ANNUAL UPDATE

Name: _____DOB: _____ Date**:** _____

Has anything changed in regard to your health in the past year? *(new illness, surgeries, new medication allergies or intolerances, etc.)*

Have there been any significant changes in your life in the past year such as i*ncreased stress, new job, home, relationship, children, ill relatives, etc.?*

Have any of your blood relatives developed any new illnesses in the past year? If any blood relative has had cancer, please list their relation to you, what they had, and how old they were when diagnosed:

Are you presently working outside the home? ❑Yes ❑ No Occupation_____ Spouse's occupation_____
If you have children, what are their names & ages? _____
Does your physical or emotional health limit your social life or ability to care for yourself? ❑Yes ❑ No
Do you currently use tobacco? ❑Yes ❑No What kind(s)? ❑Cigarettes ❑Cigars ❑Pipe ❑Vape ❑Chew
If yes, how much do you smoke (use) daily? _____
If no, have you ever used tobacco? ❑Yes ❑No What kind(s)? ❑Cigarettes ❑Cigars ❑Pipe ❑Vape ❑Chew
If yes, how many packs per day did you smoke? _____ How many years did you smoke? _____ Year Quit_____
Any exposure to secondhand smoke (others smoking around you) currently or in the past? ❑Yes ❑ No
If yes, please explain: _____
Do you currently use recreational drugs (like marijuana, etc)? ❑Yes ❑ No
Do you wear a seatbelt? ❑Yes ❑No ❑Occasionally
Do you exercise regularly? ❑Yes ❑ No If yes, what do you do for exercise and how often? _____
Please describe your diet _____
What do you and your partner use for contraception (*if applicable)*? _____
Have you had a new sexual partner in the past year? ❑Yes ❑ No Are you concerned about HIV or other STDs? ❑Yes ❑ No
Do you see a dentist at least once a year? ❑Yes ❑ No

HEALTHCARE WISHES:

Do you already have a healthcare proxy or living will? ❑Yes ❑No Are you an organ donor? ❑Yes ❑No
Do you agree with the following statement? ❑Yes ❑ No ❑Not Sure

If I had a readily reversible condition like a bad pneumonia, I would want to be placed on life support temporarily; however, I would not wish to remain on life support if I had no chance for a quality of life.

If you were unable to make your own healthcare decisions *(for instance, you were in a coma from a car accident)*, whom would you like us to ask about what your wishes would be? Please name one person and one alternate.

Name: _____Phone No: _____Relationship to You: _____
Name: _____Phone No: _____Relationship to You: _____

Please list any other physicians you are currently seeing:

Name of Physician	**Location**	**Reason**

ANNUAL HEALTH SCREENINGS:

PHQ-9 **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?** ***(Please ✓the appropriate box)***	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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 a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off <u>any</u> problems listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? *(Please **circle** your answer)*	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

S: _____ Dx: _____

AUDIT-C Please **circle** your answers:	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 - 3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

S: _____ Dx: _____

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WHAT IS THE DIFFERENCE BETWEEN AN ANNUAL PHYSICAL AND AN OFFICE VISIT? We would like to clarify some common misunderstandings regarding when a visit is considered a preventative visit, an office visit, or both. Determining how to bill a visit is not an elective decision by the physician and must be made in compliance with government and insurance billing regulations. Insurance companies sometimes request documentation of the visit and we must adhere to appropriate billing guidelines.

An **ANNUAL PHYSICAL** (also known as a "preventative" or "wellness" visit) is a yearly visit for the sole purpose of preventative care which includes a review of your general well being, including a physical exam, discussions of risk factors, health screenings, assessments, and counseling regarding alcohol, depression, obesity, cardiovascular risks, tobacco, etc, recommendations for age appropriate immunizations and screenings such as colonoscopies and mammograms, and screening lab work.

Most health plans will pay for one preventative visit per year with no deductible or co-pay. Your plan may consider this to be once per calendar year **or** one year and one day since the date of your last preventative exam. If you have had any other visit billed as preventative during this time period (including a well-woman gynecologist visit), your plan is likely to deny your preventative exam. It is the patient's responsibility to check with their plan to ensure they are eligible prior to scheduling an annual preventative exam.

An **OFFICE VISIT** is an appointment to discuss new or existing problems. This may include addressing new symptoms or follow-ups for managing chronic conditions such as diabetes, hypertension, etc., prescribing medications, discussing treatment options, ordering additional tests such as an EKG or diagnostic labs, and referrals to specialists.

We believe in treating the whole person and strive to address all of your concerns and properly investigate any issues that arise during your visit. To save time and eliminate an extra appointment, we are happy to address all concerns at one visit as long as time permits, but please be aware that, in some cases, this is considered combining an office visit and a preventative visit all in one and will result in billing for both, and you may have a co-pay and/or deductible responsibility for the portion of the visit that is not preventative. If there is not sufficient time to address both in one visit, the provider may decide to address any new problems and chronic conditions today and ask you to reschedule your preventative visit.

LABS ORDERED AT ANNUAL PHYSICAL: Generally, only a few select "screening" labs are included in the preventative benefit (such as cholesterol screening if you have never been diagnosed with high cholesterol). In the past, many insurance companies would still allow other labs to be processed as screening labs when done with a preventative visit. However, many have begun to strictly apply the preventative guidelines which may result in some of your labs having co-insurance or deductibles applied, depending on your plan. There are too many health plans with different guidelines and exceptions for us to know with 100% certainty how each patient's benefits will be applied.

Therefore, if you are concerned about getting a lab bill, we can offer you the option of paying for your labs at a reduced self-pay price rather than billing them to your insurance company. Our lab, Wake Baptist Diagnostic Lab, offers us a discounted rate that we can pass on to you. The most common set of labs ordered at an annual preventative visit (CBC, CMP, Lipids, and TSH) would cost $29.00 if you elect to self pay (*please ask for complete price list*). **If you choose this option, please let us know prior to having your labs drawn. Once Wake submits the claim to your insurance company, we can no longer make changes.**

NUMBER TO LEAVE PRIVATE MEDICAL MESSAGES: Please indicate whether we may leave voice mail messages that may contain private medical information such as lab or test results, medications, etc:

□ YES, I agree to receive private medical messages at the following phone number: _____

□ NO, do not leave voice mail messages containing private medical information.

By my signature below (or the signature of my representative), I agree that I have read and understand the above notification and that I accept financial responsibility for any services deemed "patient responsibility" by my insurance company.

_____ _____

PRINTED NAME OF PATIENT **DATE**

_____ _____

SIGNATURE OF PATIENT ***(or financially responsible party)*** **PRINTED NAME OF REPRESENTATIVE**
(if signed by someone other than patient)