MEDICARE WELLNESS: PATIENT PACKET

(Medicare patient's only)

You are scheduled with _____ on _____ for a:

☐ Medicare's "Welcome to Medicare" Visit (AKA IPPE) *Medicare Wellness*
(Benefit available one time in your first 12 months of enrollment with Medicare Part B)

☐ Medicare's Annual Wellness Visit (AKA AWV) *Medicare Wellness*
(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)

☐ Regular Adult CPX (Physical Exam)

- Medicare Part B primary: 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 service (i.e., Welcome to Medicare or Annual Wellness Visit), complete the attached form & questionnaires and present them at the time of your appointment.)
- 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 make sure your name and date of birth are on each page.

IT INCLUDES:

- Materials explaining the Medicare Wellness benefits & what to expect
- Health Risk Assessment (HRA) form
- Depression Screening Questionnaire (PHQ-9)
- List of providers & suppliers of healthcare form

Please complete all of the enclosed questionnaires prior to your appointment. Please bring all of the completed questionnaires with you to your appointment and give them to your provider. Your provider will go over these documents as part of your service. If you don't complete it before your appointment, you may be asked to reschedule.

Thank you!

PATIENT INFORMATION

Patient Name:	Date of birth:	Sex:
Address:	APT#: City:	
State: Zip: Phone (home):	(cell):	
E-Mail:	Social Security#:	
Marital Status: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ DOMESTIC PARTNERSHIP		
ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC RACE:	LANGUAGE:	
Insurance Number:	Secondary Insurance:	

AUTHORIZATION OF TREATMENT

Authorization and release for Docs Medical/ Docs Urgent Care and its subsidiaries (Docs of CT, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group, 203 Urgent Care and Urgent Care Center), hereby referred as Docs Medical Group. I voluntarily consent to the administration and costs of medical and surgical procedures for myself or my dependent.

ASSIGNMENT OF INSURANCE BENEFITS/GUARANTEE OF PAYMENT

I authorize payment directly to Docs Medical Group/Docs Urgent Care and its subsidiaries (Docs of CT, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group, 203 Urgent Care and Urgent Care Center) for all benefits payable to me. I understand that I am financially responsible and agree to pay all charges that are not paid or billed to my insurance or any third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted I must pay all applicable insurance co-payments, co-insurance, or deductible for services. I understand all services rendered are non-refundable under any circumstance. I understand that is I do not pay within 90 days upon receiving my billing statement; my account will be transferred over to "American Adjustment Bureau."

RELEASE TO RECORDS

I authorize Docs Medical Group/Docs Urgent Care and its subsidiaries (Docs of CT, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group, 203 Urgent Care and Urgent Care Center) to release (verbal or written) confidential medical information to any person or entity including my insurance carrier, employer (if treatment is related to employer purposes), or other health care operations which may be liable to me or my practitioner(s) for changes in treatment, for quality management, utilization review, transfer, and follow-up purposes.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

Social History (check all that applies)

Tobacco: □ Current Type: Freq: □ 2nd hand □ Never □Prior use Quit Date:
Alcohol: □ Never □ Occasional □ Daily History of Alcoholism: (describe)
Drug abuse: □ Never □ Occasional □ Daily □ Prior Use Quit Date: History of drug abuse: (describe)
Employment: ☐ Employed fulltime ☐ Unemployed ☐ Employed part time
Education level: ☐ Some High school ☐ High school diploma/GED ☐ Some college coursework ☐ College Degree ☐ Post graduate education Caffeine: □ Never □ Occasional □ Daily
Home environment: □ Private home □ Assisted living □ No housing (shelter, car, homeless) □ Worried about losing housing □ feels physically and emotionally safe in current living situation □ Other: (Describe)
Housing Status: (check all that applies) □ Lives alone □ Lives with spouse/partner □ Lives w/ children □ Lives with pets □ Lives with smoker How people live with you:
Social Functioning and Interaction: □ No concerns, maintains adequate social life □ Social anxiety □ Prefers isolation and limited social interaction □ Difficulty w/ interpersonal relationships

	Patient Health Questionnaire (PHQ9)			
	Not at all	*Several days*	*More than ½ the days*	*Nearly every day*
1. Little interest or pleasure in doing things	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless	◯	◯	◯	◯
3. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating	◯	◯	◯	◯
6. Feeling bad about yourself or that you are failure or have let yourself or your family down	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
8. 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	◯	◯	◯	◯
9. Thoughts that you would be better off dead or of hurting yourself	◯	◯	◯	◯
SCORE: Add columns (OFFICE USE ONLY)				

If you checked off any problem, how difficult have these problems made it for you to do your work, take care of thinks at home, or get along with other people?

☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Family History (Check all that apply)

	Self	*Father*	*Mother*	*Sisters*	*Brothers*	*Aunts*	*Uncles*	*Daughter*	*Son*
Deceased	☐	☐	☐						
Hypertension	☐	☐	☐						
Heart Disease	☐	☐	☐						
Stroke	☐	☐	☐						
Kidney Disease	☐	☐	☐						
Obesity	☐	☐	☐						
Genetic Disorder	☐	☐	☐						
Alcoholism	☐	☐	☐						
Liver Disease	☐	☐							
Alcoholism	☐	☐							
Liver Disease	☐	☐							
Depression or Manic Depressive Disorder	☐	☐							
Colon or Rectal Cancer	☐	☐							
Breast Cancer	☐	☐							
Other Cancer	☐	☐							
Other_____	☐	☐							

Medical History			
Hospital visits since last visit/ Reason	Facility	Attending Physician	Date of hospital visit

