Physician Attestation Form

INSTRUCTIONS FOR USING THIS FORM:

1. This form should be completed by an employee whose company is offering wellness programming through CareATC. If your wellness program also offers spouse participation, please ensure that your spouse includes the employee's name on the form.

2. This form may be used if you have had a comprehensive metabolic blood screening completed within your company's program timeframe. Please refer to your program manual for specific details.

3. Please provide the attached form to your doctor to complete the bottom portion of the form. Please make sure **ALL** fields are completed. Missing values may be considered out of range for incentive purposes.

4. Please complete this form and return to CareATC by:

   Fax: 918.923.3748

   Email: PAForm@CareATC.com

   Mail: CareATC
   Attn: PHA Dept.
   4500 South 129th East Avenue
   Tulsa, Oklahoma 74134-5891

5. **Please complete the PHA registration form at www.careatc.com/patients**

Questions? Please call 800.993.8244

Commitment to Patient Privacy and Confidentiality:
CareATC adheres to the legal duty of patient confidentiality as outlined in HIPAA Security Rule (45CFR Part 160 and Part 164, subparts A and C) for the maintenance and transmission of all patient records. The privacy and confidentiality of our patients are protected under federal HIPAA Regulations, state laws and regulations, and the Ethics Codes of mental health professions. Access of patient records and transmissions by third-party entities, (i.e., employers or family member) is prohibited. Patient information may not be disclosed without the explicit and informed consent of the patient and authorization by their clinician.

REV 01/01/2020

Physician Attestation Form

part 1

Please complete the information below and return to CareATC

TO BE COMPLETED BY PATIENT:
Along with completing the online PHA registration form at www.careatc.com/patients.

Your name (please print): _____

Your phone number: _____ Your email: _____

Your date of birth: _____ Last 4 of your SSN: _____

☐ I am an employee of (please note company name): _____

Company division / Location name (if applicable): _____

☐ I am the spouse of an employee of (please note company name): _____

Please note employee name: _____

Do you smoke or use tobacco products? ☐ Yes ☐ No

Authorization

I hereby consent and authorize CareATC to process my results and biometric readings for the purpose of my participation in the Personal Health Assessment (PHA). I understand that this is a voluntary screening and give my consent and hereby release my employer and CareATC from any liability associated with my participation in this health screening.

Medical information from the PHA will be shared collectively for reporting purposes and aggregate health information provided to HIPAA compliant organizations. Select medical information may be shared with a third party with whom my group health plan administrator has contracted for services for the plan and its participants, including population health management services and employer wellness program administration. I understand that my right to request restrictions on uses and disclosure of medical information, as set forth in CareATC's Notice of Privacy Practices, applies to disclosure of this PHA medical information to any health plan services or wellness program provider with whom my group health plan administrator has contracted.

I further understand that CareATC may contact me regarding my PHA results and that I should follow up with a physician if any findings/concerns arise a part of this health screening.

Signature _____

4500 South 129th East Avenue, Tulsa, OK 74134 | T: 800.993.8244 | F: 918.923.3748 | www.careatc.com

Physician Attestation Form

part 2

Please complete the information below and return to CareATC

Patient name:_____ Date of birth: _____

TO BE COMPLETED BY A PHYSICIAN

Note: *Please complete all required fields for your patient's wellness program, as missing values may result in inaccurate incentive calculations.*

I, the Physician, attest to the lab values below:

Date of lab work: _____

Cholesterol:_____mg/dL LDL:_____mg/dL HDL:_____mg/dL Cholesterol Ratio: _____

Triglycerides:_____mg/dL Glucose:_____mg/dL HbA1c:_____

Blood Pressure: Systolic_____mm Hg Diastolic:_____mm Hg

Height:_____inches Weight:_____lbs Waist Circumference:_____inches

Physical Exam Completed ☐ Yes ☐ No

Practice name: _____

Physician's name: _____

Date: _____

Please complete this form and return to CareATC by:

Fax: **918.923.3748**

Email: PAForm@careatc.com

Mail: **4500 South 129th East Avenue, Tulsa, Oklahoma 74134-5891.**

Please complete PHA registration form at www.careatc.com/patients.

CareATC Use Only

Received by: _____

Date: _____

4500 South 129th East Avenue, Tulsa, OK 74134 | T: 800.993.8244 | F: 918.923.3748 | www.careatc.com