Froedtert & Medical College of Wisconsin

Workforce Health

MRN#: _____

CONDITIONS OF AND CONSENT TO TREATMENT

Froedtert Health, Inc. doing business as "Workforce Health" has been engaged by City of Milwaukee (the "Company") to coordinate offering you coaching, health risk reduction, disease management and/or other treatment services. Froedtert Memorial Lutheran Hospital, Inc., a Workforce Health affiliate (the "Provider"), will furnish the treatment services. To participate, you must read and sign these Conditions of and Consent to Treatment (this "Consent") and authorize the disclosure of your personal and health information by the Provider to Workforce Health (via a separate "HIPAA Authorization").

By signing this Consent I understand and agree that its terms apply to all coaching, health risk reduction, disease management, and/or other treatment services I receive as part of this Company-sponsored program, beginning on or about _____, 20__ (***insert date) (the "Services")***. By signing this Consent I acknowledge, understand, and agree to the following:

Consent to Treatment: I consent to receive the treatment and medical care that the Provider believes is necessary, including the Services. I will have a chance to discuss this care with the Provider. I understand that no treatment can promise specific results.

Consent to Contact Me: The Provider's staff furnishing the Services may contact me at the address, phone number, and/or email address set forth below to discuss my health, including providing general and risk-related health information, and/or coordinating follow-up care.

Consent to Include My HRA (if any) in My Medical Record: I expressly permit Workforce Health to release the results of any health risk assessment I have taken (including any biometric or other testing results) to the Provider. I understand that the Provider may include this health risk assessment profile in the Provider's medical record.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices: I acknowledge I have received the Joint Notice of Privacy Practices, which provides information on how my Protected Health Information (PHI) may be used and disclosed. The terms of the Joint Notice may change, and, if it does, I may obtain a revised copy from my provider or by visiting www.froedtert.com

Notice of Financial Responsibility: I understand the Company will pay for the Services and I will not be billed directly.

PARTICIPANT INFORMATION:

PRINT YOUR FULL NAME _____

DATE OF BIRTH _____

SIGN HERE _____

DATE _____

TELEPHONE _____

ADDRESS _____

CITY, STATE, ZIP _____

E-MAIL ADDRESS _____

Froedtert & Medical College of Wisconsin

Workforce Health

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION COMPANY SPONSORED INDIVIDUAL COACHING AND DISEASE MANAGEMENT WORKFORCE HEALTH

PATIENT NAME:_____ **PREVIOUS NAMES, IF APPLICABLE:**_____

ADDRESS:_____ **DATE OF BIRTH:**_____

DATE/TIME OF REQUEST:_____ **PHONE: (___) ___ - ____** **MRN:**_____

I authorize the use and disclosure of my protected health information as described in this authorization. I understand that my authorization is voluntary and that I may revoke this authorization at any time by presenting a written request to the office of the practitioner who furnishes individual coaching and disease management wellness services to me. I understand that the revocation will not apply to information that has already been released.

Information Disclosed From:	Froedtert Memorial Lutheran Hospital, Inc. 9200 West Wisconsin Avenue Milwaukee, WI 53226
Information Disclosed To:	Froedtert Health, Inc. (dba Workforce Health) W129 N7055 Northfield Drive, Bldg. B Menomonee Falls, WI 53051
Records that may be Disclosed:	All records created, received, used, or maintained by Froedtert Memorial Lutheran Hospital for, and resulting from, the provision of individual coaching and disease management wellness services to me beginning on the first date such services are furnished to me and all dates on which I receive related follow up care.

I understand my records may include references to treatment of alcohol and drug abuse, psychiatric care, developmental disabilities, HIV test results/acquired immune deficiency syndrome and intoxication test results, and that these records may be released under this authorization unless I give written instructions not to release them.

Purpose of Disclosure:	Coordination of coaching, health risk reduction, disease management and/or other treatment services; aggregation with other data to create population health and other statistics; contacting me to discuss my health, including providing general and risk-related health information, and/or follow-up care; combining with any and all available claims data from any health plan insurance plans in which I am a participant for analysis and reporting purposes to such health plan; and for treatment, payment or operations of Workforce Health and its contractors, such as PDHI, and affiliates of Froedtert Health, Inc., as permitted by the privacy laws.

I understand that if the persons I authorize to receive the protected health information described on this form are not health plans or health care providers or clearinghouses they may further disclose the protected health information and it may no longer be protected by federal privacy law. Unless I revoke this authorization, it will remain in effect until the company sponsoring my treatment no longer covers such services for me.

SIGNATURE_____ DATE_____