Office Use Only – Recorded/Verified By: _____ Date: _____

City Employees/dependents who have received a physical exam by an outside medical provider (3/1/2024-6/15/2024) and wish to submit records in lieu of in-person Health Risk Assessment may complete this form and have their primary care provider complete the health risk assessment portion (page 3). **Please fax all documentation to fax# 910-251-3754 by June 15, 2024.**

Patient Information

Last Name: _____ Suffix: _____ First: _____ Middle: _____

Birthdate: _____ Sex (Male/Female): _____ Gender Identify: _____

Preferred Language: _____ Race: _____ Ethnicity: Hispanic or Not Hispanic

Contact Information

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Day Phone: _____

Email: _____ (Required field to enroll in patient portal. HRA results will be sent via the patient portal or Patients may call/text 910-395-3988 to schedule Virtual or other visit to review results).

Employee Status: ☐ Employee ☐ Dependent ☐ Retired

Primary Care Provider: _____ Provider's City/State of Practice: _____

Tobacco Use (e.g., cigarettes, cigars, snuff, e-cigarettes/vaping pens): ☐ Current User ☐ Former User ☐ Never Used

Type Used: _____ Amount Per Day: _____

# of Years Used: _____ Age Quit Use: _____

What is your willingness to quit? ☐ Not Ready to Quit ☐ Considering Quitting ☐ Ready to Quit

By signing this document, I hereby knowingly and voluntarily:

- Authorize Wilmington Health, the on-site practitioner, the clinic reference laboratory processing my blood specimens, and my employer's Health Plan Administrator to collect and disclose my individually identifiable health information, including any genetic information (such as my family history), for the purposes of rendering care in the Wilmington Health Clinic or as otherwise contemplated by the Notice of Privacy Practices; and,
- Consent to the receipt of automated health information outreach texts and voice messages, understanding that I may revoke my consent at any time by notifying my Wilmington Health on-site practitioner or opting out in response to a text or other message I receive. I understand my mobile carrier may charge for the receipt of these messages.
- **Understand that I will receive a letter from Wilmington Health uploaded into my patient portal with my health risk assessment (HRA) results. The letter will indicate whether I will be required to complete a follow-up visit (either virtual or in-person) with the City Clinic in order to receive a discount for my premiums. If I do not complete the required follow-up visit, I understand that I will lose this incentive. I further understand that I may contact the City Clinic directly at (910) 395-3988 to obtain a hard copy of these results.**

_____ _____

Patient Signature **Date**

If you have a **Wilmington Health PCP who has completed a physical with the labs needed, you only need to complete page 1, 2 and check the box below. When you fax in this document, we will verify the information in your medical record and send HRA results via your patient portal.**

☐ I have a Wilmington Health Primary Care Provider who has completed the exam and all labs between 3/1/24 and 6/15/24.

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information, as set forth below. I understand that this authorization is voluntary. I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. **This authorization will remain in place until a notice of change is provided in writing.**

Patient Information (please print):

Name: _____

Date of Birth: _____

Protected Health Information to Be Used and/or Disclosed:

I authorize Wilmington Health to discuss medical information regarding my care, test results, appointments and/or billing information with someone other than myself? **Yes□ No□**

If yes, I authorize Wilmington Health to disclose my protected health information to the following individuals, who may be contacted directly by Wilmington Health:

	NAME	RELATIONSHIP	PHONE NUMBER
1			
2			
3			

I authorize Wilmington Health to leave a message regarding my medical care on my voicemail Yes□ No□
If yes, please provide the phone number:_____

I authorize Wilmington Health to send appointment reminders via Text Message? Yes□ No□
If yes, please provide the phone number:_____
Please note data charges may apply per your cell phone carrier

I acknowledge that I have been made aware of Wilmington Health's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Wilmington Health Notice of Privacy Practices.

Signature: _____Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Health Risk Assessment - To Be Completed by a Medical Provider Only

Patient Name: _____ Date of Birth: _____

Assessment Date: _____

☐ Copy of blood analysis provided in lieu of blood draw and attached.

Weight (lbs.): _____ Height: _____(feet) _____(inches)

Biometric	**Patient Results**	
Body Mass Index (BMI)		
Blood Pressure (Systolic and Diastolic)	**Systolic**	**Diastolic**
Total Cholesterol (mg/dL)		
HDL Cholesterol (mg/dL)		
LDL Cholesterol (mg/dL)		
Triglycerides (mg/dL)		
Hemoglobin A1C		
Tobacco Use Yes/No		

By signing below, I verify that I have conducted a medical exam, assessment or testing to obtain the above information between March 1, 2024 to June 15, 2024 and date on signature line.

Physician Name: _____ Practice Name: _____

Physician Signature: _____Date: _____

Please Fax Completed Forms to Wilmington Health Direct – City of Wilmington at:
Fax #: 910-251-3754