Health Risk Assessment

Satilla Health Services Employees

Satilla Regional

Health & Wellness Center

EMPLOYEE INFORMATION Date: _____ Employee #: _____

Name_____ SSN_____

Address_____ Phone _____ Work_____

City_____ State_____ Zip Code_____

Date of Birth_____ Age_____ Gender: ☐ Male ☐ Female ☐ Part-Time ☐ Full-Time

Division:_____ Dept: _____ SHS Health Plan: ☐ Yes ☐ No

Email Address:_____

BIOMETRIC/MEDICAL INFORMATION (From Physical)

Height (in): _____ Weight: _____ Hips (in): _____ Waist (in): _____

Blood Pressure: _____/_____ Physician: _____

HEALTH HISTORY (Please answer all of the questions)

☐ I smoke cigarettes or cigars? ☐ Never smoked ☐ Former smoker ☐ Quit last year ☐ Current - cigs/day _____

☐ I exercise for more than 30 minutes on 4 or more days per week? Fitness Center: _____

☐ I Have High Blood Pressure	→	☐ BP Medications
☐ I Have Diabetes (Type 1___ Type 2__)	→	☐ Blood Sugar Medications
☐ Coronary Artery Disease	→	☐ Heart Medications
☐ High Cholesterol	→	☐ Cholesterol Medications
☐ COPD or other chronic lung condition	→	☐ COPD Medications

HEALTHY DIRECTIONS

(If you have earned more than 1000 wellness incentive points since your last physical, you qualify for a wellness incentive. Please indicate your choice below:

☐ $360 Insurance premium discount ($13.85 per pay period for the year)

☐ $180 Check (taxes will be deducted)

SATISFACTION

	Great	Good	OK	Fair	Poor
How satisfied are you with Satilla's Worksite Wellness Program:	5	4	3	2	1

Suggestions:_____

ADDITIONAL RISK FACTORS (Staff Use only)

☐ Obesity (BMI > 30) ☐ LDL > 160 ☐ HDL < 35 ☐ Total Cholesterol > 240 ☐ Triglycerides > 400

☐ Level I (Bonus Incentive) ☐ Level 2 (Risk Reduction Programs) ☐ Level 3 (CAD High Risk Program)

*2004 Pioneer Street, Waycross, GA 31501 * tel.- 912-284-2410 *fax: 912-284-2386*

Satilla Regional
Health & Wellness Center

HEALTHY DIRECTIONS PRIVACY NOTIFICATION

By signing this form, an employee agrees to actively participate in Satilla's Healthy Directions, worksite wellness, program. Participating employees agree to maintain good health, or strive towards becoming healthier, depending upon their current health status. An employee agrees to participate in an annual HRA and physical, including routine lab tests, to become eligible for the Healthy Directions program.

Health information (from an annual physical, HRA, and other Personal Health Information) will be used to determine an employee's risk level in order to determine which programs and services are appropriate to offer. It is understood that Satilla Health Services (SHS), and those performing prevention and risk-reduction services on behalf of SHS, will have access to the health information of each employee who chooses to participate. Your company will not receive individual test results, but will have access to general health status information. However, this information will only be used for the purpose of managing prevention services and risk reduction programs on behalf of the company in order to improve the overall health of employees.

In signing this form, I willingly agree to participate in any and all programs specifically offered to me as a result of my risk level.

Reward incentives are in no way tied to your risk level or to any success in achieving better health through the programs in which you participate. Instead, health incentives are offered to you for merely **participating** in the screenings, HRA's, and any resulting programs offered to you as a result of your risk level.

Employee Name: _____

Employee acknowledgment: I acknowledge that I have been provided an opportunity to review a copy of the privacy practices of Satilla's Healthy Directions program. I acknowledge that I have been provided the opportunity to ask questions regarding this notice and its contents.

Signature:_____ Date:_____

2004 Pioneer Street, Waycross, GA 31503, tel 912-284-2460, fax: 912-384-2389

Satilla Regional Medical Center

DRUG TESTING AUTHORIZATION AND RELEASE OF LIABILITY

I understand that in accordance with Satilla Health Services Drug and Alcohol Policy, employees and prospective employees are required to undergo a substance abuse test to determine whether the policy has been violated.

