Boerne Healthcare Group

PRACTITIONERS IN EXCELLENCE

Welcome to Boerne Healthcare Group!

We would like to thank you for choosing us for your healthcare needs. We look forward to participating in your care and having you as one of our valued patients. We will provide you with high quality personalized care that is comprehensive focusing on prevention through education. Our vision involves a multi-interdisciplinary team approach to ensure your healthcare needs are met. We have enclosed some forms and information to prepare for your first visit. Please review, complete, and sign where applicable to ensure your first visit is efficient and effective.

Our clinic hours are Monday through Friday, 9:00 a.m. to 5:00 p.m. The clinic will be closed for lunch between 12:00 and 1:00 p.m. We offer an online patient portal for viewing medical records.

Our mission is to provide excellence in healthcare to all our patients. We recognize the high costs and the complexity of healthcare and will work toward reducing costs and stream-lining care. In that effort, Boerne Healthcare Group has developed essential policies and procedures that, with your assistance, will ensure a successful and long-lasting relationship.

Our promise to our patients is to include:

- A safe environment in which to discuss your concerns.
- High quality professional services that meet all our healthcare needs.
- Absolute dedication that places you and your needs first.
- An appropriate fee structure that exemplifies the quality of care delivered.

In return, we ask that our patients:

- Keep appointments and arrive at least 15 minutes ahead of time.
- Notify of cancelation at least one day in advance.
- Bring all your current medications with you to each appointment to promote safety in medication management.
- Bring your photo ID, health insurance information, and any outstanding fees owed with you to each visit.

Open communication is key to maintaining safe, quality, and effective healthcare between you and your provider. If you have any concerns or questions, please feel free to discuss with your provider or ask for the office manager.

Consult our website at www.boernehealthcaregroup.com as another option for communication.

Thank you, again, for joining us and being part of the team in taking care of you!

Sincerely,

Michelle Moutre
MSN, APRN-C, AGPCNP
Chief Executive Officer

17 Old San Antonio Road, Ste 202
Kronkosky Senior Center, 2nd floor.
Boerne, Texas, 78006
Phone: 830-331-9880 Fax: 210-519-3012

Patient Registration Form

Patient Information	**Patient Information**			
	Last Name	First Name	M.I.	Previous Name (if applicable)
	Mailing Address:		Apt. #	
	City/State/Zip:			
	Home Phone:	Cell Phone:		Work Phone:
	Preferred Method of Contact for appointment reminders and messages:		□ Voice □ Text	If Voicemail, please select preferred #: □ Home □ Cell □ Work
	Date of Birth:	Gender: □ Male □Female		
	Marital Status:		Social Security #:	
	Employer:		Emergency Contact Name:	
Additional Information/Emergency Contact	**Emergency Contact Information:**			
	Last Name:		First Name:	
	Relationship to the Patient:		Phone #:	
	Address:			
	City/State/Zip:			
	Additional Information: (PLEASE FILL OUT ALL SECTIONS BELOW)			
	Email Address:		Do you want to receive Protected Health Information via Email? □ Yes □ No	
	Race: White □ African American □ Hispanic □ Other □		Cultural Background:(e.g.: American, German, French etc)	
	Preferred Pharmacy Name, location, phone:			
Insurance Information	**Primary Insurance Information**		**Secondary/Supplemental Medical Insurance**	
	Insurance Company Name:		Insurance Company Name:	
	Policy Number:		Policy Number:	
	Policyholder Name:		Policyholder Name:	
	Policyholder Date of Birth:		Policyholder Date of Birth:	
	Policyholder Social Security #:		Policyholder Social Security #:	
	Patient Relationship to Policyholder:		Patient Relationship to Policyholder:	

I have read and agree to Boerne Healthcare Group's (BHG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to BHG all money to which I am entitled for medical expenses related to the services performed from time to time by BHG, but not to exceed my indebtedness to BHG. I authorize BHG to release any medical information to my insurance carrier or third-party payer to facilitate the processing of my insurance claims.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to BHG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party _____ Printed name _____ Date _____

MEDICAL HISTORY

PATIENT NAME _____ **Birth Date:** _____

Reason for being seen today?

_____

Please provide a list of your other health care providers, if any:

_____

List any surgeries or hospitalizations you have had and when:

_____

_____

_____

SOCIAL HISTORY:

Are you on a special diet? □ Yes □ No

Do you use tobacco or vape? □ Current □ Former Smoker □ Never If so, packs/day: _____ for _____yrs.

