Name			Wellness #
Address			
City, State Zip Code			
Telephone (work)	Telephone (home)		
Social Security Number (Last 4 digits) XXX-XX-	AGE	Birth Date	Gender ○ FEMALE ○ MALE
Have a personal medical provider? □ NO □ YES			

PLEASE CHOOSE ONE OF THE FOLLOWING HEALTH SCREEN PROFILES

( ) Wellness Profile $10.00

Glucose and good/bad breakdown of cholesterol, and GFR (these are included in the Health Screen Profile)

( ) Health Screen Profile $50.00

Glucose, cholesterol/lipid panel, BUN, Creat, Lytes, Ca, Total Protein, Albumin, AST, Alk Phosphate, Total Bili, ALT, CBC, Hgb, Hct, GFR, and TSH

( ) Health Screen Profile and PSA $70.00

Same as the Health Screen Profile plus addition of the PSA Screening for Prostate Cancer for Men

( ) Blood Typing $2.00

Find out your blood type (will receive card with it listed)

( ) PSA Screening $20.00

Prostate Cancer test for men

Advance Beneficiary Notice and Release of Information:
Hamilton Memorial Hospital District

Because your physician did not order these specific Laboratory tests, they are not covered under Medicare or Private Insurance. Thus it cannot be turned in to any agency for payment coverage. By signing below you are agreeing to the statements and agree that you will not turn these in to your insurance carrier.
You must list your personal care physician as indicated below.
A Copy of your lab results will be faxed to their office.
If your physician's office is not in McLeansboro – you need to provide the listed information so we can fax to their office.

To receive a copy of your own results, an Authorization for Release of Information has to be signed. This is accomplished by signing below.

I hereby authorize to release to my primary care physician and myself the following information: Wellness Health Screen Profile and Laboratory Results.
This authorization expires 120 days from date signed.

Signature: _____ Date: _____

My Primary Care Physician in McLeansboro, IL is: ***please circle below***

Alec B. Hood, MD

K. Murugappan, MD

R. Brad Ringhofer, M.D.

Jagroop Singh, M.D.

Kristin Betz, FNP

Mike Davenport, FNP

Wes Henson, FNP

Kathy Taylor, FNP

Rene' Trotter, FNP

OTHER PROVIDER:

Name: _____

Address: _____

City /State /Zip Code: _____

TOTAL COST:

[ ] cash

[ ] check

Payable to: Hamilton Memorial Hospital