All drug tests are subject to careful testing procedures with mandatory confirmation of any preliminary positive tests.

I understand that I will be given a reasonable opportunity to explain the reason for any confirmed positive test result. Laboratory results of the drug test will be maintained in a confidential manner by the Manager of the Satilla Convenient Care.

I understand if I am referred for a drug test due to Reasonable Suspicion that I will be placed on an Administrative Leave pending the tests results and/or evaluation, treatment and release by the EAR

I understand if I am referred for a drug test due to a Random Test, an Annual Physical, a Post Rehab or Post Accident and the test is positive I will be placed on an Administrative Leave until which time there is a retest confirmation, referral to the EAP or appropriate disciplinary action is taken.

I voluntarily consent to provide a specimen at a collection facility or other location designated by Satilla Health Services promptly upon being asked to do so, and I further consent to having the specimen tested at a laboratory selected by Satilla Health Services.

I authorize the release of the drug test results to the MRO and designated Satilla Health Services management. I understand that if the drug test is part of a physical examination the results will also be disclosed to the examining physician.

I release Satilla Health Services, its employees, management and its designated medical or professional representatives, from any and all claims or causes of action resulting from this test, the release of the results of the test to such persons, and any employment decisions as a result of the test.

Print Employee or Applicant Name	Social Security # and Phone Number
Employee or Applicant Signature	Date
Witness Signature	Date

Patient's ID

SATILLA HEALTH SERVICES

CONSENT TO ROUTINE PROCEDURES & TREATMENTS

Important: Do not sign this form without reading and understanding its contents.

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals").

While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

(1) Needlesticks, such as shots, injections, intravenous lines or intravenous injections for the purpose of medication administration, hydration and/or fluid therapy. The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective) or refusal of treatment.

(2) Physical tests, assessment and treatments such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infections, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) Administration of Medications whether orally transdermally, rectally, topically or through my eye, ear or nose. The material risks associated with these types of Procedures include, but are limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) Drawing Blood for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, bruising (hematoma), inflammation of vein (phlebitis), and temporary nerve damage. Apart from long term observation and/or refusal of treatment, no practical alternatives exist,

(5) Insertion of Internal Tubes such as urinary bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The materials risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control, and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

(6) Non-invasive radiographic procedures, such as x-ray, sonogram, mammogram, CT scan, ultrasound, bone density scan, and/or other imaging studies which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of procedures include, but are not limited to, radiation exposure, bruising, and musculo-skeletal injury. Apart from using an alternative type or radiographic procedure or refusal of treatment, no practical alternatives exist.

(7) Other:_____

_____

_____

I understand that:

* The practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any Procedures;
* The Healthcare Professional participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and
* Physicians rendering services to me are licensed independent practitioners engaged in the practice of medicine or are physicians engaged in the practice of medicine through contractual relationships with the hospital,

By signing this form:

* I consent to Healthcare Professionals performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained: and
* I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.
* If I have any questions or concerns regarding these Procedures, I will ask my physician or other qualified healthcare provider (lab technician, x-ray technician, nurse, etc.) to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

_____ _____ _____

Signature of Patient (or Person giving consent) Relationship Date

Patient unable to sign because _____

Witness: _____

Patient identification sticker OR _____

Print Patient Name and Account #

SATILLA REGIONAL MEDICAL CENTER
SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information.

Parties Following The Notice: The Notice will be followed by the Hospital and its affiliates, together with their health care professionals, staff and volunteers; members of the Hospital Medical Staff and those participating in managed care networks with the Hospital; and other legal entities that provide services to the Hospital.

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons, including:

- Treatment
- Payment
- Health care operations
- Health oversight activities
- Public health purposes
- Auditing
- National security and protective services
- Research
- Workers' compensation
- Lawsuits and disputes
- Activities of managed care networks in which we participate
- Activities of our affiliates
- Appointment reminders
- Fund raising activities
- Organ donation
- To avert a serious threat to health or safety
- To coroners, medical examiners and funeral directors
- To military command authorities
- As required by law

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for: Hospital Directories or for Individuals involved in your care.

Your Privacy Rights:

You have the following rights with respect to your health information:

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain uses of your health information.
- The right to inspect and copy certain medical information that we maintain about you.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of your health information.