Do you use alcohol? □ Current □ Former Drinker □ Never If so, drinks/day: _____

FAMILY MEDICAL HISTORY: (Please list any family member with chronic medical conditions)

Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Additional Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my, or the patient's, health. It is my responsibility to inform BHG of any changes in medical status.

_____ _____ _____

Are you pregnant? Yes No N/A Are you taking oral contraceptives? Yes No Are you nursing? Yes No

Do you have or have you had any of the following:

○ Alzheimer's Disease	○ Epilepsy/Seizures	○ Kidney Problems	○ Skin Problems
○ Anemia	○ Headaches/Migraines	○ Liver Disease	○ Thyroid Problems
○ Arthritis	○ Heart Attack/Failure	○ Low Blood Pressure	○ Shingles
○ Asthma	○ Irregular Heart Rhythm	○ Osteoporosis	○ Infectious Disease
○ Blood Disorders	○ Pacemaker	○ Stroke	○ Spinal Disorders
○ Cancer	○ Heart Murmur	○ Irritable Bowel Disease	○ Bladder problems
○ Diabetes	○ High Blood Pressure	○ Crohns/Colitis	○ Vision/Hearing Issues
○ Emphysema/COPD	○ High Cholesterol	○ Prostate Problems	○ Disability

_____ _____ _____

Signature of patient or responsible party Printed Name Date

MEDICATION LIST

Please fill out this form.

Your name:

Your Medication Allergies	Reaction

Please list ALL your medications such as pills, inhalers, eye drops, patches, injections, creams, and so on. Also include any medications you buy over the counter such as herbal products and vitamins.

Your Pharmacy: **Your Family Doctor:**

Medication Name & Strength	Dose (How much do you take?)	Directions (How often do you take it?)

List reviewed/updated by (initial the actual change):

Print Name	Relationship	Date/Time

Additional Comments:

Boerne Healthcare Group

PRACTITIONERS IN EXCELLENCE

ROUTINE VACCINES & SCREENINGS

Screenings	Last Completed
Eye Exam (annually, starting at 65)	
Ear Exam/Hearing Test (annually, starting at age 65)	
Glaucoma Screen	
Cholesterol (every 5 years, high risk more often)	
Diabetes Screening (every 3 years at age 45, high risk more often)	
Fecal Occult Blood Stool tested annually	
Colorectal Screening (ages 45-80) FOB (annually) or Colonoscopy (every 10 years) or Sigmoidoscopy (every 5 years)	
Mammography (annually, starting at age 40)	
Pap Smear (Female age 21-65 every 3 years starting age 21, over 30 include HPV testing; over 30 interval can be extended to every 5 years by co-testing with combination PAP and HPV testing. Annual for women at high risk)	
Clinical Breast Exam (every 3 years ages 20-39, and annually, starting at age 40)	
Bone Density/Osteoporosis Risk Screening (women 65 or younger)	
Prostate Specific Antigen (PSA) Male starting at age 55)	
Depression Screen (annually)	
Abdominal Aortic Aneurysm Screen (former or current smoker male age 65-75)	
Smoking Cessation Counseling: up to 8 sessions/year	
Alcohol Use Counseling	
Exercise Counseling	
Depression Screen (annually)	
Cognitive Screening (annually, starting at age 65, per Medicare)	
Falls in the past year (number of falls/injury)	
COVID-19 Vaccine/Boosters	**Have not taken?** (check mark)
Influenza Vaccine	
Pneumonia Vaccine	
Tetanus Vaccine	
Shingles Vaccine	

Pfizer/Moderna/JJ	Month	Year

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* 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?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

General Anxiety Disorder (GAD-7)

NAME DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked 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 people?	☐ 0	☐ 1	☐ 2	☐ 3

Scoring *Add the results for question number one through seven to get a total score.*

If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe.

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

Introduction

It is the physician's responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability act (HIPAA) allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. Without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Boerne Healthcare Group realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medial needs. Your provider wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below.

Please note the follow points:

- If you designate no one, Boerne Healthcare Group will not release information to any family member, friend or legal representative.
- This Release of Information expires 1 year from the date it is signed.
- This designation is valid until you cancel it in writing.

Designation Statement

I, _____, designate the following person(s) to be able to speak to the provider at Boerne Healthcare Group, or other staff member, should it be necessary, on my behalf. I hereby give permission to Boerne Healthcare Group through its providers and staff to release to my designee(s) any information about my medical condition or medical needs or the status of my account and I release Boerne Healthcare Group its providers, and staff, from any claim of confidentiality in connections with the release of this information.

