# 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:

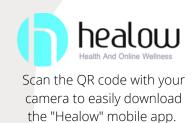
- A review of your medical and family history
- Developing or updating a list of current providers and prescriptions
- Height, weight, blood pressure, and other routine measurements
- Detection of cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options for you
- A screening schedule(like a checklist) for appropriate preventive services. <u>Get</u> details about coverage for screenings, shots, and other preventive services
- Discussion for <u>Advance Care Planning</u>
  - Please bring a copy of your current Living Will and Power of Attorney for Health Care, or a legal guardian, to 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.

#### Sign up for the patient portal:

- Manage your and your family's health information
- Easily communicate with your doctor's office.
- Check in for a healthcare appointment online in advance





**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.

## FAMILY HEALTH SERVICES Year PATIENT REGISTRATION FORM

Today's Date: Month / Day / Year



PATIENT INFORMATION	N:											
Last Name	First Name		MI Preferred Name			Birth Date			Social Security #			
Patient's Primary Physic	ian:		L						l			
Patient Billing Address (F				City					2	Zip		
Patient Residence (If different)					City			State		Zip		
Which Contact # You Prefer:			Can we send notifica			cations? Consent to share				Gender	<u> </u>	
☐ Home Phone# ()			I that A				with ext		☐ Female			
☐ Cell Phone # ()			pt-Out	.рр.у.				ncare entities:		☐ Male		
☐ Work Phone # ()			none [	П Теу	t	pt-In	_		Marital Status:			
EMAIL:					-Message		pt-III pt-Out			☐ Single ☐ Married		
			icemai	і ше	-iviessage		Out   [		☐ Widowed ☐ Divorced			
						☐ Emergency			☐ Separated☐ Life Partner			
Preferred Language:	Race:	•					slander	=				
□English □ Spanish	☐ White/Caucasian				anese   Native Hawaiian			☐ Non-Hispanic or				
□Chinese □ Japanese	☐ Black/African American ☐ Korean ☐ Other Pacific Islander Latino/Or Spanish											
□French □ Russian	☐ American Indian/Alaska Native ☐ Filipino ☐ Samoan ☐ Hispanic or ☐ Asian ☐ Asian ☐ Utetnamese ☐ Latino/Spanish Origin											
□Arabic □Other:	☐ Asian ☐ Asian Indian ☐ Vietnar											
Liother:	☐ More than one race ☐ Other: ☐ Mexican/Mexican American/Chicano											
										□Cuban □Puerto Rican		
								☐ Decline				
INSURANCE INFORMA	TION (Please present	t ALL I	nsurar	nce Ca	ards and Pi	cture l	ID to the	recept				
Primary Insurance	Policy #	Grou			Effective	Co-Pa		Policy I			Relationship	
Trimary insurance	1 Oney #	Giod	η π		Litective	\$	ау	lioncy	ioiaci	'	Relationship	
Secondary Insurance	Policy #	Grou	ın#		Effective		21/	Policy I	اماطما	r	Relationship	
Secondary insurance	Policy #	Group #			Effective		Co-Pay Police		y Holder		Relationship	
						۶						
Dental Insurance	Policy #	Group #		Effective	Co-Pay		Policy I	Holde	r	Relationship		
						\$						
Vision Insurance	Policy #	Group #		Effective	Co-Pa	av	Policy Holder		r	Relationship		
	. 55,					\$						
ADVANCED DIRECTIVE						·						
		. file	ر مر در ما الدار	Duin	aama Cana Du	' سمامان س	2	□ Na				
Do you have a living will?	'∟ Yes ∟ NO ISITO	n file w	ith you	ir Prin	nary Care Pro	ovider	r ⊔ Yes	□ NO				
REQUIRED REPORTING	ŝ											
Permanent Housing:	Temporary/Transition	nal	Veter	an:			Family	/ Income	:	Prefer	red Pharmacy:	
☐ House/Apt/Mobile	Housing:	☐ Yes ☐ No			, ,							
Home	☐ Shelter					<u> </u>						
	☐ Homeless/Street	Migrant Agriculture W			rker:		_					
	☐ Transitional			☐ Yes ☐ No								
	☐ Temporarily Living w	ith	Soco	nal A	gricultura 144	lorker	$\dashv$					
	Friends/Family (NON OH/IN Residents)											
						,	1_					
	with Friends/Family											
Family Size:												
· — —	☐ Other:									1		

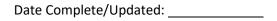
Family Health is required to report the following information annually. You do have the right to refuse to report.

