Dear Valued Dallas Diagnostic Association Patient,

As you may know, starting in January of 2011, Medicare covers what they are calling the yearly "Preventative and Wellness Visit." We'd like to share some information with you about this new exam.

What is covered during the Wellness Visit?

The wellness visit will include a review of your medications, medical history, allergies to medications and social history pertaining to your health habits. Any change in family history will be added to your medical data. You will be asked about how you are functioning in your daily activities. You will be given recommendations regarding wellness such as when to perform screening tests like colonoscopies, mammograms and other examinations based on current preventative recommendations. You will have your blood pressure, weight, height, body mass index and vision checked. Additional physical examination is not required but may be performed based on your medical history. You may be eligible for a cholesterol or blood sugar lab, but only if you have not previously been diagnosed with diabetes or high cholesterol. We will ask you to fill out a health history form ahead of time to help us make your information complete. The exam can be performed by a physician, nurse practitioner or physician assistant.

What is not part of the Wellness Visit?

There is no coverage in this visit for review of any new issues or existing medical conditions that you may have. The focus of the exam is on preventing and screening for new diseases. Lab tests that monitor your existing conditions are not covered as preventative but can be performed and billed under your regular Medicare insurance. New medical conditions or existing medical conditions that are not under control are best evaluated during an office visit at another time.

Why aren't all aspects of your personal care addressed and billed under the Wellness Visit?

Please understand that these changes are per Medicare regulations. A traditional "Annual Physical" will not be covered by your insurance. Medicare rules and regulations are continually changing and we are making our best effort to be up to date and compliant with these changes while still providing you with excellent care. Please understand that accurate documentation is required by Medicare and we have to work within their stated guidelines to prevent fraud.

I consider it a privilege to be your physician and hope you will understand how the new wellness visit will be performed and billed. Please indicate when you schedule your appointment if you are booking a "Wellness Visit" or regular office visit so we know how to best assist you. We feel that this is an excellent opportunity, at no cost to you, to focus on the things you can do to improve your overall health.

MEDICARE PREVENTIVE EXAM - IPPE INITIAL - PPPS SUB - PPPS

rev:12/10/11

Circle Type of Exam

Patient Name_____DOS:_____Chart#_____DOB:_____ AGE____

Address: _____

Medicare Eligibility Date:_____ Gender M/F Race/Ethnicity:_____ Last Physical Exam Date _____

Other Providers involved in your care:_____

Medical/Surgical History ☐ See Problem List in Chart

Surgeries/Hospitalizations:

Past Medical History:

Allergies: _____

Medications: ___see chart medication list (please bring a list of your prescription medications)

Over the counter medications and supplements: _____

Do you consider yourself to be healthy Yes No If not why:_____

Social History

Smoking: Yes No Quit

Alcohol: Yes No Drinks/Day____

Illicit drug use: Yes No

Sexually Active? Yes No

Diet: Diabetic____ Low Cholesterol____ Low Salt____ Other____

Exercise:(minutes/week and type)_____

Notes:

Family History

Father: _____ Mother: _____

Brother(s) _____ Sister(s) _____

Children: _____ Other: _____

History/Family History Notes: _____

Depression Screen:			**Functional Ability/Safety Screen**		
Since your last visit have you had:			Do you need help with:		
Loss of energy/fatigue	Y	N	Cooking/Housework/Shopping/Feeding	Y	N
Irritability/Anger	Y	N	Dressing/Bathing/Toileting/Grooming	Y	N
Loss of interest in activities	Y	N	Do you drive your own vehicle	Y	N
Feelings of worthlessness	Y	N	Managing Money	Y	N
Sleep Disturbances	Y	N	Is your home safe	Y	N
Feelings of sadness	Y	N	Clear of clutter/ throw rugs/cords	Y	N
Appetite Changes	Y	N	Do you use nightlights and handrails	Y	N
Feelings of Lonliness	Y	N	Are you able to use telephone	Y	N
Are you in pain	Y	N	Do you wear a seatbelt	Y	N
Fall Risk			**Cognitive Screen**		
Have you fallen in the last year	Y	N	Do you forget recent conversations	Y	N
Do you suffer from dizziness	Y	N	Do you ask the same thing repeatedly	Y	N
Do you use any assist devices	Y	N	Are you responsible for your medication	Y	N
(i.e. cane, walker, wheelchair)			Do you get lost outside the house	Y	N
Do you have trouble hearing	Y	N	Do you forget appointments	Y	N

Notes/Risk Factors Identified: _____

End of Life Planning (complete this section if patient wishes) Do you have the following? If so, please bring a copy.

Advance Directive Living Will Out of hospital DNR Power of Attorney

Notes:_____

Patient Signature: _____ Date_____

Physician Signature: _____ Date_____