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, 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

healow
Health And Online Wellness

Scan the QR code with your camera to easily download the "Healow" mobile app.

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.

Today's Date: Month / Day / Year

FAMILY HEALTH SERVICES
PATIENT REGISTRATION FORM

FAMILY Health
BUILDING HEALTHY LIVES TOGETHER

PATIENT INFORMATION:

Last Name	First Name	MI	Preferred Name	Birth Date	Social Security #

Patient's Primary Physician:

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (If different)	City	State	Zip

Which Contact # You Prefer:
☐ Home Phone# (____)_____
☐ Cell Phone # (____)_____
☐ Work Phone # (____)_____
EMAIL:
_____

Can we send notifications?
☑ **All that Apply:**
☐ Opt-Out
☐ Phone ☐ Text
☐Voicemail ☐e-Message

Consent to share data with external healthcare entities:
☐ Opt-In
☐ Opt-Out
☐ Emergency

Birth Gender:
☐ Female
☐ Male

Marital Status:
☐ Single ☐ Married
☐ Widowed ☐ Divorced
☐ Separated☐ Life Partner

Preferred Language:
☐English ☐ Spanish
☐Chinese ☐ Japanese
☐French ☐ Russian
☐Arabic
☐Other: _____

Race:
☐ White/Caucasian ☐ Chinese ☐ Hawaiian/Pacific Islander
☐ Black/African American ☐ Japanese ☐ Native Hawaiian
☐ American Indian/Alaska Native ☐ Korean ☐ Other Pacific Islander
☐ Asian ☐ Asian Indian ☐ Filipino ☐ Samoan
☐ More than one race ☐ Other:_____ ☐ Vietnamese

Ethnicity:
☐ Non-Hispanic or Latino/Or Spanish Origin
☐ Hispanic or Latino/Spanish Origin
☐Mexican/Mexican American/Chicano
☐Cuban ☐Puerto Rican
☐ Decline

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:
☐ House/Apt/Mobile Home

Family Size: _____

Temporary/Transitional Housing:
☐ Shelter
☐ Homeless/Street
☐ Transitional
☐ Temporarily Living with Friends/Family
☐ Permanently Living with Friends/Family
☐ Other: _____

Veteran:
☐ Yes ☐ No

Migrant Agriculture Worker:
☐ Yes ☐ No

Seasonal Agriculture Worker: (NON OH/IN Residents)
☐ Yes ☐ No

Family Income:
$_____

☐ **Refuse to report**

Preferred Pharmacy:
_____

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

FAMILY Health
BUILDING HEALTHY LIVES TOGETHER

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

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):

☐Home Telephone: (_____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐Work Telephone: (_____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to this number

☐Other: _____

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.

FAMILY Health
BUILDING HEALTHY LIVES TOGETHER

Date Complete/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

Revised 08.10.2023_cw

Date Complete/Updated: _____

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 hourshold?

☐ 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