NEMAHA VALLEY COMMUNITY HOSPITAL · 1600 Community Drive · Seneca, Kansas 66538 · 785-336-6181

HEALTH FAIR SCREENING/DIRECT ACCESS LAB TESTING
REGISTRATION, CONSENT, AND WAIVER OF LIABILITY

REGISTRATION

Name:_____ Date of Birth:_____
First, Middle Initial, Last Name

Address:_____

Home Phone Number:_____ Cell Phone Number:_____ Gender: M/F

Are you under a health care provider's care (physician, nurse practitioner, physician assistant, etc.)?
____Yes ____No

_____.

CONSENT TO HEALTH SCREENING AND WAIVER OF LIABILITY

1. Consent to Participate. I acknowledge and agree that I am voluntarily participating in Hospital's heath fair screening/direct access lab testing. *My involvement is as a participant and not as a patient*. I further acknowledge and understand that the screening/testing is limited in nature and is not a substitute for seeking medical treatment or follow up with a health care provider.

2. Types of Screenings. I acknowledge and understand that the health fair/direct access lab testing is offering the following screenings/testings:

   LAB WORK – fee payable at time blood is drawn. (NOT INSURANCE BILLABLE)

   - **LIPID PROFILE with LDL/HDL ratio**:

   Includes cholesterol, triglyceride, high density lipoprotein (HDL), low density lipoprotein (LDL), and risk factor.

   - **GENERAL CHEMISTRY SCREEN PLUS TSH: CHEM 14 PLUS TSH**

   Includes liver function, kidney function, electrolytes and thyroid function.

   - **HEMOGLOBIN A1C:**

   A blood test that provides an index of a person's average blood glucose concentration during the previous 3 month period. Used to monitor patients diagnosed with diabetes.

   - **CBC WITH PLATELET**

   Includes white blood count, red blood count, hematocrit, hemoglobin, and platelets.

   TOTAL DUE: $__25.00__

   ____**PROSTATIC SPECIFIC ANTIGEN (PSA):** Additional $10.00

   A blood test to screen for prostate cancer

   I realize that even if my PSA result is normal, the test does not rule out the possibility of prostate cancer.

   _____
   Patient Signature

   TOTAL DUE with PSA:__$35.00__

3. Consent for Blood/Body Fluid Testing; Risks. I acknowledge and understand that by participating in the health screening/direct access lab testing, I will be required to submit to blood and/or body fluid testing. I understand that I may experience slight pain or a bruise at the puncture site. There is also the risk of an accidental needle puncture or other biohazard exposure. In such a case, I authorize additional precautionary testing of the sample.

4. No Health Care Provider/Patient Relationship. With respect to my participation in the health screening/direct access lab testing, I acknowledge and understand that the health care provider is not my personal health care provider and is offering the screenings/testings, recommendations, and self-care solely for my educational purposes. I understand that this means that I do not have a health care provider/patient relationship for purposes of the results of the screenings/testings and I must contact my personal health care provider if I have additional questions or require follow up after the health fair.

5. Preliminary Results. I further acknowledge and understand that the screening/testing results provided to me at the health fair/direct access lab testing are preliminary in nature and are in no way conclusive. I further understand that the screening/testing is not diagnostic and it could fail to detect certain abnormalities that might be detected by more definitive screenings/testings; or it might detect apparent abnormalities that would be found normal with more conclusive testing. For a conclusive medical diagnosis of any medical condition I may have, I understand that I need to be examined by my personal health care provider.

6. No Guarantees; Recommendations. The Hospital, its employees, agents, officers, members, and health fair/direct access lab testing participating health care providers make no claims, representations, or guarantees with respect to the accuracy or precision of screenings/testings due to the limited nature of the evaluation provided. I acknowledge and understand that it is my sole responsibility to follow up on any recommendations that are made to me during the screening/testing and obtain follow up evaluation, testing, and medical diagnosis from my personal health care provider.

7. Consent to Share Results. The results will only be sent to you in approximately 2-4 weeks. **It will be your responsibility to review your results with your physician. Please do not call NVCH lab or your physician for results.** NVCH laboratory personnel are not allowed to discuss or interpret the results for you. If you have any questions, please contact your physician.

8. Confidentiality. I understand that the Hospital will maintain the confidentiality of the screening results in accordance with the Hospital's ***Notice of Privacy Practices for Health Fair or Direct Access Lab Testing Participants*** and applicable state and federal laws.

____ Initials. I acknowledge that I have been offered/received a copy of the Hospital's ***Notice of Privacy Practices for Health Fair or Direct Access Lab Testing Participants***.

9. Waiver and Release of Liability. In exchange for being given free or low-cost health screenings/testings, I release, discharge, and hold harmless, the Hospital, its employees, agents, officers, members, and health fair participating health care providers from any and all claims, demands, losses, damages, or injuries, arising from, or based in whole or in part on, my participation in the Hospital's health fair/direct access lab testing, including, but not limited to, the results of the health fair screenings/direct access lab testings; any statements made to me by any health fair/lab agent, employee, or volunteer; nondisclosure to me of any information; or my receipt or non-receipt of any information from the health fair.

HEALTH FAIR PARTICIPANT ACKNOWLEDGMENT: I have read this form, or have had it read to me, and understand the contents of this form. I believe that I have the knowledge upon which to base consent to participate in the Hospital's health fair. All questions have been answered to my satisfaction. I hereby give consent to the screenings indicated above.

_____ _____

Health Fair Participant Date

_____ _____

Witness Date