Barry Pointe Family Care
Preventive/Wellness Information

Dear patients,
Thank you for choosing our practice for your medical needs. We value our relationship with you and want to serve as your medical home and provide the highest quality healthcare.

Unfortunately, many changes have occurred in healthcare coverage. In most cases, insurers **will not cover** a patient to have a preventive exam with medication refills other than contraceptives or hormone replacements. If you have any medication refills or new concerns that you would like to talk with your doctor about you will need to schedule a separate appointment for insurance to cover your preventive exam in full. We understand the inconvenience this may cause and regret that insurer's payment policies have led us to make this business decision. Your understanding of this situation is appreciated.

Preventive Exams:

Age and gender appropriate medical history, examination, counseling, risk factor reduction, and the ordering of laboratory/diagnostic procedures.

The focus of your visit will be:

- Assessment of Risk Factors (personal and family history)
- For pediatrics (growth chart), and for adults (BMI, weight, blood pressure, waist to hip ratio, smoking, etc.)
- Appropriate Immunizations - We follow CDC recommendations for pediatrics, adolescents and for adults. This is based on risk factors, co-morbidities, age, etc. We do the immunization(s) during the preventive exam time if the patient prefers.
- Appropriate referrals for further preventive services (colonoscopies, mammograms, etc.)
- Appropriate lab work (if any) and review of lab results

Discussing new or other concerns that you are already diagnosed with such as change of medication, renewal, etc. during a preventive generates a co-pay otherwise insurance will not cover the full cost of your preventive.

If other concerns are documented during a preventive exam, then two services will be billed to your insurance company. If two services are not billed through to insurance, then you will risk insurance not covering either service. As each plan is different, it is best to verify how your plan will process this.

Most preventive labs should be fasted:

- Nothing to eat 12 hours prior to appointment but we do recommend drinking water to make the lab draw easier and to prevent dehydration.
- If a patient is not fasting, labs can be done at your convenience and the nurse will call with results.
- Pap smear & breast exams for women unless done by an OB/GYN, labs and preventive screening.
- It is the patient's responsibility to know whether your insurance covers both a preventive exam by PCP and a pap/breast exam by OB/GYN as this varies plan to plan.
- Prevention of health problems based on sex and age.

Annual Follow Ups consist of:

Patients on any long-term medications or with any chronic or ongoing problems. Some chronic problems, diabetes/hypertension, require more frequent visits.

The focus of an annual follow up visit will be:

- Appropriate lab work and review lab results
- Review and Refill of medications
- Referral to specialist if necessary
- Appropriate Immunizations
- Multiple issues may require more than one visit

Barry Pointe Family Care
Preventive/Wellness Visit

You are here for a preventive/wellness exam. Your insurance does not require a co-pay. <u>However</u>, if you have new issues or the doctor needs to take action concerning your current health issues, you will be charged an office visit which may require a co-pay or apply to your deductible/co-insurance benefits.

Examples:

- You are healthy with no new concerns and your evaluation is normal - Preventative benefits, per your specific insurance plan, will apply.
- You discuss your new shoulder pain issues during this visit. An office visit will be added.
- Your doctor notices your elevated blood pressure and needs to start/change a medication. An office visit will be added.

Your signature below indicates you have read, understand and agree to the terms stated above.

_____ _____

Printed Name (Patient) **Date of Birth**

_____ _____

Signature (Patient/Guardian) **Date**

Yearly Adult Comprehensive Questionnaire

Name: _____ Birthdate: _____ Date: _____

Insurance: (Please circle) Blue Cross Other

Please Complete the questions below:

Employment status: Working Retired Homemaker Student Other: _____

Current Occupation (or former if retired): _____

Within the past year have you had:

Immunizations and Screenings:

			Name of immunization or study	Provider name/Location
Yes	No	Any immunization at another facility (i.e., flu or pneumonia vaccinations)		
Yes	No	Colorectal cancer screening through another physician (Colonoscopy, Cologuard, FOBT, Sigmoidoscopy)		
Yes	No	Dilated eye exam		
		FEMALES ONLY	Date	Location
Yes	No	Mammogram		
Yes	No	PAP (cervical cancer screening)		

Surgery or other procedure: Please list below. Include where the procedure was done and the physician:

_____

_____

Family History: List any changes since your last complete exam. Include relationship and diagnosis

_____

_____

Allergies: Please list any new allergies or intolerances below. Please include the reaction i.e., rash.

