NAME: DOB:

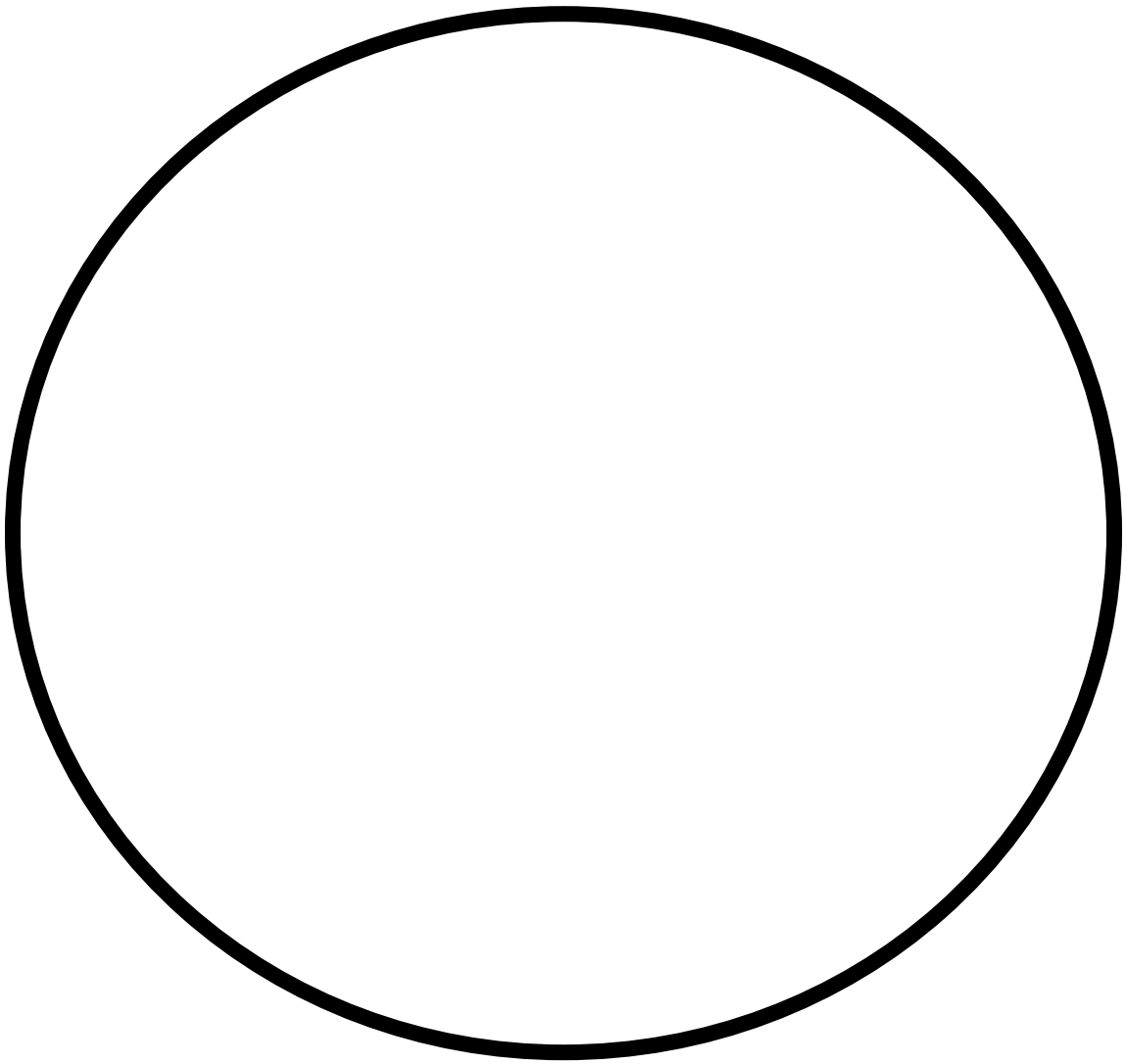
Medicare Annual Wellness Visit

The Medicare Annual Wellness Visit (AWV) is an opportunity to meet with a provider and focus on important health screenings and preventions. ***It is not a visit to evaluate new or ongoing medical problems and does not cover the management of medical problems such as labs/prescriptions/etc.*** *It's a proactive discussion about 'big picture' issues regarding your health. The focus of an AWV is on preventive services which are proven to keep you well; or to catch potential medical conditions as early as possible. The AWV includes services such as: immunizations, on-site screenings, and referrals for screening services.* ***Topics discussed that fall outside of the Medicare AWV guidelines may incur a copay or deductible charge, following the CMS (Medicare) coding rules.***

This circle represents the face of a clock.