Name	Relationship	Phone #

Patient's Name: _____ Patient's Signature: _____

Date: _____ Witness: _____

I decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: _____ Date: _____ Witness: _____

Boerne Healthcare Group

17 Old San Antonio Road, Suite 202
Boerne, Tx, 78006
Phone: 830-331-9880
Fax: 210-519-3012
Email: contact@boernehealthcaregroup.com

Authorization for Release of Personal Health Information (PHI)

Must BE Completed for All Authorizations:

I hereby authorize the use and disclosure of my personal health information as described below. I understand that this authorization is voluntary, and will in no way affect treatment, payment, enrollment or benefit eligibility. I further understand that I may inspect and copy any information disclosed pursuant to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ **DOB:** _____ **SSN:** _____

Person/organization providing the information:	Person/organization receiving the information:
	Boerne Healthcare Group
	17 Old San Antonio Road, Suite 202
	Boerne, Texas, 78006
	Fax: 210-519-3012

The purpose for this authorized release of information is _____ and is at the request of the individual.

I authorize the health care provider to rlease the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If thee are not marked they cannot be released.

☐ Drug Abuse	☐ Substance Abuse	☐ Psychological or Psychiatric conditions	☐ AIDS/HIV

Please release the following records:

	History & Physical		Recent lab results		Recent Imaging Results		Progress Notes
	All records generated in your office						
	Records that apply to these specific dates of treatment						
	Records that apply to this specific problem or intervention						

Are you leaving our practice? Yes No
If yes, please explain: _____

Must be Completed for All Authorizations:

1. I understand that this authorization will experie 90 days from the date of signature.
2. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations ad that the information may be redisclosed by the parties listed, and no longer protected.
3. I understand that Federal and State Regulations allow for a reasonable fee to be charged for the duplication of Protected Health Information, and that I may be charged a fee to copy and mail the records I am requesting.

_____ _____ _____
Signature of Patient or Patient's Representative **Date** **Printed Name of Patient or Patient's Representative**

Revocation of Authorization:

I understand that authorization is voluntary and may be revoked at any time by signing below and returning to the practice. I further understand that any such revocation oes not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

I hereby revoke this authorization, effective _____.

_____ _____ _____
Signature of Patient or Patient's Representative **Date** **Printed Name of Patient or Patient's Representative**

PLEASE COMPLETE THIS SECTION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(The Notice of Privacy Practices is available for review on the website at www.boernehealthcaregroup.com)

Practice Name: BOERNE HEALTHCARE GROUP

I acknowledge that I have reviewed a copy of the Practice's Notice of Privacy Practices.

_____ ___/___/____

Print Name Date of Birth

_____ ___/___/____

Patient (or Patient Representative*) Signature Today's Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

	Individual refused to sign
	Communication barriers prohibited obtaining the acknowledgement
	An emergency situation prevented us from obtaining acknowledgement
	Other (Please specify)

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*If the patient representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

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Cancellation, No show and Late arrival policy

In an effort to maximize the time your physician spends with you and minimize your wait time, we have made changes to our No-Show, Cancellation, and Late Arrival Policies as follows.

No show policy

Effective June 1, 2015, we will implement a "no-show" policy, which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

- First occurrence – Patient will receive a warning letter advising of our policy.
- Second occurrence – Patient will receive a 2nd letter and a $25.00 no show fee
- Third and subsequent occurrences – May result in dismissal from practice and additional $25 no show fee

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Late arrival policy

Patients arriving more than 20 minutes late for a scheduled follow up visit or new patient visit appointment will be rescheduled for another day.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to management.

Please sign below that you have read, understand, and agree to this policy.

Patient Name _____

Date of Birth _____

Signature of Patient or Patient Representative

_____ **Date** _____

Boerne Healthcare Group

PRACTITIONERS IN EXCELLENCE

THE NO SURPRISES ACT

STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care. If you are uninsured, this document is to let you know what your estimated costs will be for care.

IMPORTANT: You aren't required to sign this form and should not sign it if you did not have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you are getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out- of-pocket limit. Contact your health plan for more information.

You **should not** sign this form if you **did not** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

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Estimate of what you could pay: from $20.00 to $250.00 depending based on out-of-network or self-pay

Patient Name: _____

Out-of-network provider(s) or facility name: Boerne Healthcare Group PLLC

Total cost estimate of what you may be asked to pay:

- ▶ Review your detailed estimate. See Page 4 for a cost estimate for each item or service you'll get.
- ▶ Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
- ▶ Questions about this notice and estimate? Call Boerne Healthcare Group at 830-331-9880 or email at contact@boernehealthcaregroup.com.
- ▶ Questions about your rights? Contact www.cms.gov/nosurprises or call 1-800-985-3059.