Changes to the Notice: We reserve the right to change the Notice. We will post any revised Notice in the Hospital.

Complaints: If you believe your rights have been violated, you may file a written complaint with the Hospital's Chief Privacy Officer Kathy Amsler @ 912-287-2619 or kathya@satilla.org or with the Secretary of the U.S. Department of Health and Human Services. Office of Civil Rights HIPAA Hotline (404)562-7886.

ACKNOWLEDGMENT

Patient Name: _____ **Age:** _____

Patient Acknowledgment: I acknowledge that I have been provided an opportunity to review a copy of the Notice of Privacy Practices for Satilla Regional Medical Center. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Signature of Patient: _____ Date: _____

(Signature of individual or, if screening is for a minor, parent or legal guardian signature.)

For Use by Hospital Personal Only: [Complete if patient acknowledgment is not obtained]

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgment was not obtained because _____

Signature of Hospital Representative: _____ Date:

SATILLA REGIONAL MEDICAL CENTER
RESUMEN DEL AVISO SOBRE PROCEDIMIENTOS DE PRIVACIDAD

Nuestra obligacion legal: Tenemos el deber de proteger, con caracter confidencial, los datos medicos sobre su persona. Se nos exige entregarle un Aviso sobre procedimientos de privacidad, que detalla las diversas formas en que tenernos derecho a utilizar y divulgar sus datos medicos. En este tambien se describen sus derechos y nuestras obligaciones sobre el uso y divulgacion de los datos medicos sobre su persona.

Partes que cumpliran con el Aviso: Cumpliran con el Aviso el Hospital y sus afiliadas, los profesionales de atencion a la salud, el personal y los voluntarios de estos; el plantel medico del Hospital y aquellas personas que participen con el Hospital en redes de atencion administrada; asi como y otras entidades juridicas que presten servicios al Hospital.

Uso y divulaacion de los datos medicos sobre su persona: Tenemos derecho a utilizar o divulgar datos de salud identificables con su persona por varios motivos, entre ellos los siguientes:

- Tratamiento
- Pago de honorarios
- Procedimientos en materia de atencion a la salud
- Actividades de supervision sanitaria
- Fines de salud publica
- Auditorias
- Seguridad nacional y servicios de proteccion
- Investigaciones
- Indemnizacion por accidentes de trabajo
- Juicios y disputas
- Actividades de las redes de atencion administrada en las que participemos
- Actividades de nuestras afiliadas
- Recordatorios de citas
- Campanas de recaudacion de fondos
- Donacion de organos
- Para evitar una arnenaza grave a la salud o seguridad personal
- A medicos forenses y directores de empresas funebres
- A autoridades militares
- En los casos exigidos por ley

Por lo general, usted debera otorgar una autorizacion escrita para otros casos de uso y divulgacion de sus datos medicos. Tenemos derecho a utilizar o divulgar ciertos datos limitados sobre su persona, a menos que usted lo objete o solicite que se limite la divulgacion, en los siguientes casos:• Directorios de hospitales • Personas que participan en su atencion medica o pago de honorarios

Sus derechos de privacidad:

Usted tiene los siguientes derechos con respecto a sus datos de salud:

- El derecho de solicitar communicaciones con caracter confidencial y otras formas de comunicacion dirigidas a usted.
- El derecho de solicitar restricciones en ciertos usos de los datos de salud.
- El erecho de inspeccionar y copiar ciertos datos medicos que consten en nuestros archivos.
- El derecho de solicitar una modificacion de sus datos de salud.
- El derecho de solicitar un listado de ciertos casos en que se han divulgado sus datos de salud.

Modificaciones del Aviso: Nos reservamos el derecho de modificar el Aviso, y anunciaremos el Aviso actualizado en el Hospital.

Quejas: Si cree que se han violado sus derechos, podra presentar una queja por escrito ante el Hospital (Kathy Amsler @ 912-287-2619) oante el Secretario del Departamento de Salud y Servicios Humanos de EE.UU. (U.S. Department of Health and Human Services).Office of Civil Rights HIPAA Hotline (404)562-7886.

RATIFICACION

Nombre del paciente: _____ edad _____

Ratificacion del paciente: Ratifico haber recibido una copia del Aviso sobre procedimientos de privacidad correspondiente al Hospital _____ Asimismo, ratifico que se me ha concedido la oportunidad de formular preguntas sobre el Aviso.

