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Primary Care Provider Visit Form-Employee Instructions

Choose Well™, St. Joseph Health's employee well-being benefit program, supports and rewards you for engagement with all aspects of your personal health and wellness. One of the most important things that you can do for your well-being is to visit your primary care provider (PCP) annually to set and discuss health and wellness goals and issues. By taking time to meet with your PCP, you will be rewarded with **14,000 points** in your *Choose Well* account. The *Choose Well* program is powered by Virgin Pulse, Inc.

Be sure to complete the following steps:

1. Schedule your Primary Care visit. Print the attached Primary Care (PCP) Visit Form to take to your appointment.
2. Complete the top portion of the PCP Visit Form.
3. Have your primary care provider sign the bottom portion of the PCP Visit Form and return to you.
4. You will submit PCP Visit Form using one of the following methods:

Fax to: 508-302-0055 or scan (take picture of form with your smart phone) and e-mail to:
forms@virginpulse.com

5. Be sure to complete the form no later than December 31, 2017.

6. Your **14,000 points** will show up in your Choose Well account. You can find them in the Monthly Statement under the Rewards section. Please allow 7 days for processing.

Questions? Contact 888-671-9395 or support@virginpulse.com

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Primary Care Provider Visit Form

Completed by Participant

Consent to use information: I, participant, hereby authorize my provider to release any information within this form to my well-being program, Virgin Pulse, Inc. I understand that Virgin Pulse, Inc. will utilize this information solely for the purposes of administration of its well-being program and will dispose of this form in accordance with any applicable law. My submission of this form confirms that I agree to all of its terms and that I authorize Virgin Pulse to process my information accordingly.
This form must be signed directly by the primary care provider and not by a medical office staff member or the patient himself/herself.

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First Name: ☐☐☐☐☐☐☐☐☐☐ Male: ☐ Female: ☐

Employee ID # ____________________

Completed by Primary Care Provider

This portion must be signed directly by the primary care provider and not by a medical office staff member or patient himself/herself.

As the primary care provider for this patient, I have taken the time during this office visit to discuss my patient's personal well-being goals, biometric measurements, and lifestyle behaviors with them and have provided feedback and counseling as appropriate.

Primary Care Provider Name ______________________________

Date ______________________________

Primary Care Provider Signature ______________________________