

## Physician Form

Thank you for participating in Hospice of the Piedmont's wellness program. It was designed to help you see how your lifestyle affects your health and often serves as a motivator for behavior change.

Please complete the attached Physician Form along with your medical provider.

***It is important to complete the forms in their entirety by September 30, 2026; missing or incomplete participation information may impact incentives.***

1. Complete Health Questionnaire (provided with these instructions & Physician Form):  
**Participants** must complete the Health Questionnaire and the top portion of the Physician Form.
2. Visit your Health Care Provider to complete the health screenings listed on this Physician Form:  
You **MUST** have your Health Care Provider complete all required areas of the form. Please keep the original copy of the form for your records.
3. Send the forms to Health Designs:  
Send the completed Physician Form to Health Designs before **September 30, 2026**. It is your responsibility to ensure the Physician Form is received by Health Designs; it is not the responsibility of the Health Care Provider.

### **You can send to Health Designs in any of these ways:**

- **By Secure Fax:** 904-285-2779
- **By Secure Email:** [data@healthdesigns.net](mailto:data@healthdesigns.net)
- **By Mail:**  
Health Designs  
135 Executive Way Suite 104  
Ponte Vedra Beach, FL 32082

Health Designs will process your information when we receive the Physician Form.

4. A health coach from Health Designs will reach out by email to schedule your **telephonic coaching session**. During this call, they'll review your screening results, answer any questions you may have, and **discuss your unique health and wellness goals**. If you miss the call or have questions, please email [virtualcoach@healthdesigns.net](mailto:virtualcoach@healthdesigns.net).

To confirm receipt of a completed Physician Form, you can contact Health Designs after the first business day of the next month at 904-285-2014 or [data@healthdesigns.net](mailto:data@healthdesigns.net).

**\*Please note – we are only able to discuss this personal health information directly with the participant, in accordance with HIPAA and other privacy regulations.**



## Physician Form

<b>PARTICIPANT:</b> Complete this section. Your signature verifies that the information is complete and accurate. As an employee of Hospice of the Piedmont this information will be used to determine your participation and benefit status.		
Name (Print Clearly)	YOUR Date of Birth:	Work LOCATION/CITY the employee reports to:  _____
Signature	Email address:	
Phone Number with Area Code	For confirmation of receipt of paperwork via email, please initial here:	
<input type="checkbox"/> I am an employee <input type="checkbox"/> I am a spouse		
Mailing/Street Address (PRINT CLEARLY)	City	State/Zip Code

<b>Health Care Provider:</b> Complete and sign this form for your patient to be considered a participant in the Hospice of the Piedmont wellness program. <b>EXAM DATE:</b> _____		
Health screening measures	Patient/Participant data	Notes
Height (determined <b>without</b> wearing shoes)	ft.      in.	
Weight (determined <b>without</b> wearing shoes)	lbs.	
Blood Pressure	/      mm/Hg	
Total Cholesterol	mg/dL	
HDL	mg/dL	
LDL	mg/dL	
Triglycerides	mg/dL	
Glucose	mg/dL	
Fasting prior to blood work?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

<b>HEALTH CARE PROVIDER SIGN-OFF:</b> I verify the information supplied is complete and accurate.		
Provider Name (Print Clearly)	Credential(s)	
Provider Signature	Telephone	Email, if available
Office street address	City	State/Zip Code

**This form must be received by Health Designs by September 30, 2026.**

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**By Secure Fax:** 904-285-2779

**By Mail:** Health Designs, 135 Executive Way Suite 104, Ponte Vedra Beach, FL 32082