Firma del paciente: _____ Fecha: _____

La firma de individuo o, si la investigación es para un menor, el padre o firma legal de guardián.

Para uso exclusivo del personal del Hospital: [Llenar si el paciente no firmo la ratificacion]

Se le entrego al paciente una copia del Aviso sobre procedimientos de privacidad y se intento de buena fe hacer que este lo firmara como acuse de recibo del Aviso. No fue posible obtener la ratificacion porque _____

Firma del representante del Hospital: _____ Fecha: _____

SATILLA CONVENIENT CARE
PATIENT HISTORY FORM

"The following information is very important to your health. Please take the time to fully and accurately fill out this form."

Name: _____ _____ _____ _____ _____
Last First Middle Initial Date of Birth: Social Security Number:

Address: _____ Phone: _____

_____ _____ _____
City State Zip

Date of Last Physical: _____ Private Physician: _____

Present State of Health: (***Circle One***) Excellent Good Fair Poor

Occupation: _____ Immunizations Up-To-Date: Yes____ No____

Do you have difficulty with written material? Yes____ No____

Do you utilize any of the following services? (***check if applicable***) Medical equipment/medical supply agency_____
Home health agency_____ Rehab service_____

Primary Language: _____

Are there any physical limitations that keep you from doing what you need/like to do?_____

Do you have difficulty: (***check if applicable***) obtaining medications _____ obtaining transportation_____
obtaining food_____

Do you have any special needs related to your cultural or religious beliefs?_____

Do you have any problems with food intake?_____

Do you (***check if applicable***): live alone with disabilities _____ live alone without disabilities _____
live with others who can assist with care_____ live with others who can not assist with care_____

ALLERGIES:

List all medicines, shots, foods and/or insect stings to which you are allergic:

ALLERGY	REACTION	ALLERGY	REACTION

MEDICATIONS:

List all medications you regularly take or are now taking (including over-the-counter medications, herbals and nutritional supplements):

MEDICATION	DOSE	FREQUENCY	REASON PRESCRIBED

OPERATIONS:

List all operations you have had and the approximate date:

DATE	OPERATION/PROCEDURE

PREVIOUS HOSPITALIZATIONS:

List dates and reasons for hospitalizations:

DATE	REASON FOR HOSPITALIZATION

Patient's ID

MEDICAL HISTORY: HAVE YOU EVER HAD OR DO YOU NOW HAVE?:

	Yes	No		Yes	No		Yes	No		Yes	No
arthritis, frozen joints			diabetes, thyroid disease			hernia			pneumonia		
asthma, bronchitis			drug problem			hepatitis			rheumatic fever		
back trouble of any kind			epilepsy (seizures)			high blood pressure			stomach trouble or ulcers		
blood clots or varicose veins			fainting spells			IV drug use			tuberculosis, silicosis		
blood transfusions, hemophilia			foot problems			kidney trouble			veneral disease		
cancer			hearing difficulty			measles			do you smoke or use tobacco products?		
chicken pox			heart trouble			mumps			do you drink alcoholic beverages?		
dermatitis (skin condition)			hemorrhoids (piles)			nervous or mental illness			do you use drugs? (recreational)		
									do you have menstrual problems		

WHAT OTHER INJURIES OR ILLNESSES HAVE YOU HAD THAT WERE SERIOUS?

_____

_____

FAMILY HISTORY:

Has any blood relative ever had the following:

MEDICAL CONDITION	YES	NO	MEDICAL CONDITION	YES	NO
CANCER			STROKE		
TUBERCULOSIS			SEIZURES		
DIABETES			MENTAL ILLNESS		
HIGH BLOOD PRESSURE			MIGRAINE HEADACHE		
HEART TROUBLE			OTHER		

List age, general state of health, diseases present or age at death and cause of death of your relatives:

RELATIVE	AGE	GENERAL STATE OF HEALTH Excellent, Good, Fair, Poor	DISEASES PRESENT	AGE AT DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER					
BROTHER					
BROTHER					
SISTER					
SISTER					
SISTER					
CHILD					
CHILD					
CHILD					

"I attest that the above information is true and correct to the best of my belief."

