MCAD

Minneapolis College of Art & Design

Preventative Care Exam Form

Visit a health care provider to complete a preventive care visit. **Please return the completed form to Minneapolis College of Art and Design's Human Resources department by *August 31, 2020.*** Forms submitted after this date will not be accepted.

To be completed by patient

Employer Name: _____

Patient Name: (please print) _____

Patient date of birth: (DD/MM/YYYY) _____ **Patient phone number:** (with area code) _____

Patient email: (optional) _____

Patient Unique ID: (Employee ID) _____

Signature: _____ **Date:** _____

By signing this you are authorizing your employer, Minneapolis College of Art & Design, to release program completion information to the employer sponsored health and well-being program or their designated business associate in order to administer the reward program. This authorization expires once the information is disclosed. Please note: You may incur costs such as co-pay and/or deductible for conditions discussed with a healthcare provider. Please speak to your clinic regarding their billing practices.

Important Information: You may revoke this authorization any time by writing to Minneapolis College of Art & Design, 2501 Stevens Ave, Minneapolis, MN 55404); but this will not affect information that has already been disclosed. You are not required to sign this authorization to be eligible for plan coverage or benefits; however, if you do not authorize this disclosure of information, you will not be eligible for any incentive discount. Information disclosed may no longer be protected by federal privacy laws. You can have a copy of this signed form.

Provider instructions

This form helps employees earn an incentive from their employer. The employee is meeting with you for a preventive care exam.

To be filled out by your healthcare provider

Date of visit: (DD/MM/YYYY) _____

At our visit, we completed a preventive care exam. ☐ **Yes** ☐ **No**

Provider name and title: (please print) _____ **Phone:** _____

Provider signature: _____ **Date:** _____

A signature is required on all submitted forms.

MCAD Internal Office Use Only

Date Received: _____

Date Processed: _____