#### ☐ Kiosk Check-In

## FAMILY HEALTH SERVICES PATIENT REGISTRATION FORM



RESPONSIBLE PARTY:									
Last Name	First Name		MI	Social Security #		Birth Da	te	Relationship	
- 1 2									
Employer Name:	Employer				Employer Phone:				
		Address:			(	)			
I understand that by signing this fo									
delinquent, I realize that my inform	•	_	•	•	•				
healthcare provider, including thos mailing address provided.	e using automat	ed dialing systems, to	comm	unicate with me for any	reason r	y any telep	none nu	mber, email, and	
maning address provided.		<b>W</b> 7							
Patient Name/Responsible Par	tu (Drint)	X Signature o	f Datio	nt/Responsible Party	<del>-</del>	_	Data	of Signature	
☐ Patient ☐Parent ☐Guardia	n	Signature o	i Palle	nt/ kesponsible Party	/		Date	of Signature	
IF PATIENT IS UNDER 18 YEA		, du C							
Is there custody involvemen		lo *If yes please	see fr	ont desk for Ackno				istody Matters	
·	uardian #1		Final		Parent/G	uardian #2			
First Name Phone:	me Last Name			: Name ne:		Last N	ame		
EMERGENCY CONTACT:			FIIO	ne.					
Name	Relatio	nshin		DOB	Ph	ione			
Nume	Relatio	пэтгр		202		ione			
Н	ealth Insur	ance Portabilit	y and	l Accountability	(HIPA	A)			
			•	nation/Notice o	_	-	tices		
<b>Authorization for Release of</b>	-			•		•			
I authorize that the following pe	eople may have	e access to my heal	th info	rmation. I understan	d that th	e physicia	n must	have looked	
at and signed off the information	n before it wil	be copied and give	en to th	e authorized person	(s) name	d below.			
Name		Relationship			Phone (	)			
Name		Relationship			Phone (	)			
Name		Relationship			Phone (	)			
Name		Relationship			Phone (	)			
	I wish to be co	ntacted in the follo	owing r	nanner (check all tha	at apply)	:			
☐Home Telephone: ( )				☐Written Commun	ication				
☐ O.K. to leave message with detailed information			☐ O.K. to mail to my home address						
☐ Leave message with call-back number only			☐ O.K. to mail to my work address						
<u> </u>				☐ O.K. to fax to	this num	ber			
☐Work Telephone: ()				_					
☐ O.K. to leave message with detailed information ☐ Leave message with call-back number only			Other:						
Leave message with ca	II-back numbe	r only							
Notice of Privacy Practices									
Acknowledgment of Receipt Pa	itient's Name	(PRINTED)							
Family Health Nation of Drivery	Drastices prov	idas information ab	+ h .		رم معمامة	ratastad b	aalth in	formation	
Family Health Notice of Privacy about you, the patient.	Practices prov	ides information at	out no	w we may use and d	isciose p	rotected n	eaith in	Tormation	
I, the patient (or Patient Repres Health <i>Notice of Privacy Practice</i>		half of the patient)	acknov	wledge that I have se	en or red	ceived a co	py of th	ne Family	
Patient's Name (PRINTED)				Relationship to Patient					
X									
Patient Signature or Patient's F	Representative				Dat	:e			
[ ] Check here to opt out of rec	•		d-raisin	g efforts Family Heal		_			





### **PRAPARE**

Patient Name:	Date of Birth:
Money & Resources	
What is your current housing situation	?
☐ I have housing	
$\square$ I do not have housing (staying with others	s, 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 hou	using?
Yes	
□ No	
☐ I choose not to answer this question	
What is the highest level of school that	t 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	
	vork (ex. student, retired, disabled, unpaid primary care giver)
☐ I choose not to answer this question	voi k (ex. student, retired, disabled, dripaid primary care giver)
·	ly members you live with been unable to get any of the following
when it was really needed? Check a	
□ Food	in that appry.
☐ Clothing	
□ Utilities	
☐ Child care	
☐ Medicine or any health care (medical, de	ental, mental health or vision)
☐ Phone	
☐ Other	
$\square$ I do not have problems meeting my nee	ds
☐ I choose not to answer this question	
Has lack of transportation kept you from needed for daily living?	om medical appointments, meetings, work or from getting things
☐ Yes, it has kept me from medical appoin	tments or form getting my medications
•	eetings, appointments, work, or getting things needed for living
□ No	
☐ I choose not to answer this question	

Date Complete/Updated:
ocial and Emotional Health
ow often do you see or talk to people that you care about and feel close to?
or 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
ow stressed are you?
ress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled
l Not at all
l A little bit
l Somewhat
l Quite a bit
l Very much
I choose not to answer this question
the past year, have you been afraid of your partner or ex-partner or someone in your hoursehold?
] Yes
] No
]Unsure
I have not had a partner in the past year
I choose not to answer this question
ow often do you need to have someone help you when you read instructions, pamphlets, or other written
naterial from your doctor or pharmacy? (Nurses: Document under HPI> General> SILS)
1 (never)
2 (rarely)
3 (sometimes)

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

☐ Yes

☐ 4 (often)

☐ 5 (all of the time)

□ No