_____ _____

Patient or Parent/Guardian Date

I give permission for a representative from Satilla Convenient Care to call me and check on my progress.

_____ _____

Signature Date

Healthy Directions
Satilla's Worksite Wellness Program

I Screen all employees annually for risk factors for cardiovascular disease. Every employee has an annual physical, along with a free lab profile, and completes a health risk assessment. This is part of SHS annual update requirements.

Risk Factors

- Male age 45+/Female age 55+
- Immediate family history of CAD or stroke
- Cigarette Smoker (Automatic Level II)
- Diabetic
- Current Chest Pains (Automatic Level III)
- Sedentary Lifestyle
- Hypertension
- Obesity, BMI > 30
- LDL > 160
- HDL < 35

Lab Values (abnormal)

Cholesterol > 240
Glucose > 125
Triglycerides > 400

II Risk stratify employees

Level I	Normal labs, less than three risk factors	- LOW Risk
Level II	Abnormal labs & less than three risk factors Normal labs & 3 three risk factors Smoking is automatic Level II	- MODERATE Risk Prevention
Level III	Abnormal labs and 3 or more risk factors Current Chest pains, Previous cardiac event, Diagnosis of Chronic Disease (CAD, Diabetes, CHF, Uncontrolled Hypertension, Hyperlipidemia)	- HIGH Risk Preventing future

III Risk Reduction and Incentive Programs

- Incentive bonus for maintaining good health - $360 HRA/$180 Check/$30 per month
- Premium discount - Level I (Level II/III must earn by participating in risk reduction)
- Nutrition counseling with a Registered Dietician. - Level II/III
- Pharmacy consults - Medication therapy management - Level III
- YMCA exercise program/membership - Level II/III
- Fitness memberships. (Accountable for monthly attendance) - Level II/III
- Weight Watchers - Employees with BMI > 30, fees paid by Satilla. All other employees pay ½ price, SHS pays ½ price.
- If abnormal labs - Refer to personal physician - Level II, III
- CAD High Risk program (6 weeks), Stress Test/EKG - Level III
- Employee Rx Assistance - a program to assist employees with chronic illnesses in getting their chronic medications, to ensure compliance and controlling risks.
- Smoking Cessation assistance for all smokers. One-to-one or group counseling, referrals to the Georgia Quit Line, SRMC will provide pharmaceutical aids

SATILLA CONVENIENT CARE
1921 ALICE STREET, SUITE 4A.
WAYCROSS, GA 31501

PATIENT INFORMATION

First Name:_____ Middle:_____ Last:_____
Date of Birth:_____ Sex:_____ SSN:_____
Martial Status: ___Married ____Divorced ___Widowed___Single____Separated
Address:_____ City:_____ State_____ Zip_____
Home Phone: _____ email:_____ ok to contact by email __yes ___ no
Work Status: ____F/T___P/T__ Self Emp __Active Military__Unemp ___ Retired
Employer: _____ Employer Phone: _____ Retire date:____
Employer Address: _____ City:_____State____Zip_____
Emergency Contact: _____ Relation: _____ Phone:_____

RESPONSIBLE PARTY OR SPOUSE (CIRCLE ONE) INFORMATION

Full Name:_____ DOB:_____ SSN:_____ Relation:____
Employer:_____ Employer Phone: _____ Retire Date:_____
Employer Address :_____ City:_____ State:_____ Zip:_____

INSURANCE INFORMATION

Primary Insurance:
Insurance Company: _____ Co-Pay $_____
Billing Address : _____ ID #_____
Group Name: _____ Group #:_____ Effective :_____
Insured Name:_____Relation to Patient: _____
Insured's SSN :_____ Insured's Date Of Birth :_____

Secondary Insurance:
Insurance Company: _____ Co-pay # _____
Billing Address :_____ Policy # _____
Group Name : _____ Group# _____ Effective Date _____
Insured Name:_____ Relation To Patient :_____
Insured's SSN: _____ Insured's Date Of Birth :_____

Is your visit related to an accident ___Y___N Work Related ___Y ___N
Auto Accident ___Y___N Accident Date _____ Accident Location: _____
Responsible Insurance :_____

Signature of Patient_____ Date:_____
Signature of Responsible Party_____