Dear Medicare Patients, Effective 1/1/12

This letter is intended to set the expectations for the preventative services you will receive in our office as we follow Medicare guidelines for providing care for your well exam. This information is important and valuable. It is important that you fully understand that your physician will talk to you during the visit about how you are feeling emotionally, assess your risk for chronic diseases, and take notes on your medical history. Some patients expect the well visit to include a physical exam with direct contact from the provider, but this visit does not cover a physical exam. Should you have additional questions, please call our office as we are prepared to answer most of your questions.

The Medicare Adult Well Exam (AWE) or the Initial Preventive Physical Exam (IPPE) is not the physical exam you are probably accustomed to as an existing patient in our office. By our interpretation, our role is to cover several points, to create a baseline of care, and to plan for your future care goals. Please note that Medicare will not allow us to order lab work or other diagnostic tests in conjunction with your visit.

Please see the additional attachments which include the exam paperwork that must be filled out completely and thoroughly in order to perform your well visit. If the paperwork is not filled out in its entirety, including but not limited to a list of physicians you have seen in the past year and a full list of your medications with dosage instructions, you will be asked to reschedule your appointment at your expense for not arriving to your appointment prepared. These exams can take some time and your providers need your assistance to remain courteous to other patients who may be waiting for care.

Enclosed you will find the *Seven Components of a Medicare Well Exam* for informational purposes, a *Health Risk Assessment (HRA),* and the *Medicare Preventive Physical Exam* paperwork. All of these forms must be filled out completely prior to your visit. If for some reason, you do not have all of your paperwork, your appointment will be rescheduled with no exceptions.

Please also note if you have any other conditions such as medication refills, lab work, or medical complaints that you would like to have addressed, you will either be asked to schedule a follow-up exam to discuss the additional concerns or you may encounter out of pocket expenses that are not covered with your Medicare Exam. You may also refer to your Medicare benefits at www.CMS.gov.

Thank you,

Anna M Boecker MD, PA

_____**Patient Initials**. This is an acknowledgement of receipt of this information and this information will be scanned into your patient chart.

7 Components of Welcome to Medicare Well Exam

Patient History Section

1. Review of individual medical and social history with attention to modifiable risk factors
    a. Past medical/surgical history (illnesses, hospital stays, operations, allergies, and injuries)
2. Review of individual's potential risk factors for depression
    a. Use HRA form
3. Review of the individual's functional ability and level of safety
        i. Hearing impairment
        ii. Activities of daily living
        iii. Fall risk
        iv. Home safety
        v. Sexual Behavior

Physical Exam Section

4. Physical exam to include height, weight, blood pressure, visual acuity, and BMI
    a. Include any other factors deemed appropriate based on medical, social, or current conditions
5. End of life planning: Advanced directive discussion only with patient consent.
    a. Define what a Power of Attorney and an Advance Directive are and their use
    b. Give paperwork for patient to review with family and attorney

Counseling Patient

6. Education, counseling, and referral based on the results of from above components
    a. Example: Counseling on diet, smoking, chronic conditions
    b. Handouts and patient education packets (if available)
7. Education, counseling and referral including a brief written plan such as check list of obtaining appropriate screening and/or other preventative services for the next 5 to 10 years. This should also include a list of possible risk factors. *(Recommendations should follow USPSTF)*

NOTE:

Patient needs to have

1. Medical records (if not established patient with records on file)
2. Immunization records
3. Family history (as much detail as possible)
4. Health Risk Assessment (HRA)
5. Full list of medications and/or supplements (including vitamins and how often and what dose)

Health Risk Assessment (HRA): This form **MUST COMPLETEY** be filled out prior to your visit!

Scale: (1-poor 2-declining 3-average 4-improving 5-above average for age) Circle One

1.	Overall how do you think your health is?	**1**	**2**	**3**	**4**	**5**
2.	Overall how do you feel that your bone strength is?	**1**	**2**	**3**	**4**	**5**
3.	Overall how do you feel that your muscle strength is?	**1**	**2**	**3**	**4**	**5**
4.	Overall how do you feel your balance is?	**1**	**2**	**3**	**4**	**5**
5.	Overall how do you feel your nutrition is?	**1**	**2**	**3**	**4**	**5**
6.	Overall how do you feel your finances are handled?	**1**	**2**	**3**	**4**	**5**
7.	Overall how do you rank your life satisfaction?	**1**	**2**	**3**	**4**	**5**
8.	Overall how comfortable are you in doing activities compared to 10 years ago?	**1**	**2**	**3**	**4**	**5**

How often do you drink coffee? _____ cups/day
How often do you drink any form of alcohol? _____ glasses /week
How often do you consume tobacco products? _____ times per/day
How many times per week do you participate in physical activities? _____ per week
How often do you have unprotected sex? _____ per week
How many unique partners have you had in the last 12 months? _____
How often do you drive without wearing your seatbelt? _____ per week
Do you find it difficult taking and keeping track of your prescribed medications? **Y / N**
Do you take any illegal drugs? **Y / N** If so, please identify: _____
Do you take any non-prescribed medication such as vitamins or supplements? **Y/N**
If so, please list: _____
Can you still safely provide your own transportation? **Y / N**
If you rely on other for transportation, are they available to meet your transportation needs? **Y / N**
Do your do your own housekeeping? **Y / N** Laundry? **Y / N** Grocery Shopping? **Y / N**
Are you still working? **Y/N** Actively participating in hobbies? **Y / N**
Please list some of your hobbies? _____

How many times per day do you participate in the following activities?

Brush your teeth? _____ per day	Do you use mouthwash and floss? **Y / N**
Take a bath/shower? _____per day	Do you require assistance with bathing? **Y / N**
Eat a nutritious meal? _____per day	Do you prepare your own food? **Y / N**
Groom yourself? _____per day	When was your last hair cut? _____
Dress yourself? _____per day	Do you require any assistance with dressing? **Y / N**

How often in the past month have you felt…

Depression:	**1**	**2**	**3**	**4**	**5**	**6+**
Stress:	**1**	**2**	**3**	**4**	**5**	**6+**
Anger:	**1**	**2**	**3**	**4**	**5**	**6+**
Loneliness:	**1**	**2**	**3**	**4**	**5**	**6+**
Social Isolation:	**1**	**2**	**3**	**4**	**5**	**6+**
Pain:	**1**	**2**	**3**	**4**	**5**	**6+**
Fatigue:	**1**	**2**	**3**	**4**	**5**	**6+**