A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient,

We want you to receive wellness care/health care assessments that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you may need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care, but Medicare does not pay for a traditional head to toe physical. Medicare does pay for a wellness visit once per year to identify health risks and to help you reduce them. The Medicare Wellness Visit includes the following assessments:

- Screenings to detect depression, risk for falling, cognitive, and other problems;
- A limited physical exam to check your blood pressure, weight, and other items depending on your age, gender, and level of activity; and
- Recommendations for other wellness services and healthy lifestyle changes.

A wellness visit does not deal with new or existing health problems. These would be separate services and require a longer appointment. Please let our scheduling staff know if you need the doctor's help with a health problem, a medication refill, or any other issue outside of your wellness visit. We may need to schedule a separate appointment to address your concerns. Please be aware that a separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.

We hope to help you get the most from your Medicare Wellness Benefits.

Patient Chart# -	
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PLEASE READ THIS NOTICE PRIOR TO SIGNING

Dear Patient,

You are here today for a Medicare Annual Wellness Visit. This is a preventive assessment and is billed as such. The Medicare Annual Wellness Visit is NOT the same as a routine physical checkup. Medicare does NOT cover routine physical examinations.

This Medicare Annual Wellness Visit will include:

- A review of your medical and family history
- Developing or updating a list of current providers and medications
- Height, weight, blood pressure, and other routine measurements
- Detection of any cognitive impairment
- A screening schedule (like a checklist) for appropriate preventive services.

This Medicare Annual Wellness Visit does NOT include:

- Laboratory tests
- Discussion of on-going or chronic conditions
- Medication refills
- Addressing acute conditions

As a courtesy, your provider may provide additional services during the scheduled time allotted for your Medicare Annual Wellness Visit, but there will be an additional office visit charge assessed. If you would prefer your provider only perform services covered under the Medicare Annual Wellness Visit today you must inform the staff PRIOR to seeing your provider.

We will be happy to schedule additional appointments to cover any of your health concerns including follow ups for ongoing conditions, medication refills, and acute issues.

To learn more about Medicare Annual Wellness Visits please go to www.medicare.gov and search for "Annual Wellness Visit".

Date:	<u> </u>	
Patient Name Printed:		
Patient Signature:		

Medicare Annual Wellness Visit Questionnaire

Please complete this questionnaire and bring it with you to your next primary care appointment.

Patient Demographics
Date:/
Name (first, last, middle):
Date of Birth:/ Gender:/ Marital Status:
Home Address:
City: State: Zip Code:
Home Phone: () Cell Phone: ()
Emergency Contact Name:
Emergency Contact Phone: ()
TO BE COMPLETED DURING OFFICE VISIT:
WEIGHT: BMI: BP:
Current Medical Problems (Patient to List Medical Problems)

Past Medical History		
(Hospitalizations, Surgeries, Ot	her Conditions)	
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	WX 0.0.	
Family Medical History		
	any of the following conditions	including their age at onset and
please note if deceased.		
Heart Disease	Hypertension	Diabetes
Mental Health/Depression	Cancer/Type	Other:
Relative Type	Medical History	Deceased (Y/N)
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Other Healthcare Providers You See on a Regular Basis

Provider Name:			
Reason for Visits: _			
Date of Last Visit: _			Next Visit:/
Provider Name:			
Reason for Visits: _			
Date of Last Visit: _	/		Next Visit:/
Provider Name:			
Reason for Visits: _			
Date of Last Visit: _			Next Visit:/
Provider Name:			
Reason for Visits: _	14		
Date of Last Visit: _		_/	Next Visit:/
Provider Name:			
Reason for Visits: _			
Date of Last Visit: _			Next Visit:/
Allergies			
Allergen			Reaction
		U.	
			·

Current Medications (please include OTC and supplements)

Name	Strength	Direction	Pre	escribed By

Detection of Cognition Are you worried about		Yes	No 🔲	
How often has confusion		*	***************************************	k valuntaar or
engage in social activitie	<i>'</i>	interfered with	your ability to wor	k, volunteer, or
Always 🔲 Usua	lly 🔲 Som	etimes	Rarely 🔲	Never 🔲
During the past 30 days for you because of conf		-	or friend provided	care or assistance
		etimes 🔲	Rarely 🔲	Never
Functional Status				
Do you have difficulty g Yes No 🔲	etting out of a cha	ir or car withou	t assistance?	
Do you use a cane or wa	alker?	Yes 🔲	No 🔲	
Do you notice any trouk	ole hearing?	Yes 🔲	No 🔲	
Do you have problems v	with vision?	Yes 🔲	No 🔲	
Falls Risk Screening				
In the last 12 months ha	ave you fallen?	Yes	No	
If yes, how many times?	•			
Were you injured as a re	esult of a fall?	Yes 🔲	No 🔲	

Tobacco Product Use
Select One: None Current Use Past Use
Type of Product: Smoke Smokeless
How much per day?
How long?
Are you willing to quit? Yes No
Screenings and Immunizations (If unknown, please leave blank)
Mammogram:/ Colonoscopy:/ Hemoccult (Stool Card):/ Abdominal Aortic Aneurysm (males who ever smoked only):/ Immunizations (date of last) Flu Shot:/ Pneumonia Shot:/ Tetanus:/ Shingles Vaccine:/ PSA (males only):/
Depression Screening
 Over the past two weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things Yes No Feeling down, depressed, or hopeless Yes No I
Advance Directive Do you have an advance Directive (Living Will)? Yes No II If yes, please bring a copy with you for your medical records.

Patient Health Questionnaire (PHQ-9) Patient Name: _____ Date: _____ 1. Over the last 2 weeks, how often have you been bothered by any of the following problems? More than Nearly Not at all Several half the every day (0)days (1) days (2) (3)a. Little interest or pleasure in doing things b. Feeling down, depressed, or hopeless c. Trouble falling/staying asleep, sleeping too much d. Feeling tired or having little energy e. Poor appetite or overeating f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down g. Trouble concentrating on things, such as reading the newspaper or watching TV h. Moving or speaking so slowly that other people could have noticed, or the opposite; being so fidgety or restless that you have been moving around more than usual i. Thoughts that you would be better off dead or of hurting yourself in some way 2. If you checked any off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other selgoog? ☐ Not difficult ☐ Somewhat □ Very Extremely difficult at all difficult difficult

Total Score