Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Registration Form

PLEASE PRINT CLEARLY

Employer: City of Hamilton Select One: Male ○ Female ○

First Name:_______________ Last Name:_______________

Are you: City Employee ○ Covered Spouse ○ City Work Location (or Department): _______________

Plan Coverage: Single ○ Employee+1 ○ Family ○ Social Security Number (last 4):_______________

If Employee+1 or Family Plan, list your spouse's first and last name: _______________

Date of Birth: _ _ / _ _ / _ _ _ _ Member Number (from Insurance Card): _______________

Home Address: _______________ City: _______________ State:_______ Zip:_______

Daytime Phone:_______________ Email: _______________

Preferred Means of Contact: Phone ○ Email ○

My participation in Kettering Health Network's (KHN) Living Well Program is voluntary. I understand that the responsibility for initiating a follow-up examination to confirm results of any physical screening and obtaining professional medical assistance is mine alone, and not that of my health plan, employer or KHN.

My employer and/or health plan will have access to and review aggregate data (my individually identifiable medical information combined with those of other participants in the Program that does not personally identify me) to assess population trends. I consent to my health plan/employer's receipt of aggregate data as described in the prior sentence. I further consent to receipt of such aggregate data by my health plan/employer/wellness advisor. My health plan/employer will not receive nor have access to my individually identifiable medical information as part of the Program. I further consent to the disclosure of my personally identifiable biometric data/report by Kettering Health Network to the third party data analytic vendor specified by my health plan/employer in order for such vendor to determine my eligibility for medical insurance premium discounts and/or for data aggregation as described above in this form.

I understand that should I participate in the biometric screening, it is not a substitute for a thorough clinical examination and/or consultation with my physician. I understand that the information derived from this screening is meant to provide preliminary information only and that in order to obtain the full benefit from the program, it is important that I follow-up with my physician or other health care practitioner. I understand that a screening that is read as normal is still not a guarantee that no abnormalities are present. I understand that my health is my responsibility. The responsibility of initiating any follow-up examination for abnormalities identified at the KHN Kettering Health Outreach screening lies with me as the responsible person, not with the participating organization. I hereby release KHN, its employees, officers, directors, agents, contractors, and volunteers from all claims, liabilities, damages, costs, and expenses related to the screening process and from any inaccuracies or errors in the screening results or recommendations. I understand that my personal results will also be shared with my primary care physician for continuum of care purposes, should the health-screening test(s) or service(s) show that any high-risk abnormalities are present. I do give my permission for my screening results to be shared with KHN departments responsible for tracking program outcomes. I give permission for KHN employees to use my contact information to promote future educational programs, seminars, and/or screenings.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or alternative standard by contacting Lauren Gersbach at lauren.gersbach@hamilton-oh.gov or 513-785-7278.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

I affirm that I have read, understand and agree to the terms set forth above and I wish to participate in the Living Well Program on the terms specified.

Signature of Participant: _______________ Date:_______________

Kettering Health Network Release of Medical Information

As a participant of the Kettering Health Network Living Well Program I, (*Print Full Name*) _______________
hereby consent to the disclosure of my biometric screening results by my primary healthcare provider,
(Print name of Primary Care Provider) _______________
to Kettering Health Network.

Submit this Registration Form and the Exam Reporting Form together:

- Scan and email to healthyhamilton@ketteringhealth.org
- Send via secure fax: (513)867-6900

Kettering Health Network.