Please put the numbers on it so that it looks like a clock.

Please add the hands of the clock to indicate the time "three forty-five", or 3:45.



NAME: DOB:

Activities of Daily Living

In the past WEEK, have you needed help with any of the following activities?

Using the toilet ☐ YES ☐ NO

Dressing ☐ YES ☐ NO

Eating ☐ YES ☐ NO

Bathing ☐ YES ☐ NO

Housework ☐ YES ☐ NO

Difficulty driving ☐ YES ☐ NO

Falls

Do you feel unsteady on your feet?

YES NO

Do you worry about falling?

YES NO

Have you fallen 2 or more times in the past YEAR?

YES NO

Number of times: _____

Were you injured? YES NO

Memory

In the last MONTH, how often did you have trouble remembering or thinking clearly?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

Home Medical Equipment

Do you use home medical equipment?

☐ YES ☐ NO

Who do you receive your home medical equipment from? _____

Hospital and ER Visits

During the past 6 MONTHS, how many times did you go to the Emergency Room? _____

During the past 6 MONTHS, how many times did you stay in the hospital overnight as a patient?

_____

Family History

Have any of your immediate family members (parents, siblings, or children) had the following diseases?

Heart Attack ☐ YES ☐ NO

If yes, who? _____

Stroke ☐ YES ☐ NO

If yes, who? _____

Diabetes ☐ YES ☐ NO

If yes, who? _____

Cancer ☐ YES ☐ NO

If yes, who? _____

Living Situation

Who lives with you? _____

If you live alone, who can you call if you need help?
Contact Name: _____

Contact Phone Number: _____

Do you have a caretaker or someone that helps you with daily living?

Caretaker Name: _____

Pain

Over the last 4 weeks, how much bodily pain have you generally had, on a scale of 0 (lowest) to 10 (highest)? _____

NAME: DOB:

Social Needs

Housing: Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as part of a household?

YES NO

Think about the place you live. Do you have problems with any of the following?

- ☐ Bug infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ No or not working smoke detectors
- ☐ Water Leaks
- ☐ None of the above

Food: Within the past 12 months, have you been worried that your food would run out before you got money to buy more?

YES NO

Transportation: Do you put off or neglect going to the doctor because of distance or transportation?

YES NO

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

YES NO

Are you having difficulties driving your car?

YES NO N/A

Utilities: In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home? YES NO

Tobacco Use: Please indicate your tobacco history:

- ☐ Never used tobacco
- ☐ Current tobacco user
  - _____ packs per day
  - _____ cans per day
- ☐ Former tobacco user
  - Quit Date: _____
  - Previously used: _____ years
  - Previously used: _____ packs/cans per day

Alcohol Use: In the last 4 weeks, how many alcoholic beverages have you had on average?

_____ per week

Exercise: In general, how many days per week do you exercise? _____

On days that you exercise, how long do you exercise? _____

How intense is your typical exercise?

Light Moderate Heavy Very Heavy

Advanced Directive:

Do you have a living will? (If you haven't already, please bring a copy to the office at your convenience.)

YES: _____ NO

Do you have a Durable (healthcare) Power of Attorney?

YES: _____ NO

NAME: DOB:

Specialty Providers: Outside of CFP, list all physicians/providers that you currently see:

Allergy:	Oncology (cancer):
Cardiology (heart):	Opthalmology (eye):
Dermatology (skin):	Physical Therapy:
Gastroenterology (stomach/liver):	Podiatry (foot):
Endocrinology (diabetes/thyroid):	Pain:
Head Neck and Ear:	Pulmonary (lungs):
Nephrology (kidney):	Rheumatology:
Neurology:	Urology (bladder):
OB/GYN:	Other:

In general, how would you rate your current health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How confident are you that you can control and manage most of your health problems?

☐ Very confident ☐ Somewhat confident ☐ Not very confident ☐ N/A

Review of Systems:

(Reminder: If your concerns fall outside of the Medicare wellness visit guidelines listed on page 1, it will lead to a separate evaluation which may not be covered 100% by Medicare (or Medicare Advantage Plans). If so, you will receive a bill for the balance.)