_____

_____

Specialists or other healthcare providers: Please list below and include the reason for the visit. (Include dental, chiropractic, eye specialists, OB-Gyn, etc.)

_____

_____

How would you rate your overall health? Excellent Good Average Below average Poor

Name:_____ Birthdate: _____ Date: _____

Please answer the following questions:

Depression and Anxiety Screening:

Over the past 2 weeks, have you been bothered by any of the following problems? (Place an X in the box that applies to you)

PHQ-2 (Depression Screening)	Not at all	Several Days	More th half in th days	Nearly everyday
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
GAD-7 (Anxiety Screening)				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

If you noted any concerns above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle your answer)	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult

Alcohol Screening:

Please circle your response to the questions below. Over the past two months:

Yes	No	Have you felt the need to cut down on your drinking?
Yes	No	Have you ever felt annoyed by criticism of your drinking?
Yes	No	Have you felt guilty about your drinking?
Yes	No	Have you ever taken a morning “Eye-opener?”

How Active Are You? (Mark the response that most reflects your activity level in the past two months.)

	I exercise regularly (3 or more times a week for 20 or more minutes most weeks)
	I exercise intermittently
	I do not have an exercise routine, but I am on my feet and active most days.
	I do not have an exercise routine and I am not very active most days.
	Other:

Name: _____ Birthdate: _____ Date: _____

Your environment and other stressors can make it hard for you to maintain good health. Please help us identify issues that can impact your health by completing all sections of this questionnaire.

Please circle your response to the questions below.

Yes	No	Do you have an advance directive (living will) with someone authorized to make healthcare decisions for you if you are unable to speak for yourself? Please make sure we have a copy on file. Please ask for a form if you do not have one.	
Yes	No	Do you wear glasses and still have severe vision problems?	
Yes	No	Do you wear hearing aids and still have severe hearing problems?	
Yes	No	Do you have trouble expressing yourself clearly (make your needs known)?	
Yes	No	Are you currently using cigarettes, marijuana, vaping, cigars, chewing tobacco?	
Yes	No	If you are a **non-smoker**, are you exposed to second-hand smoke on a regular basis?	Z57.31
		In the past 12 months:	
Yes	No	Are you using non-prescribed substances (illicit/street drugs)?	
Yes	No	Are you currently using narcotic pain medications for reasons other than short-term pain management? (Do you feel compelled to take these medications?)	
Yes	No	Do you worry about being able to afford enough healthy food for you and your family?	Z59.41
Yes	No	Have you worried about your ability to pay utility bills?	Z59.9
Yes	No	Do you **LACK** access to air conditioning during warm weather, and/or access to heat during cold weather?	Z59.11
Yes	No	Did you miss taking medicine because you could not afford to buy it?	Z59.6
Yes	No	Have you decided not to come to the doctor's office because of cost?	Z59.6
Yes	No	Have you missed or canceled a medical appointment because you did not have a way to get there? (No transportation)	Z59.82
Yes	No	Have you worried about your health insurance coverage?	Z59.7
Yes	No	Have you worried about losing your job or other steady source of income?	Z56.2
		Home safety:	
Yes	No	Are you worried about your safety in your neighborhood?	Z60.8
Yes	No	Are you concerned that someone in your home might threaten or physically hurt you?	Z60.8
Yes	No	Are you being bullied by anyone at home, in the community or online?	Z60.5
Yes	No	Do you feel alone or isolated from other people?	Z60.8

X	Please check the boxes that apply to you	
	I own my home	
	I rent my home (apartment or home)	
	I am homeless	Z59.0
	I live with my parents or other family members (Minors or others dependent of family for housing)	
	I am worried about losing my home	Z59.91
	My home has problems with mold, bug infestation, lead paint/pipes, or inadequate heating	Z59.1

Office use only:

_____ _____

Provider Signature Date