

**MEDICARE ANNUAL WELLNESS VISIT (AWV)**

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 *increased 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? \_\_\_\_\_

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 \_\_\_\_\_

Have you had a new sexual partner in the past year?  Yes  No Are you concerned about HIV or other STDs?  Yes  No

Does your physical or emotional health limit your social life or ability to care for yourself?  Yes  No

Do you have any difficulties with hearing that limits your personal life?  Yes  No

Do you see a dentist at least once a year?  Yes  No

**During the past 4 weeks**, how would you rate your health?  Excellent  Very Good  Good  Fair  Poor

Do you have any difficulties driving your own car or getting transportation if you do not drive?  Yes  No

**During the past 4 weeks**, was someone available to help you if you needed and wanted help?  Yes  No

Have you fallen 2 or more times in **the past year**?  Yes  No Are you afraid of falling?  Yes  No

Are you able to handle the following activities without help?

Shopping for groceries or clothes :  Yes  No Preparing your own meals:  Yes  No

Doing housework:  Yes  No Handling your money:  Yes  No

Keeping track of medications:  Yes  No Bathing or dressing:  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 #: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

**Please list any other physicians you are currently seeing:**

<u>Name of Physician</u>	<u>Location</u>	<u>Reason</u>

**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 <b>circle</b> your answer)	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

S: \_\_\_\_\_ Dx: \_\_\_\_\_

AUDIT-C Please <b>circle</b> 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: \_\_\_\_\_

**PROGRESSIVE MEDICAL ASSOCIATES, PLLC**  
13220 Rosedale Hill Avenue  
Huntersville, NC 28078

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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)*