



FAMILY
Health
Building healthy lives
Together

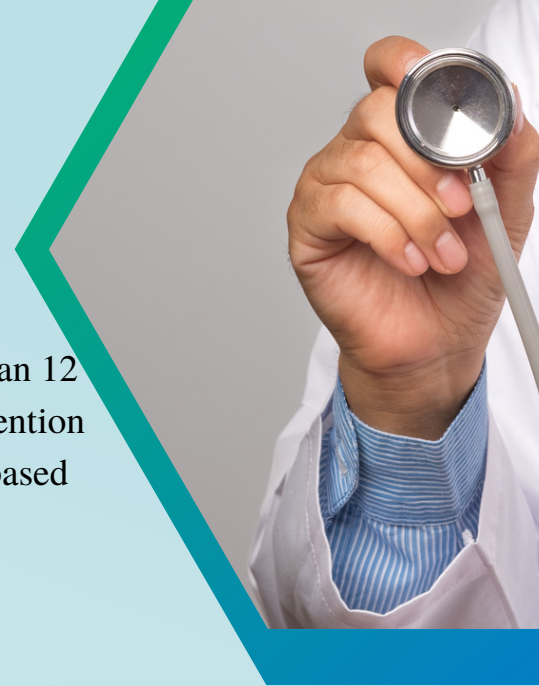
Medicare "Wellness" visit:

Yearly "Wellness" visits: If you've had Medicare Part B for longer than 12 months, you can get this visit to develop or update a personalized prevention help plan. This plan is designed to help prevent disease and disability based on your current health and risk factors. It can also include:

- A review of your medical and family history
- Developing or updating a list of current providers and prescriptions
- Height, weight, blood pressure, and other routine measurements
- Detection of cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options for you
- A screening schedule (like a checklist) for appropriate preventive services. Get details about coverage for screenings, shots, and other preventive services
- Discussion for Advance Care Planning
 - Please bring a copy of your current Living Will and Power of Attorney for Health Care or a legal guardian for the office to place in your medical file
- Review of the following forms that are filled out BEFORE your appointment (Complete using either the HEALOW app or filling out the attached forms):
 - **Medicare Annual Health Risk Assessment:** Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit
 - **PRAPARE:** List of non-medical questions to better understand you as a person and any needs you may have. This information will help us determine if we need to add new services or programs to better care for our patients
 - **Family Health Registration** form if not already updated within the calendar year

**This visit is covered once every 12 months.
More than 365 days since previous Medicare annual.**

Note: You pay nothing for the "Welcome to Medicare" preventive or yearly "Wellness" visit. **However, if your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under these preventive benefits, you will have to pay a copay, and the Part B deductible will apply.**





Medicare Annual Health Risk Assessment

Patient Name: _____ Date of Birth: _____

1. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?
<input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely
2. In past 4 weeks, was someone available to help you if you needed help? e.g. if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help, just taking care of yourself.
<input type="checkbox"/> Yes- as much as I wanted <input type="checkbox"/> Yes- quite a bit <input type="checkbox"/> Yes- some <input type="checkbox"/> Yes- a little <input type="checkbox"/> No- not at all
3. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
<input type="checkbox"/> Very heavy <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> Very light
4. Can you shop for groceries or clothes without help?
<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Can you prepare your own meals?
<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Can you do your own housework without help?
<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Can you handle your own money without help?
<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you need help eating, bathing, dressing, or getting around your home?
<input type="checkbox"/> Yes <input type="checkbox"/> No
9. During the past 4 weeks, how would you rate your health in general?
<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
10. How have things been going for you during the past 4 weeks?
<input type="checkbox"/> Very well- could hardly be better <input type="checkbox"/> Pretty good <input type="checkbox"/> Good and bad parts, about equal <input type="checkbox"/> Pretty bad
<input type="checkbox"/> Very bad- could hardly be worse
11. Do you always fasten your seatbelt when you are in a car?
<input type="checkbox"/> Yes, usually <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> No

Initials of Provider Reviewing the Health Risk Assessment (HRA) _____
Date HRA reviewed/ updated _____

