Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_ GWY#\_\_\_\_\_\_\_\_\_\_

Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You have scheduled an appointment on \_\_\_\_\_\_\_\_\_\_\_\_\_ for:

\_\_\_\_\_\_\_ Medicare’s “Welcome to Medicare” Visit

(Benefit available 1 time in your first 12 months of enrollment with Medicare Part B)

\_\_\_\_\_\_\_ Medicare’s Annual Wellness Visit (Initial or Subsequent Exam)

(For beneficiaries past their first 12 months of Medicare Part B enrollment and 12 months after a Welcome to Medicare exam, if that was received)

\_\_\_\_\_\_\_ Adult Wellness or Annual Physical

A. Medicare Part B: This service continues to be non-covered by original Medicare Part B Medicare will deny this service and payment will be your responsibility. If you qualify and would prefer to receive one of Medicare’s covered Wellness services (i.e., Welcome to Medicare or Annual Wellness Visit), complete the attached forms & questionnaires and present them at the time of your appointment.)

B. Medicare Advantage primary (i.e. Medicare Part C / Replacement Plan): Please check with your insurance plan to verify your benefits and coverage for this routine annual physical exam

service.

-Enclosed you will find the Patient Questionnaire packet required for the covered Medicare Wellness services.

-Please complete all the enclosed questionnaires and bring the completed forms to your visit.

-If you don’t complete it before your appointment, you may be asked to reschedule.

Thank you! We are looking forward to seeing you.

**Reeves Medical Associates PLLC.**

**Understanding Medicare Wellness Visits**

IMPORTANT: There are two types of Medicare covered wellness visits. They are focused on wellness, risk factor reduction, and prevention. They are not the same as a “routine physical checkup” or “routine annual exam” and do not include a review of already diagnosed conditions. There continues to be no coverage from Medicare for traditional, age-specific physicals.

These 2 Medicare Wellness Visits are covered by Medicare at 100%, without deductible or coinsurance, if the frequency limits are not exceeded.

1. “**Welcome to Medicare**” or IPPE: once per lifetime in the first 12 months of Part B Enrollment.

2. **Annual Wellness Visit**

**Initial**: once per lifetime after the first 12 months of Part B enrollment and at least 12 months after a “Welcome to Medicare” visit (if applicable)

**Subsequent**: once every 12 months, first one at least 12 months after the initial Annual Wellness Visit

**Items billed separately from the Medicare Wellness Visit** include Laboratory, Radiology tests and other routine preventive services such as mammograms, vaccinations etc. which may be ordered at the same time but will be subject to usual Medicare applicable coverage guidelines and frequency limits. Deductible and coinsurance may apply.

**An additional office visit service code** may be applied if your visit included discussion of chronic health conditions, new health concerns or previously diagnosed medical conditions for which routine follow up is necessary.

**List of Providers & Suppliers of Healthcare**

Please list all of your current providers and suppliers of healthcare

Specialist(s): Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternative medicine providers (i.e., chiropractors, acupuncturists, etc.):

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy(s): Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Doctor: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bring All medication bottles to your visit**

**Health Risk Assessment**

1. In general, would you say your health is:

\_\_\_ Excellent\_\_\_ Very Good \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

2. How have things been going for you during the past 4 weeks?

\_\_\_ Very well; could hardly be better

\_\_\_ Pretty well

\_\_\_ Good and bad parts about equal

\_\_\_ Pretty bad

\_\_\_ Very bad; could hardly be worse

3. How confident are you that you can control and manage most of your health problems/issues?

\_\_\_ Very confident\_\_\_ Somewhat confident\_\_\_ Not very confident

\_\_\_ I do not have any health problems

4. How often in the last 4 weeks have you been bothered by any of the following problems?

-Dizzy when standing up\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Sexual problems or concerns\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Trouble swallowing or eating\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Teeth or denture problems\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Problems with memory \_\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Tiredness or fatigue\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Problems with your vision \_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Difficulty using the phone\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Difficulty speaking or writing\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Problems sleeping\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