Surgical History		
Type of Surgery	Date of Surgery	Complications

Medication List			
Medication Name	Dosage	How many tablets	How many times a day

Problem List	
Chronic Problems	*Managing Physician*

OFFICE USE ONLY	Ht	Wt	TEMP	BP	RR	HR	O2

Patient Name: _____ D.O.B: _____

Please list all of your current providers and suppliers of health care

Primary Care Physician/ Provider(s):	
Clinic/ Provider Name	Location

Specialist(s): (ie. Cardiologist, GI, Neurology)		
Clinic/ Provider Name	Location	Specialty

Alternative medicine providers (ie. Chiropractors, acupuncturist, etc.):		
Clinic/ Provider Name	Location	Specialty

Preferred Pharmacy (s): Name & Location	
Pharmacy	Location

Dentist:	
Dentist Name	Location

Other:	

Patient Name: _____ D.O.B: _____

Wellness: Health Risk Assessment

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
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
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
How often in the last 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	sometimes	Often	Always
Falling or dizzy when standing up					
Sexual problems or concerns					
Trouble eating well					
Teeth or denture problems					
Problem using the telephone					
Tiredness or fatigue					
Problems sleeping					

Have you fallen two or more times in the past year? ☐ YES ☐ NO

Are you afraid of falling? Do you feel unsteady? ☐ YES ☐ NO

HOME SAFETY CHECKLIST:

Are entrance ways well lit? ☐ YES ☐ NO

Are sidewalks/entrance well maintained? ☐ YES ☐ NO

Is a carbon monoxide detector installed? ☐ YES ☐ NO

Are smoke detectors installed? ☐ YES ☐ NO

Are all medicines kept in original containers with original labels intact? ☐ YES ☐ NO

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

How often do you have trouble taking medicines that way you have been told to take them?

☐ I do not have to take medicine ☐ I always take them as directed

☐ Sometimes I take them as directed ☐ I seldom take them as directed

Are you having difficulties driving your car? ☐ YES, often ☐ Sometimes ☐ NO ☐ N/A

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

☐ Yes, always ☐ Yes, sometimes ☐ No

How often in the last 4 weeks have you experienced the following: (Hear loss screening)

	Never	Seldom	sometimes	Often	Always
Straining to understand conversation					
Trouble hearing in a noisy background					
Misunderstanding what others are saying					

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

☐ No Pain ☐ Very mild pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain

Do you have someone who is available to help you if you needed or wanted help?

☐ Yes, as much as I want/need ☐ Yes, some ☐ No, not at all

Because of any health problems, do you need the help of another person with shopping, preparation of meals, or housework? ☐ Yes ☐ No
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
Can you handle your own money without help? ☐ Yes ☐ No
What is your nutrition and diet? (Check all that apply) ☐ Healthy well-balanced diet ☐ Unhealthy diet ☐ Weekly dining out ☐ Disordered eating ☐ Takes vitamin/minerals/ herbal supplements ☐ Problems with meal preparation ☐ Binge eating ☐ Overeating ☐ Extended periods of time without eating
During the past 4 weeks, did you exercise for about 20 minutes, 3 or more days a week? ☐ Yes, most of the time ☐ Yes, some of the time ☐ No, I usually do not exercise this much ☐ No, I am not currently exercising
When you exercise, how intensely to you typically exercise? ☐ Light (stretching/ slow walking) ☐ Moderate (brisk walking) ☐ Heavy (jogging/ swimming) ☐ Very heavy (running/stair climbing)
In the past 7 days, on how many days did you drink alcohol? _____ days 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
Advance care planning: Do you have an advance directive on file? ☐Yes ☐No ☐ I would like to have one
In the past 12 month, have you or your household been without: ☐ Transportation to medical appointments ☐ Clothing ☐Food ☐ Utilities ☐ Childcare ☐ Healthcare ☐Phone ☐ None

Thank you for completing this Wellness Health Risk Assessment.

Provider's Review				

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Authorization and release for Docs Medical Group/Docs Urgent Care and its subsidiaries (Docs of CT, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group, 203 Urgent Care and Urgent Care Center), hereby referred to as Docs Medical Group.

This document is to be signed by the person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Docs Medical Group/Docs Urgent Care has provided me with a copy of its notice of privacy policies that describe how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have question or complaints I may contact Docs Medical Group Administration Directors at 203-874-3682 or by e-mailing contact@docsofct.com.

I also understand that I am entitled to receive updates upon request if and when for Docs Medical Group/Docs Urgent Care and its subsidiaries (Docs of CT, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group, 203 Urgent Care and Urgent Care Center), amends or changes its notice of privacy practices material in any way.

I allow Docs Medical Group/Docs Urgent Care and its subsidiaries (Docs of CT, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group, 203 Urgent Care and Urgent Care Center), to obtain prescription history from an external source:

SIGNATURE: _____ DATE: _____

_____
RELATION TO THE PATIENT IF SIGNED BY SOMEONE OTHER THAN THE PATIENT

My preferred contact number to call or text regarding an appointment, labs or other tests/ consultations is _____
(home/cell)

CONSENT FOR NOTIFICATION OF TEST RESULTS

I give permission to Docs Medical Group/Docs Urgent Care and its subsidiaries (Docs of CT, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group, 203 Urgent Care and Urgent Care Center) to notify _____ (relationship to patient) _____ about my health information.

I give permission to Docs Medical Group/Docs Urgent Care and its subsidiaries (Docs of CT, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group, 203 Urgent Care and Urgent Care Center) to share health information via voicemail or text message.

SIGNATURE: _____ DATE: _____

_____

RELATION TO THE PATIENT IF SIGNED BY SOMEONE OTHER THAN THE PATIENT