12. How often..	
How often during the past 4 weeks, have you been bothered by falling or being dizzy when standing up?	
<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
>How often during the past 4 weeks, have you been bothered by sexual problems?	
<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
>How often during the past 4 weeks, have you been bothered by having trouble eating well?	
<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
>How often during the past 4 weeks, have you been bothered by your teeth or dentures?	
<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
>How often during the past 4 weeks, have you been bothered by having problems using the phone?	
<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
>How often during the past 4 weeks, have you been bothered by being tired or fatigued?	
<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
13. Have you fallen 2 or more times in the past year?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Are you afraid of falling?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Do you exercise for about 20 minutes 3 or more days a week?	
<input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, some of the time <input type="checkbox"/> No, I usually do not exercise this much	
16. Have you been..	
>Have you been given any information to help you with hazards in your house that might hurt you?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
>Have you been given any information to help you with keeping track of your medications?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. How often do you have trouble taking medicines the way you have been told to take them?	
<input type="checkbox"/> I do not have to take medicine <input type="checkbox"/> I always take them as prescribed <input type="checkbox"/> Sometimes I take them as prescribed	
<input type="checkbox"/> I seldom take them as prescribed	
18. How confident are you that you can control and manage most of your health problems?	
<input type="checkbox"/> Very confident <input type="checkbox"/> Somewhat confident <input type="checkbox"/> Not very confident <input type="checkbox"/> I do not have any health problems	
19. Current list of medical providers and suppliers who provide regular care:	
Specialty Type:	Name of Specialist/ Medical Suppliers:
_____	_____
_____	_____
_____	_____

Initials of Provider Reviewing the Health Risk Assessment (HRA) _____
Date HRA reviewed/ updated _____



PRAPARE

Patient Name: _____ Date of Birth: _____

Money & Resources

What is your current housing situation?

- I have housing
- I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, or in a park)
- I choose not to answer this question

Are you worried about losing your housing?

- Yes
- No
- I choose not to answer this question

What is the highest level of school that you have finished?

- Less than a high school degree
- High School diploma or GED
- More than high school
- I choose not to answer this question

What is your current work situation?

- Unemployed and seeking work
- Part time or temporary work
- Full time work
- Otherwise unemployed but not seeing work (ex. student, retired, disabled, unpaid primary care giver)
- I choose not to answer this question

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

- Food
- Clothing
- Utilities
- Child care
- Medicine or any health care (medical, dental, mental health or vision)
- Phone
- Other _____
- I do not have problems meeting my needs
- I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- Yes, it has kept me from medical appointments or form getting my medications
- Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for living
- No
- I choose not to answer this question

Social and Emotional Health

How often do you see or talk to people that you care about and feel close to?

For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

- Less than once a week
- 1 or 2 times a week
- 3 to 5 times a week
- More than 5 times a week
- I choose not to answer this question

How stressed are you?

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much
- I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner or someone in your household?

- Yes
- No
- Unsure
- I have not had a partner in the past year
- I choose not to answer this question

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? **(Nurses: Document under HPI> General> SILS)**

- 1 (never)
- 2 (rarely)
- 3 (sometimes)
- 4 (often)
- 5 (all of the time)

Would you like staff to contact you for help with any of these needs? **(Staff: If Yes, Send Referral to CHW)**

- Yes
- No

Today's Date: / /

**FAMILY HEALTH SERVICES
PATIENT REGISTRATION FORM**



PATIENT INFORMATION:

Last Name	First Name	MI	Preferred Name	Birth Date	Social Security #
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Patient's Primary Physician:

Patient Billing Address (Responsible Party)	City	State	Zip
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Patient Residence (If different)	City	State	Zip
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Which Contact # You Prefer: <input type="checkbox"/> Home Phone# () _____ <input type="checkbox"/> Cell Phone # () _____ <input type="checkbox"/> Work Phone # () _____ EMAIL: _____	Can we send notifications? <input checked="" type="checkbox"/> All that Apply: <input type="checkbox"/> Opt-Out <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Voicemail <input type="checkbox"/> e-Message	Consent to share data with external healthcare entities: <input type="checkbox"/> Opt-In <input type="checkbox"/> Opt-Out <input type="checkbox"/> Emergency	Birth Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Life Partner
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Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Arabic <input type="checkbox"/> Other: _____	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Female-to-Male (FTM) Transgender Male <input type="checkbox"/> Male-to-Female, (MTF) Transgender Female <input type="checkbox"/> Neither exclusively Male or Female (Genderqueer) <input type="checkbox"/> Choose not to Disclose <input type="checkbox"/> Other	Sexual Orientation: <input type="checkbox"/> Straight, Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian, Gay, Homosexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to Disclose <input type="checkbox"/> Other	Pronouns: <input type="checkbox"/> he/him/his/himself <input type="checkbox"/> she/her/hers/herself <input type="checkbox"/> they/them/their/theirs/themselves <input type="checkbox"/> Other: _____
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Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Chinese <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Korean <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> More than one race <input type="checkbox"/> Other: _____	Ethnicity: <input type="checkbox"/> Non-Hispanic or Latino/Or Spanish Origin <input type="checkbox"/> Hispanic or Latino/Spanish Origin <input type="checkbox"/> Mexican/Mexican American/Chicano <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Decline
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INSURANCE INFORMATION (Please present ALL Insurance Cards and Picture ID to the receptionist):