-Problems with access to nutritional foods\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

5. Have you fallen in the past year? \_\_\_ YES \_\_\_ NO -How many? \_\_\_\_\_

7. HOME SAFETY CHECKLIST

Are entrance ways well lit? \_\_\_ YES \_\_\_ NO

Are sidewalks/entrance ways maintained? \_\_\_ YES \_\_\_ NO

Is a carbon monoxide detector installed? \_\_\_ YES \_\_\_ NO

Are smoke detectors installed? \_\_\_ YES \_\_\_ NO

Are all medicines kept in original containers labels intact? \_\_\_ YES\_\_\_ NO

Do you throw out all unidentified or out-of-date medications? \_\_\_ YES \_\_\_ NO

8. How often do you have trouble taking medicine the way you were advised to take them?

\_\_\_ I do not have to take medicine

\_\_\_ I always take medicine as directed

\_\_\_ Sometimes I take them as directed

\_\_\_ I often have trouble taking them as directed

9. Are you having difficulty driving your car?

\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time\_\_\_ N/A – I do not use a car

10. Do you always fasten your seat belt when you are in a car?

\_\_\_ Yes, always \_\_\_ Sometimes \_\_\_ No

11. With your hearing, in the last 4 weeks have you experienced the following:

Strain to hear conversation \_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

Trouble with background noise\_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

Misunderstanding others \_\_\_ Not at all \_\_\_ Half the time \_\_\_All the time

12. During the past 4 weeks how much have you been bothered by being down, depressed or hopeless?

\_\_\_ Not at all \_\_\_ Several Days \_\_\_ Half or more days \_\_\_ Daily

13. During the past 4 weeks have you lost interest or pleasure in usual activities?

\_\_\_ Not at all \_\_\_ Several Days \_\_\_ Half or more days \_\_\_ Daily

14. During the past 4 weeks, has your physical or emotional health limited your social activities with family and friends?

\_\_\_ Not at all \_\_\_ Several Days \_\_\_ Half or more days \_\_\_ Daily

15. During the past 4 weeks, how much bodily pains have you generally had?

\_\_\_ Not at all \_\_\_ Several Days \_\_\_ Half or more days \_\_\_ Daily

16. Do you have someone who is available to help you if you needed or wanted help? \_\_\_ Not at all \_\_\_ Several Days \_\_\_ Half or more days \_\_\_ Daily

17. Because of any health problems, do you need the help of another person with shopping, preparation of meals, or house work? \_\_\_ Yes \_\_\_ No

18. Because of any health problems, do you need the help of another person with your personal care needs, such as eating, bathing, dressing, or getting around the house? \_\_\_ Yes \_\_\_ No

19. Can you handle your own money without help? \_\_\_ Yes \_\_\_ No

20. During the past 4 weeks, did you exercise for about 20 minutes, 3 or more days a week? \_\_\_ No, I am not currently exercising

\_\_\_ Less than 20 minutes 3 days a week

\_\_\_ More than 20 minutes 3 days per week

\_\_\_ Daily

21. When you exercise, how intensely to you typically exercise?

\_\_\_ Light (stretching/slow walking)

\_\_\_ Moderate (brisk walking)

\_\_\_ Heavy (jogging/swimming)

\_\_\_ Very Heavy (running/stair climbing)

22. Are you a smoker/tobacco user?

\_\_\_ No – never

\_\_\_ No – former

\_\_\_ Yes, and I am interested in quitting

\_\_\_ Yes, but I’m not ready to quit

23. In the past 7 days, on how many days did you drink alcohol? \_\_\_\_\_ days

24. On days when you drank alcohol, how often did you have 4 or more drinks?

\_\_\_ Never

\_\_\_ Once during the week

\_\_\_ 2-3 times during the week

\_\_\_ More than 3 times during the week

Thank you for completing this Medicare Wellness Health Risk Assessment.

**Don’t forget to bring all 7 pages to your office visit.**