



Dear Valued Patient,

Our records indicate you have traditional Medicare Part B benefits. If you are within the first 12 months of your Medicare Part B coverage, you are eligible for a service called the Initial Preventive Physical Exam (also called the Welcome to Medicare visit). This visit includes screening of your vision, hearing, functional ability and psychological status. Your physician will also discuss ways to help you stay healthy. It also may include an EKG, which is a test to check your cardiac function.

Effective January 1, 2011 Medicare introduced another covered visit called the Annual Wellness Visit. You are eligible to receive this visit if you have been enrolled in Medicare longer than 12 months or you had your Welcome to Medicare visit more than a year ago. This visit includes updating your history forms, taking your vital signs, and screening your functional ability, safety and psychological status. Your physician will also discuss ways to help you stay healthy.

Your deductible and co-insurance are waived for the Welcome to Medicare visit and the Annual Wellness Visit so these services are free to you.

Neither the Welcome to Medicare visit or the Annual Wellness Visit are complete 'head to toe' physical exams. Lab tests are not included as a free part of these visits.

In both scenarios above, if you receive other services such as management of your chronic diseases and/or sickness there will be an additional office visit charge. There are also separate charges for labs, x-rays, and procedures as these services are not included in the Welcome to Medicare or the Annual Wellness Visit. You will be responsible to pay your deductible and/or co-insurance for these other services received on the same day as your Welcome to Medicare or Annual Wellness Visit.

When you call our office to schedule these visits, please let our office know you want to schedule the **Welcome to Medicare** or the **Annual Wellness Visit**. This will help us ensure we provide the appropriate services and also make sure we bill Medicare correctly.

If you need additional information or have questions, you may find www.medicare.gov to be a helpful website or you may call our office.

Thank you for allowing us to provide your healthcare needs.

Depression Screening – PHQ2 tool

Over the past two weeks, have you been bothered by any of the following problems?

Little Interest or pleasure in doing things	Yes	No
Feeling down, depressed or hopeless	Yes	No

If YES response to either of these = complete the PHQ9 below.

Depression Screening – PHQ9 tool

Over the past two weeks, how often you been bothered by any of the following problems?

	Not at all	Several Days	More than 7 days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in any way	0	1	2	3

For Physician Use **TOTAL SCORE:**

If you checked off any problems, 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?

- | | |
|---|--|
| <input type="checkbox"/> Not difficult at all | <input type="checkbox"/> Somewhat difficult |
| <input type="checkbox"/> Very difficult | <input type="checkbox"/> Extremely difficult |

Patient Name: _____

DOB: _____

DOS: _____

Activities of Daily Living (ADL) Assessment

Information obtained from Patient _____

Information obtained from other person _____

Who? _____

Using Telephone	I = Able to look up numbers, dial, receive and make calls without help A = Able to answer phone or dial operator in an emergency but needs special phone or help in getting number, dialing D = Unable to use telephone
Traveling	I = Able to drive own care or travel alone on buses, taxis A = Able to travel but needs someone to travel with D = Unable to travel
Shopping	I = Able to take care of all food/clothes A = Able to shop but needs someone to shop with D = Unable to Shop
Preparing Meals	I = Able to plan and cook full meals A = Able to prepare light foods but unable to cook full meals alone D = Unable to prepare any meals
Housework	I = Able to do heavy housework, (i.e. scrub floors) A = Able to do light housework, but needs help with heavy tasks D = Unable to do any housework
Taking Medicines	I = Able to prepare/take medications in the right dose at the right time A = Able to take medications, but needs reminding or someone to prepare them D = Unable to take medications
Managing Money	I = Able to manage buying needs, (i.e. write checks, pay bills) A = Able to manage daily buying needs but needs help managing checkbook, paying bills D = Unable to manage money

I = Independent
A = Assistance Required
D = Dependent

Patient Name: _____

DOB: _____

DOS: _____

Safety & Fall Risk Assessment

1.	Have you fallen the past 6 months?	YES	NO
2.	If you answered YES to question #1, were you injured?	YES	NO
3.	Have you experienced urgency or frequency with elimination in the past 6 months?	YES	NO
4.	Have you experienced episodes of dizziness in the past 6 months?	YES	NO
5.	Do you use any assistive devices for ambulation? If you answered YES, please circle the device(s) used: a) another person; b) railing; c) cane; d) walker; e) wheelchair	YES	NO
6.	Do you feel you could benefit from installing grab bars on your tub and/or shower?	YES	NO
7.	Does your home lack smoke detectors or sprinklers?	YES	NO
8.	Do you sometimes forget to fasten your seat belt when traveling in a car?	YES	NO
9.	Does your home have a fireplace?	YES	NO
10.	Do you smoke?	YES	NO
11.	Do you drink alcohol at least twice a week?	YES	NO
12.	Do you use oxygen on a regular basis?	YES	NO
13.	Does your home lack fire extinguishers?	YES	NO
14.	Do you use scatter rugs throughout your home?	YES	NO
15.	Does your home have a pool or hot tub?	YES	NO

Provider Signature: _____

Date: _____ Time: _____