Circle any symptoms you have had over the last 4 weeks and/or would like to discuss with the provider

GENERAL	Fever Chills Sweats Weakness Fatigue Weight Loss Weight Gain
CARDIOLOGY	Irregular Heartbeat Chest Pain Passing Out Leg Swelling
DERMATOLOGY	Skin Lesion Rash New/Changing Mole
ENDOCRINOLOGY	Excessive Sweating Excessive Urinating Excessive Thirst Increased Appetite Cold Intolerance Heat Intolerance
GASTROENTEROLOGY	Abdominal Pain Nausea Vomiting Diarrhea Constipation Blood in Stool
HEMATOLOGY	Swollen Glands Easy Bruising
MUSCULOSKELETAL	New/Worsening Joint Pain; Back Pain; Cramping Down Back of Leg; or Cramping in Lower Leg
NEUROLOGY	Headache Dizziness Memory Loss Numbness/Tingling Unsteady Walking
OPHTHALMOLOGY	Blurred Vision Visual Changes
PSYCHOLOGY	Depression Anxiety Sleep Disturbances
RESPIRATORY	Shortness of Breath Wheezing Coughing Up Blood Persistent Cough
UROLOGY	Painful Urination Blood in Urine Urinary Incontinence
GENITOURINARY	Pelvic Pain Breast Pain Pain w/ Intercourse Frequent Nighttime Urinating Obstructive Symptoms when Urinating Abnormal Bleeding Abnormal Discharge

NAME: DOB:

Patient Health Questionnaire – 9 (PHQ9):

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

Not at all Several days More than ½ the days Nearly every day

Feeling down, depressed, or hopeless

Not at all Several days More than ½ the days Nearly every day

Trouble falling asleep, staying asleep, or sleeping too much

Not at all Several days More than ½ the days Nearly every day

Feeling tired or having little energy

Not at all Several days More than ½ the days Nearly every day

Poor appetite or overeating

Not at all Several days More than ½ the days Nearly every day

Feeling bad about yourself, or that you are a failure or have let your family down

Not at all Several days More than ½ the days Nearly every day

Trouble concentrating on things, such as reading or watching TV

Not at all Several days More than ½ the days Nearly every day

Moving or speaking so slowly that other people may have noticed – or the opposite- being so fidgety or restless that you are moving around a lot more than usual

Not at all Several days More than ½ the days Nearly every day

Thoughts that you would be better off dead or hurting yourself

Not at all Several days More than ½ the days Nearly every day

Generalized Anxiety Disorder 7-Item Scale (GAD7):

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Feeling nervous, anxious, or on edge

Not at all Several days More than ½ the days Nearly every day

Not being able to stop or control worrying

Not at all Several days More than ½ the days Nearly every day

Worrying too much about different things

Not at all Several days More than ½ the days Nearly every day

Trouble relaxing

Not at all Several days More than ½ the days Nearly every day

Being so restless that it's hard to sit still

Not at all Several days More than ½ the days Nearly every day

Becoming easily annoyed or irritable

Not at all Several days More than ½ the days Nearly every day

Feeling afraid as if something awful might happen

Not at all Several days More than ½ the days Nearly every day

NAME: DOB:

Medicare Shared Savings Program Accountable Care Organizations

Working together to give you the best care.

Community Family Practice is part of an Accountable Care Organization (ACO). We've teamed up with other doctors, hospitals, and health care providers to make sure you get the best care.

We provide coordinated care for you to get well & stay well

- You get patient-centered care focused on YOUR needs.
- Your health care providers can see the same test results, treatments, and prescriptions.
- More coordination helps prevent medical errors and drug interactions.
- You may save time, money, and frustration by avoiding repeated tests and appointments.
- Better communication can help protect against Medicare fraud and waste.

Get the most from your care with our communication & support

- **Ask about signing up for our secure online portal.** You'll get 24-hour access to your personal health information, including lab results and communication from your health care provider.
- When you choose a health care provider that participates in an ACO, they'll help you get the right care at the right time. You can visit **Medicare.gov** and log into (or create) your secure Medicare account to choose a primary care doctor.
- Medicare protects the privacy of your health information. If you don't want Medicare to share information with your health care providers for care coordination, call 1-800-MEDICARE (1-800633-4227). Medicare may still share general information to measure provider quality. For more information on how Medicare may use and give out your information, visit Medicare.gov and search for "privacy."

Want more information?

Ask our front desk, or call us at 828-254-2444. You can also visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | MEDICARE SHARED SAVINGS PROGRAM

NAME: DOB:

Today's Date:

YEARLY DEMOGRAPHIC UPDATES

PATIENT INFORMATION

Patient's Name:

Date of Birth:

Marital status:

Employment status:

Gender (current gender identity):

Sex assigned at birth:

Preferred pronouns (circle one):

She/Her He/His They/Their

Former name (if different):

Preferred name (if different):

Race:

Ethnicity:

Address:

Social Security no.:

Home phone no.:

Cell phone no.:

OK to leave message on machine? Yes No

Preferred method of contact for reminders? Text Call

Primary Language Spoken:

Interpreter needed? Yes No

EMAIL Address: _____

*By giving this email address, I consent to being signed up for the Patient Portal.

