



# Primary Care Provider Wellness Visit Verification Form - City of Racine

You may use the results of your last annual physical with your provider only in this timeframe to count for credit for the Biometric Health Screening.

**January 1, 2026 - November 6, 2026**

*Charges from this visit are the responsibility of the participant.*

**For the provider:** Please complete the following information and sign in the signature section to document this wellness visit.

**PLEASE PRINT LEGIBLY TO ENSURE ACCURATE DATA ENTRY**

Patient Name	
Patient Date of Birth	
Employee ID	
Address, City, State, Zip	
Email Address	
Date of Visit	
Total Cholesterol	
HDL	
Triglycerides	
LDL	
Glucose	
Blood Pressure	
Height (feet, inches)	
Weight (lbs)	
Tobacco user (circle one)	YES NO
Fasting (circle one)	YES NO

**IMPORTANT!**

Securely fax this form to  
Ascension Wellness to  
262-912-0084 by:

**November 6, 2026**

**DO NOT** submit this  
information to your  
Human Resources  
department!

\_\_\_\_\_  
Provider - Print Name

\_\_\_\_\_  
Provider - Date Signed

\_\_\_\_\_  
Provider Signature

**FOR THE PARTICIPANT:** Biometric Screening Information

**\*\* Please securely fax this form to our Wellness staff from your PCP to 262-912-0084.**

*"I understand that Ascension may use these results to determine aggregate group health risk factor statistics for my employer and/or spouse's employer and my wellness program reward level (if applicable)."*

\_\_\_\_\_  
Participant Signature and Date



## Ascension Wisconsin Employer Solutions Biometric Screening Consent Form

By signing this consent and release, I agree to participate in Ascension Wisconsin Employer Solutions wellness program. As part of a Biometric Screening, I agree to permit Ascension Wisconsin Employer Solutions, directly or through its affiliates, employees, subcontractors or agents (Ascension), to complete the test and measurements for the wellness screening, such as lab results, biometrics and tobacco usage. I understand that the results of the screening and the completion of my health questionnaire will be used as part of a Health Profile and result in the creation of a health risk profile about me.

I understand that my biometric results may be provided securely to me through the internet or on paper. I understand that if certain risk factors are found, I may be contacted at the address and phone number I provided to my employer about participating in wellness programs to address those risk factors. I understand that the data derived from my screening is preliminary and not a complete diagnosis and that I should consult with my personal primary care practitioner regarding my biometric results and any follow up care. I understand that participation in a wellness program will not be a substitute for a medical checkup and is not, by itself, a basis for making any decision about the need for medical care. Wellness programs are intended to be informative and educational and cannot predict whether I might develop a particular disease.

I understand that Ascension’s affiliates provide medical care in Wisconsin. I agree that if I see an Ascension physician or obtain medical services from an Ascension hospital or outpatient clinic, that those Ascension providers will have access to the biometric data and my health risk profile. I understand that these Ascension medical providers may not be “In-Network” providers under my employer’s health plan.

I understand that Ascension and agents of my employer’s health plan (e.g. brokers, third party administrators, etc.) may use the de-identified results of my screening and my health risk profile to determine aggregated group health risk factor statistics. I further understand and agree that Ascension and my employer’s health plan may use and release any health information obtained as a result of my participation in the screening in the following ways: combining my health information with other individuals’ health information to create and release de-identified, aggregated group health risk factor statistics; releasing my health information to Ascension and health professionals hired by my employer and its subcontractors, for each of them to contact me and follow up with me regarding any risk factors I may present; using my health information for research purposes to study the value of risk reduction and the maintenance of low risk behaviors; releasing the fact that I participated in the screening and any wellness programs to my employer and its health plan; and releasing a list of the wellness programs in which I participated to an administrator at my employer for the calculation of the incentive credits. I hereby release Ascension Wisconsin Employer Solutions and my employer from any liability in connection with sponsoring or conducting this screening.

My participation in the wellness program, including the wellness screening is voluntary. I may revoke this consent and release at any time (except to the extent that anyone already has acted in reliance upon it) by giving written notice to SDSM Health & Wellness Center, 1001 15th Avenue, Door #56, South Milwaukee, WI 53172. If not previously revoked, this consent for participation in the wellness screening and for the release of information is effective so long as my employer offers health risk assessment screenings or wellness programs. A copy or facsimile of this document is as valid as the original. Employment, payment, enrollment, or eligibility for benefits will not be conditioned on obtaining this consent.

I, \_\_\_\_\_ **CONSENT TO THE ABOVE:** \_\_\_\_\_  
[PRINT LEGAL NAME] [SIGNATURE]

DATE OF SIGNATURE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

FEMALE  MALE

EMPLOYEE  SPOUSE  RETIREE

HOME PHONE NUMBER: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

COMPANY: \_\_\_\_\_

LOCATION: \_\_\_\_\_