

HILLSBORO AREA HOSPITAL WELLNESS FAIR REGISTRATION FORM

(12-HOUR FASTING REQUIRED FOR HEALTH FAIR PANEL)

SCHEDULED APPOINTMENTS ARE ENCOURAGED (NO EARLY ARRIVALS, PLEASE)

Walk-ins Welcome

SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS

Wed., July 13 & Thurs., July 14, 2022
6:30am-9:00am
Hillsboro Area Hospital Campus
Cloud Room (Patio Entrance)
You are required to have a healthcare practitioner to participate in the Health Fair.
Scheduled appointments are highly recommended to decrease wait times.
Please call 217-532-4200.

Advance Beneficiary Notice and Registration Form

This testing is offered as a part of Hillsboro Area Hospital's efforts in community wellness. These tests are completed on a cash basis only. These tests are for screening purposes and are not considered medically necessary testing. They will not be billed to nor will they be covered by Medicare, Medicaid, or any insurance companies.

VN# _____

Required Registration Information (Please Print)

Name: (Last, First, Middle)		Address: (Street, City, State, Zip)
Sex: (M / F)	Date of Birth: (Month / Day / Year)	Phone Number: () -
Physician's Name: (Please supply their address if not a local physician)		

Because of the high discount and non-medical necessity of this testing, no receipt will be given and no bills will be sent.

Testing Requested

- Health Fair Panel** (Blood sugar, BUN, Creatinine, Potassium, Sodium, SGOT, SGPT, WBC, Hematocrit, Hemoglobin, Bilirubin, Cholesterol, Triglyceride, LDL, HDL, T/C Ratio, Calcium)
\$ 45.00
- Thyroid Stimulating Hormone (TSH)** **Vitamin D**
\$ 45.00 \$ 45.00
- Health Fair PSA testing only** **Hemoglobin A-1C** (3-month average glucose level)
\$ 45.00 (Men only) \$ 30.00
- Hepatitis C**
\$ 45.00

Acknowledgement of Privacy Notice

THIS PRIVACY NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- I acknowledge receipt of the Privacy Notice on this date.
- I have received it on a prior date and do not want a copy of the most recent notice.
- Information not given: Reason: _____

I release the results to Hillsboro Area Hospital, my doctor or assigned healthcare provider and Montgomery County Health Dept. for statistical use. All names and identifying data will be removed from the health department's data. **Testing cannot be done without a healthcare provider receiving the results.**

XSignature: _____ Date: _____

Witness: _____

Dr. Zhu, Pathologist _____

SPECIAL INSTRUCTIONS FOR WELLNESS FAIR REGISTRATION

TO REGISTER AND TO SCHEDULE AN APPOINTMENT

- A. Call 532-4200 Monday through Thursday from 8:00 a.m. to 3:30 p.m. to schedule an appointment.
- B. Submit your completed registration form with payment by **July 8, 2022**.
- C. See below for mailing/payment instructions or your appointment may be cancelled.

MAIL COMPLETED REGISTRATION FORMS AND PAYMENT BY 7/8/2022 TO:

**Hillsboro Area Hospital
Attn: Alicia Murzynski
1200 E. Tremont St.
Hillsboro, IL 62049**

**You must have a healthcare provider to participate in the Health Fair.
If not a local provider, please provide a fax number.**

You are required to wear a mask following the screening when entering our facility.