Primary Insurance	Policy #	Group #	Effective	Co-Pay \$	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Co-Pay \$	Policy Holder	Relationship
Dental Insurance	Policy #	Group #	Effective	Co-Pay \$	Policy Holder	Relationship
Vision Insurance	Policy #	Group #	Effective	Co-Pay \$	Policy Holder	Relationship

ADVANCED DIRECTIVE:

Do you have a living will? Yes No Is it on file with your Primary Care Provider? Yes No

REQUIRED REPORTING

Permanent Housing: <input type="checkbox"/> House/Apt/Mobile Home	Temporary/Transitional Housing: <input type="checkbox"/> Shelter <input type="checkbox"/> Homeless/Street <input type="checkbox"/> Transitional <input type="checkbox"/> Temporarily Living with Friends/Family <input type="checkbox"/> Permanently Living with Friends/Family <input type="checkbox"/> Other: _____	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No Migrant Agriculture Worker: <input type="checkbox"/> Yes <input type="checkbox"/> No Seasonal Agriculture Worker: (NON OH/IN Residents) <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Income: <input type="checkbox"/> < \$10,000 <input type="checkbox"/> \$10 - \$20,000 <input type="checkbox"/> \$20 - \$40,000 <input type="checkbox"/> \$40 - \$60,000 <input type="checkbox"/> \$60,000 < <input type="checkbox"/> Refuse to report	Preferred Pharmacy: _____
Family Size: _____				

Family Health is required to report the following information annually. You do have the right to refuse to report.

**FAMILY HEALTH SERVICES
PATIENT REGISTRATION FORM**



Kiosk Check-In

RESPONSIBLE PARTY:

Last Name	First Name	MI	Social Security #	Birth Date	Relationship
Employer Name:		Employer Address: _____		Employer Phone: ()	

I understand that by signing this form, I agree to pay all balances pertaining to the services rendered. If I do not pay or should my account become delinquent, I realize that my information may be sent to a collection agency. I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, to communicate with me for any reason by any telephone number, email, and mailing address provided.

_____ **X** _____
Patient Name/Responsible Party (Print) **Signature of Patient/Responsible Party** **Date of Signature**
 Patient Parent Guardian

IF PATIENT IS UNDER 18 YEARS OLD:

Is there custody involvement? Yes No *If yes please see front desk for Acknowledgement of Child Custody Matters

Parent/Guardian #1		Parent/Guardian #2	
First Name	Last Name	First Name	Last Name
Phone:		Phone:	

EMERGENCY CONTACT:

Name	Relationship	DOB	Phone
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Health Insurance Portability and Accountability (HIPAA)

Accountability for Release of Health Information/Notice of Privacy Practices

Authorization for Release of Health Information

I authorize that the following people may have access to my health information. I understand that the physician must have looked at and signed off the information before it will be copied and given to the authorized person(s) named below.

Name	Relationship	Phone ()
Name	Relationship	Phone ()
Name	Relationship	Phone ()
Name	Relationship	Phone ()

I wish to be contacted in the following manner (check all that apply):

<input type="checkbox"/> Home Telephone: () _____ <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only <input type="checkbox"/> Work Telephone: () _____ <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Written Communication <input type="checkbox"/> O.K. to mail to my home address <input type="checkbox"/> O.K. to mail to my work address <input type="checkbox"/> O.K. to fax to this number <input type="checkbox"/> Other: _____
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Notice of Privacy Practices

Acknowledgment of Receipt Patient's Name (PRINTED)

Family Health Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, the patient.

I, the patient (or Patient Representative on behalf of the patient) acknowledge that I have seen or received a copy of the Family Health *Notice of Privacy Practices*.

Patient's Name (PRINTED)

Relationship to Patient

X _____
Patient Signature or Patient's Representative

Date

[] Check here to opt out of receiving notifications regarding fund-raising efforts Family Health may undertake.