HEALTH DYNAMICS
PREVENTIVE CARE PROGRAM
Thorough exams. Individualized counseling. Unsurpassed ease.

Informed Consent Document

I _____, do hereby voluntarily consent to participate in a cardiovascular disease and cancer screening program provided through a Health Dynamics provider site.

I understand that the Health Dynamics Preventive Care Program provides only health screening services, and does not diagnose or treat medical conditions and that such diagnosis and treatment of medical conditions are the prerogative of my Primary Health Care Physician. I know that release of the results of my screening to my Primary Care Physician is necessary for proper diagnosis and treatment, but that Health Dynamics cannot transmit the results to my Primary Care Physician without my specific direction to do so. I understand that signing this Informed Consent does not constitute a direction to release my screening results to my Primary Care Physician, and the I can direct Health Dynamics to release my results only by specifically requesting in person, or by phone, that the results of my screening be released to my Primary Care Physician. Without such specific direction, the results will not be released.

I understand that the screening program I will receive may include any or all of the following procedures: a physician directed examination, pap smear available upon request (for women), a chest x-ray (for member) based on OSHA standards **OR** mammogram/breast screen (for women) based on ACS guidelines, and evaluations of strength, flexibility, body composition, pulmonary function, 12 lead EKG, blood pressure, height and weight, complete blood chemistry, colorectal cancer screening (multiple FOBT slides), cardiovascular fitness and in certain circumstances other procedures. All questions I may have had regarding these procedures have been answered to my satisfaction, and I have been informed that persons undergoing these procedures may experience, depending on their physical condition, abnormal blood pressure, reduced or elevated heart rate or arrhythmia, nausea, fainting, or on rare occasion, heart attack. Health care personnel will be available to respond to such events and, in responding, will follow appropriate facility specific protocol. I hereby give my consent to health care personnel to take such appropriate measures as they deem advisable to alleviate such conditions.

The information that is obtained as a result of my screenings will be retained by Health Dynamics and treated as confidential, and will not be released without my prior consent to anyone other than the providers of my Health Dynamics screening program and business associates of Health Dynamics bound by appropriate business associate agreements limiting use and distribution of such information as contemplated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Genetic Information Nondiscrimination Act of 2008 (GINA). If I choose to participate in Health Dynamics screenings at multiple provider locations,

the provider performing the most recent service will have access to all of my prior years' test results for comparative analysis. I agree that information pertaining to me may be used for statistical purposes or scientific study so long as such use does not identify or attribute that information personally to me, and does not violate my right of privacy as a patient.

I know that I may discontinue my participation in the screening program at any time.

I understand that the Health Dynamics medical provider I have elected to see may not be a network provider in my personal plan of benefits and so, any follow-up care I pursue with the Health Dynamics provider may result in additional out-of-pocket expense to me. I should therefore consult my personal plan of benefits Summary Plan Description, PPO network or health insurance company to verify the provider's network status as well as any need for pre-approval, and co-payments, coinsurance or other personal expense relating to recommended follow-up medical care.

If I am a woman, I understand that a mammogram and a pap smear are available. If I choose not to have the mammogram and pap smear performed through Health Dynamics, and intend to see my personal physician for these procedures, I understand that these procedures may not be covered by my health insurance plan, and I will consult with my health insurer to verify the availability of benefits under my insurance plan. I understand that I will be financially responsible for procedures as are not covered by my health insurer. I also understand that the Health Dynamics medical provider may not be an in-network provider, so any follow-up care that I elect to pursue may create additional out of pocket expense if I do not consult with my health insurer to verify network status and pre-approval of any follow-up care I seek if they are not covered.

Any inquiries I may have had regarding the matters raised in this Informed Consent Document have been answered to my satisfaction, and I have freely executed this Informed Consent Document with full knowledge of such matter.

Patient's Signature:_____

Month/Day/Year:_____/_____/_____

Witness Signature:_____

Month/Day/Year:_____/_____/_____