MANNM | Medical Associates of Northern New Mexico

Patient:_____DOB:_____

Medicare's "Annual Wellness Visit" (AWV) has very specific definitions, limitations and required elements.
• Coinsurance and deductibles are waived by Medicare for 2 visit charges.
• These visits are preventive health visits and not designed to address chronic existing medical problems. They have very specific components and are not a comprehensive physical exam as you may have been used to with commercial insurance: they are not a "routine physical checkup." Medicare Part B still does not provide any coverage for comprehensive routine physical exams. If you want a comprehensive physical exam you will be responsible for the charges. If you want a visit to refill medications, discuss your problems (for example diabetes), you should schedule a chronic problem visit and not a Medicare Annual Wellness Visit. The AWV visit charges do not include any laboratory tests or EKG testing as these are separately billed services.
• Other covered preventive services that are performed during your visits will be billed in addition to the AWV charges (e.g. breast & pelvic exam, rectal exam, stool occult blood test, transporting PAP to lab, vaccinations).

At this "Annual Wellness Visit," your provider will:

1. Complete a review of your medical, medication and family health history.
2. Measure your height, weight, blood pressure and calculate your body index ("BMI")
3. Do a simple vision test.
4. Establish a list of current providers & suppliers who regularly provide healthcare services to you.
5. Question you about your functional ability, home safety, hearing and screen for depression.
6. Assess your cognitive function and ask about family or friend's comments about your memory.
7. Establish a list of risk factors & conditions for which referrals/intervention are recommended.
8. Provide personalized health advice or resources to help you prevent disease & improve your health on topics such as weight loss, physical activity, smoking cessation, fall prevention and nutrition.
9. Establish a screening schedule for preventive services recommended over the next 5-10 years.

PREVENTIVE SCREENINGS WHICH MAY BE RECOMMENDED FOR YOU:

Abdominal Aortic Aneurysm Screening
Bone Density (Osteoporosis) Screening
Lung Cancer (CT chest) Screening
Colon Cancer Screening
Breast Cancer Screening
Cervical Cancer (PAP) Screening
Diabetes (high blood sugar) screening
Cholesterol screening
Hepatitis A and B vaccinations
Hepatitis C screening
Flu and Pneumonia vaccines

I understand the above information and received a copy of my personalized care plan.

_____ Patient Signature

_____/_____/_____ Date

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Medicare Wellness: List of Providers & Suppliers of Healthcare

Patient:_____DOB:_____

Please list all of your current providers and suppliers of healthcare.

Name of Specialists or other healthcare providers (ex: dermatologist, gastroenterologist, etc.)

Clinic/Provider Name	They Help Take Care Of My	Last Visit Date

Preferred pharmacy(s): Name & Location

Pharmacy Name	Location

Please list any new health problems your family has experienced in the past year:

Mother	Father	Sibling(s)	Children

Changes in Your Health History:

Have you had any new surgeries, procedures or new medical diagnoses in the last year? If so, please list.

1.	3.	5.
2.	4.	6.

Patient Name: Date of Birth:

1) During the past 4 weeks, how much has your physical health or emotional well-being affected your ability to participate in social activities with family, friends, neighbors, or groups?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

2) During the past 4 weeks, how much physical pain have you had in general?

- ○ No pain
- ○ Very mild pain
- ○ Mild pain
- ○ Moderate pain
- ○ Severe pain

3) During the past 4 weeks, was there someone available to help you if you needed it?

- ○ Yes, as much as I needed
- ○ Yes, most of the time
- ○ Yes, some of the time
- ○ Yes, a small amount of time
- ○ No, not at all

4) During the past 4 weeks what was the hardest level of physical activity you could do for at least 2 minutes?

- ○ Very heavy
- ○ Heavy
- ○ Moderate
- ○ Light
- ○ Very Light

5) Can you travel alone by bus, taxi, or drive your own car?

○Yes ○No

6) Can you shop for your own groceries or clothes without help?

○Yes ○No

7) Can you prepare your own meals?

○Yes ○No

8) Can you do your own house work?

○Yes ○No

9) Can you handle your own finances?

○Yes ○No

10) Do you need help eating, bathing, dressing, or getting around your home?

○Yes ○No

11) During the past 4 weeks, how would you rate your overall health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

12) How have things been going for you in the past 4 weeks?

- ○ Very well, things could hardly be better
- ○ Good
- ○ Equally good and bad
- ○ Bad
- ○ Very Bad

13) Do you have any difficulty driving a car?

○Yes ○Sometimes ○No ○I do not drive

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

○Yes ○Sometimes ○No

15) During the past 4 weeks, how aften have any of the following been a problem for you? (Choose one for each.)

- Feeling dizzy or lightheaded when standing up:

○Never ○Rarely ○Sometimes ○Often ○Always

- Concerns or difficulties with sexual health:

○Never ○Rarely ○Sometimes ○Often ○Always

- Trouble eating healthy meals or getting enough food:

○Never ○Rarely ○Sometimes ○Often ○Always

- Problems with your teeth or dentures:

○Never ○Rarely ○Sometimes ○Often ○Always

- Difficulty using a telephone:

○Never ○Rarely ○Sometimes ○Often ○Always

- Feeling tired or lacking energy:

○Never ○Rarely ○Sometimes ○Often ○Always

16) Have you fallen 2 or more times in the past year?

○Yes ○No

17) Are you afraid of falling?

○Yes ○No

18) Are you a smoker?

○Yes ○No

19) Do you have any difficulty hearing?

○Yes ○No

20) During the past 4 weeks about how many alcoholic drinks have you had?

- ○ 10 or more drinks per week
- ○ 6-9 drinks per week
- ○ 2-5 drinks per week
- ○ 1 drink or less per week
- ○ I do not drink alcohol

21) Do you exercise 3 or more times a week, for about 20 minutes each time?

○Yes ○Sometimes ○No

22) Have you received information or guidance about:

Making your home safer and reducing fall hazards?

○Yes ○No

Keeping track of your medications and taking them safely?

○Yes ○No

23) How often do you have trouble taking medications the way you have been told to take them?

- ○ I do not take medicine
- ○ I always take them as prescribed
- ○ I sometimes take them as prescribed
- ○ I seldom take them as prescribed

24) How confident are you in your ability to manage your health and medical conditions?

- ○ Very confident
- ○ Somewhat confident
- ○ Not very confident
- ○ I do not have ongoing health issues