38th Community Wellness Screening

Rotary Club of Martinsburg

WVU Medicine

Sponsored by Rotary of Martinsburg with services provided by WVU Medicine.

Saturday, April 20, 2024
6:00 A.M. — 10:00 A.M.

located at

WVU Medicine Physical Therapy and Rehabilitation
1002 Tavern Road, Martinsburg

Expanded Testing Allows You To Customize Your Screening Options!

Pick the time most convenient for you!

Event registration and payment must be received by Friday, April 12, 2024.

Prior to the event you will receive a reminder confirming your scheduled appointment time. For questions, call 304-264-1223.

Test results will be available in MyWVUChart and mailed to your home.
Visit www.MyWVUChart.com to establish your own account, if interested.

Take advantage of our new online registration/ payment option or use the event registration form on the reverse side.

Wellness Screening Registration
www.martinsburgrotaryfoundation.org

38th Community Wellness Screening Registration Form

Registration and payment must be received by mail no later than Friday, April 12, 2024.

There is no drop off location. Please print legibly and select your screening options.
Please make check payable to Rotary Club of Martinsburg and mail this form and check to:

WVU Medicine Corporate Center, 121 Administrative Drive, Suite 200,
Martinsburg, WV 25404 Attention: Dana DeJarnett/Promotion Coordinator

Legal Name of Participant: _____ Date of Birth: _____

Address: _____ City _____ State ____ Zip _____

Telephone: _____ Last 4 Digits of SSN: XXX-XX-_____ ❒ Male ❒ Female

Email: _____

Select the screenings you desire:

❑	CBC *(with automated differential)*	$10	❑	Hemoglobin A1C *(Hb A1c, Diabetes)*	$15
❑	CMP (*Comprehensive Metabolic Panel)*	$20	❑	TSH *(Thyroid Stimulating Hormone)*	$20
❑	Lipid *(Cholesterol)* Panel	$15	❑	Hepatitis C* *(Antibody Screen)*	$20
❑	PSA *(Prostate Specific Antigen; Men only)*	$20	❑	Vitamin B12	$20
❑	Vitamin D	$30	❑	Fit Kit *(Colorectal Screening kit)*	$25

Total Screening Cost: _____

Indicate your choice of appointment time:

☐ 6:00 — 7:00 A.M. ☐ 7:00 — 8:00 A.M ☐ 8:00 — 9:00 A.M. ☐ 9:00 — 10:00 A.M.

Authorization for Testing and Release of Protected Health Information:

I authorize Rotary Club of Martinsburg ("Rotary") via its contractor, City Hospital, Inc. dba Berkeley Medical Center ("BMC") to perform this laboratory testing, which may include venipuncture or capillary puncture to obtain a blood sample. ● I understand that this testing is not a substitute for examination by a medical doctor and should not be used as the only means to diagnose a condition or lack of a condition. ● I understand that Rotary and BMC are not proposing a diagnosis, offering treatment, or offering medical advice by supplying these tests and their results to me. ● I understand that I should contact my health care provider to discuss these results and their relation to my health and that it is my responsibility alone to do so. ● I understand that in the event of a positive result for infectious disease testing, BMC is required by law to submit my test results to the West Virginia Health Department. ● I understand that reportable conditions are denoted above with an asterisk (*). ● I understand that payment for all tests must be made before or at the time of service. ● I understand that the tests ordered will not be billed to my insurance, Medicare, Medicaid, or any other third party. ● I understand that Rotary, BMC, and their affiliates disclaim liability for any costs, claims, injuries, actions, or damages suffered by an individual, no matter what their relationship, as a result of my participation in this Direct Access Testing program. My participation in this Direct Access Testing program is strictly voluntary. I agree to release Rotary, BMC, their affiliates, and other entities associated with the Direct Access Testing program from any liability whatsoever in connection with sample collection, testing, reporting, or any other aspect of this testing. ● I understand that my test results are confidential and subject to the Health Insurance Portability and Accountability Act (HIPAA). ● I understand that I have no obligation to authorize the release of my test results to any physician and choosing not to authorize the release of my results to a provider will not prevent my providers from obtaining a copy of these results in the future so long as there is a proper authorization. ● I understand that my test results WILL be included in the WVU Medicine electronic health record and I can access the results through MyWVUChart. ● I understand that my results will be provided to me by mail. ● I understand that these results WILL NOT be forwarded by mail to my health provider. ● I understand that my test results WILL be accessible through the West Virginia Health Information Network ("WVHIN"), unless I opt out by visiting www.connect.wvhin.org/optoutform or by calling WVHIN at 1.844.468.5755.

_____ _____ _____

Printed Name *Signature* *Date*

Relationship to Participant (if Participant, please write "Self".) _____