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

More information about your rights and protections

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care, or I am agreeing to the cost estimate for self-pay if I am uninsured.

With my signature, I am saying that I agree to receive items or services from:

Michelle A. Mourre, CNP

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice. • I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

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IMPORTANT: You do NOT have to sign this form. But if you do NOT sign, this provider might not treat you. You can choose to get care from a provider or in your health plan's network.

_____ or _____	
Patient's signature	Guardian/authorized representative's signature
_____	_____
Print name of patient	Print name of guardian/authorized representative
_____	_____
Date and time of signature	Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

Boerne Healthcare Group

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FEDERAL TAX ID: 45-4406550
GROUP NPI: 1720791056

More details about your estimate.

Patient name: _____

Out-of-network provider: Boerne Healthcare Group PLLC

The amounts highlighted below are only an estimate, it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan will cover. This means that the final cost of services may be different than this estimate. Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

Initial Visit New OON or Uninsured Patients			50% discount
New Patient Visit (15-29 min – 1 problem)	$150.00	-$75.00	$75.00
New Patient Visit (30-44 min – 2 problems)	$220.00	-$100.00	$110.00
New Patient Visit (45-59 min – 3 problems)	$330.00	-$165.00	$165.00
New Patient Visit (60-74 min) – 4+ problems)	$430.00	-$215.00	$215.00
Est Patient Follow Up Visit OON or Uninsured Patients	50% discount off of a 20% reduced rate		
Est Patient Follow Up Visit (10-19 min, 1 problem)	$110.00	$55.00	$55.00
Est Patient Follow Up Visit (20-29 min, 2 problems)	$180.00	$90.00	$90.00
Est Patient Follow Up Visit (30-39 min, 3 problems)	$250.00	$125.00	$125.00
Est Patient Follow Up Visit (40-54 min, 4+ problems)	$325.00	$175.00	$175.00
Other Common Testing & Services (Inquiries are required for other services not listed)			
Urine Dipstick			$25.00
12L ECG			$95.00
Strep Test			$10.00
Influenza Test			$22.00
Hgb A1c			$25.00
Glucose Check			$5.00

Total Estimate: This good faith estimate explains our rates for each service provided by Boerne Healthcare Group. Telehealth or in-person charges are identical. Not all services are listed. The patient is responsible to inquire about any additional charges that may be included in the proposed care or treatment.

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ANNUAL PHYSICAL VISITS vs OFFICE VISITS

Annual Physical, Preventive, or Wellness Visit	Office Visit, Sick Visit, or Medication Management
Focused on prevention, education, immunization, and annual screenings. **Physical Exams may include:** 1. **Well Women's Visit – Pap smears, breast exams** 2. **Male Exam – Prostate & Testicular Screenings** 3. **Skin inspection** 4. **Fall Risk Assessment** 5. **Cognitive Assessment** 6. **ADLs and IADLs Assessment** 7. **Immunizations** 8. **Follow up lab testing as appropriate** 9. **Referrals for:** a. **Mammogram** b. **Colonoscopy** c. **Eye Exams** d. **Hearing Tests** e. **Bone Scan** **Wellness visits are usually copay exempt. If a new or chronic condition(s) are addressed, an office visit will also be performed and billed.**	**The appointment visit will include discussion and evaluation of a new or existing mental health condition or medical condition:** **Office Visit/Follow Up appointment will be to:** 1. **Evaluate and treat symptoms and concerns.** 2. **Address Chronic problems.** 3. **Adjust medications and process refills.** 4. **Laboratory testing results to be ordered or reviewed.** 5. **Request and/or process referrals.** **Copays, deductibles, and co-insurance may apply.**

MEDICARE VISITS EXPLAINED

Medicare Coverage of Physical Exams—Know the Differences

Initial Preventive Physical Examination (IPPE)

Review of medical and social health history, and preventive services education

- ✔ Covered only once, within 12 months of Part B enrollment
- ✔ Patient pays nothing (if provider accepts assignment)

Annual Wellness Visit (AWV)

Visit to develop or update a personalized prevention plan, and perform a health risk assessment

- ✔ Covered once every 12 months
- ✔ Patient pays nothing (if provider accepts assignment)

Routine Physical Examination (See Section 90)

Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury

- ⊘ Not covered by Medicare; prohibited by statute
- ⊘ Patient pays 100% out-of-pocket