participant to drink 8 ounces of water an hour before their visit to help prevent dehydration.
8. Fasting is recommended but not required
9. Upon completion of your visit please request a copy of your results for your records
10. The lab will automatically send your biometric screening results to Triad Care upon completion
11. Triad Care will process your paper upon receipt and provide notification to your employer of your participation

Triad Care – Lab Voucher Request and Biometric Screening Form

Participant completes the section below and returns to Triad Care for processing

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

Please indicate how you would like to receive the lab voucher

__Email to address provided above

__Mail to address provided above

__ Alternative email: _____

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.

Signature_____ Date_____

Please send the signed and completed form to Triad Care via:

Email: CustomerCare@triadcare.com

OR

Fax: 1-866-822-4606

OR

Mail: Triad Care, Inc.
302 Pomona Drive Suite L
Greensboro, NC 27407

Consent and Privacy Practice Acknowledgement Form

Consent to Disclosure. Triad Care, Inc. may 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. or by another service contractor. I understand that Triad Care, Inc. may provide this data to my insurance company for data analysis and possible enrollment into a health or wellness program. 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. 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. Triad Care, Inc. and other contracted data analysis companies may also use my Personal Information as part of group statistical research and analysis.

By signing this form, I confirm that I agree to the terms listed above and have been given a copy of Triad Care Inc.'s "Notice of Privacy Practices".

Employee (print): _____

(sign):_____ Date _____