PHARMACY:

INSURANCE INFORMATION: GIVE CARD TO THE FRONT DESK

Subscriber's Name:

Subscriber's DOB (if different):

Address (if different):

Phone number (if different):

Employer (if applicable):

Primary Insurance Company:

Policy number/Subscriber ID:

Group Number:

Secondary Insurance Company (if applicable): GIVE CARD TO FRONT DESK

IN CASE OF EMERGENCY

Name of Emergency Contact: Relationship to patient: Phone Number:

HIPAA CONSENT: **This must be updated yearly. Without signed consent, we can NOT share information regarding your medical care (ex: lab results, appointment dates, etc) or billing to anyone, including family members. Please list anyone that you want to allow to have access to this information.**

1. _____ **2.** _____

SIGNATURE: HIPAA CONSENT, ALL POLICIES, DISCLOSURES, AND CONSENTS including ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (SEE NEXT PAGE FOR FULL LIST): (Refusal to sign does NOT prevent responsibility/obligation regarding this office's policies) I consent to evaluation and treatment by my provider. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Community Family Practice or insurance company to release any information required to process my claims.

Patient Signature **Date**

Financial Policy, Office Policies, and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Community Family Practice, PA.

NAME: DOB:

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give any or new updated insurance information 3) Expenses not covered by insurance including labs 4) deductible not met 5) services rendered deemed medically unnecessary by insurance or non-covered/excluded services by your plan 6)not in network with your plan. ****Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries). Your contract is between you and your insurance carrier. YOU ARE RESPONSIBLE FOR VERIFYING NETWORK STATUS DIRECTLY WITH YOUR INSURANCE CARRIER.** Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections reported to your credit. The billing office may use multiple forms of communication to inform you about your bill, including email, text, and mail. Please inform the office if you wish to unenroll from any of these forms of communication for billing purposes.

Returned Checks: In the event a check is returned for Non-Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non-Sufficient Funds.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. If you need a prescription refill, please call your pharmacy and ask that they fax a refill request to our office. Our providers will review the request and refill the prescription by return fax or we may request you make a follow up appointment, if necessary. Please allow 48 hours to respond to refill requests.

Missed Appointments: We charge up to $45.00 for a no-show or late-cancel appointment (less than a 24-hour notice) and for 3 or more rescheduled appointments in a 12-month period. This charge cannot be billed to insurance and will be billed directly to the patient. Please help us to serve you better by keeping all scheduled appointments. Patients that "no-show" or late-cancel 3 appointments within 1 year may be dismissed from the practice.

Inactive Patients: Continuity of care is important. Patients should see their PCP at least once a year. Charts for patients that haven't been seen in 3 years will be automatically inactivated. If the patient chooses to return, they will be considered a new/return patient.

HIPAA:

HIPAA COMPLIANCE STATEMENT - *THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE COMPLY WITH ALL FEDERAL, STATE, AND LOCAL LAWS. PLEASE REVIEW IT CAREFULLY.*

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our office, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION MAY BE USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include: other physicians, laboratories, Accountable Care Organizations, and view/share information with the NC Health Information Exchanges (HIE). To protect your privacy, we have business associate agreements with applicable organizations, requiring them to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

CUSTODY AGREEMENTS – If you have a child custody agreement/court order, we will need a copy to have on-file. We cannot contact parents separately regarding patient care, unless specifically stated in a legal child custody agreement. Please reference our Divorce/Marital Discord Policy via the practice website communityfamilyonline.com for more information.

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager at 828-254-2444.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES – I have received a copy of the Notice of Privacy Practices for Community Family Practice, PA.

Other Disclosures and Consents:

View and Share Aggregate Data –

I hereby grant consent to CFP to share or view aggregated data with Health Information Exchanges. *If you do not consent, please get a declination form from the front desk.

Authorization to mail, call, text, or email -

I certify that I understand the privacy risks of mail, phone calls, text, and emails. I hereby authorize a CFP representative or my physician to mail, call, text, or email me with communications regarding billing, my health care, including but not limited to such things as appointment reminders, referral arrangements, laboratory results and billing statements. I understand that I have the right to rescind this authorization at any time by notifying CFP to that effect in writing.

Lab/X-Ray/Diagnostic Services –

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services, if they are not reimbursed by my insurance for whatever reason.

Consent to Treatment -

I hereby consent to evaluation and treatment as directed by my CFP physician or his/her designee. Treatment may include but is not limited to: procedures, medications, or vaccines. I hereby consent to CFP obtaining and viewing my prescription and vaccine histories as reported by outside sources.

**** SIGN AND DATE PREVIOUS PAGE ****