



VN#: _____

WELLNESS FAIR REGISTRATION FORM

June 16 and June 17, 2026
 Hillsboro Health Fitness and Aquatics Gym
 (Fitness and Aquatics Entrance)
6:30am-9:00am
 You are required to have a healthcare practitioner to participate in the Health Fair.
Scheduled appointments are encouraged.
Please, call 217-532-4200 to schedule your appointment.
 See Reverse side for additional information

Advance Beneficiary Notice and Registration Form

These tests are offered as a part of Hillsboro Health efforts in community wellness. These tests are completed on a cash basis only. These tests are for screening purposes and are not considered medically necessary testing. They will not be billed to nor will they be covered by Medicare, Medicaid, or any insurance companies.

Required Registration Information (Please Print)

Name: (Last, First, Middle)		Address: (Street, City, State, Zip)	
Sex: (M / F)	Date of Birth: (Month / Day / Year)	Phone Number: () -	E- mail Address:
Physician's Name: (Please supply their address and fax number if not a local physician)			

- I wish to receive E-mail notifications about news and events from Hillsboro Health
 Because of the high discount and non-medical necessity of this testing, no receipt will be given, and no bills will be sent.

Testing Requested

- Health Fair Panel -\$40.00**
 (Glucose, BUN, Creatinine, Sodium, Potassium, Calcium, ALT, AST, Total Bilirubin, Triglycerides, Total Cholesterol, HDL, LDL, TC/HDL Ratio, eGFR, WBC, RBC, Hemoglobin, Hematocrit, Platelet Count)
- Thyroid Stimulating Hormone (TSH)- \$35.00** **Vitamin D- \$35.00**
- Hemoglobin A_{1c} (3-month average glucose level)- \$30.00** **PSA (men only)- \$35.00**
- Hepatitis C- \$35.000**

Acknowledgement of Privacy Notice

THIS PRIVACY NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- I acknowledge receipt of the Privacy Notice on this date.
 I have received it on a prior date and do not want a copy of the most recent notice.
 Information not given: Reason: _____

I release the results to Hillsboro Health, my doctor or assigned healthcare provider and Montgomery County Health Dept., for statistical use. All names and identifying data will be removed from the health department's data. **Testing cannot be done without a health care provider receiving the results.**

Signature: _____ **Date:** _____

Witness: _____

Laboratory Medical Director: _____

SPECIAL INSTRUCTIONS FOR WELLNESS FAIR REGISTRATION

TO REGISTER AND TO SCHEDULE AN APPOINTMENT

- A. Call **217-532-4200** Monday through Friday from 8:30 am to 3:30 pm to schedule an appointment.
- B. Submit your completed registration form with payment by **June 12, 2026**

MAIL COMPLETED REGISTRATION FORMS AND PAYMENT BY **6/12/26 TO:**

**Hillsboro Health
Attn: Alicia Murzynski
1200 E. Tremont St.
Hillsboro, IL 62049**

**You must have a healthcare provider to
participate in the Health Fair.
If not a local provider, please provide a fax
number.**

Water, juice, and granola bars will be available to participants.