Medicare Annual Wellness Visit

The Medicare Annual Wellness Visit is a way for our practice to keep you as healthy as possible. If you've had Medicare Part B (Medical Insurance) for longer than 12 months, you can get a yearly "Wellness" visit to develop or update your personalized plan to help prevent disease or disability, based on your current health and risk factors. **The yearly "Wellness" visit isn't a physical exam.**

Your costs in Original Medicare

You pay nothing for this visit if your doctor or other qualified health care provider accepts assignment
The Part B deductible doesn't apply.

However, you may have to pay coinsurance, and the Part B deductible may apply if:

- Your doctor or other health care provider performs additional tests or services during the same visit.
- Medicare doesn't cover these additional tests or services under this preventive benefit.

If Medicare doesn't cover the additional tests or services , you may have to pay the full amount.

What it is

Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy. Your visit may include:

- A review of your medical and family history.
- A review of your current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- Personalized health advice.
- A list of risk factors and treatment options for you.
- A screening schedule (like a checklist) for appropriate preventive services.

Signature_____Date of Birth_____Date_____

Health Risk Assessment

Patient Name:_____DOB:_____Date: _____

1. Can you get places out of walking distance without help?
*For example, can you travel alone by bus, taxi, or drive your own car?

Yes ☐
No ☐

2. Can you shop for groceries or clothes without help?

Yes ☐
No ☐

3. Can you prepare your own meals?

Yes ☐
No ☐

4. Can you do your own housework without help?

Yes ☐
No ☐

5. Can you handle your own money without help?

Yes ☐
No ☐

6. Do you need help eating, bathing, dressing, or getting around your home?

Yes ☐
No ☐

7. Are you having difficulties driving your car?

No ☐
Sometimes ☐
Yes, often ☐
Not applicable, I do not use a car ☐

8. Have you been given any information to help you keep track of your medications?

Yes ☐
No ☐

9. How often do you have trouble taking medicines the way you have been told to take them?

I do not have to take medicine ☐
I always take them as prescribed ☐
Sometimes I take them as prescribed ☐
I seldom take them as prescribed ☐

10. During the past 4 weeks, was someone available to help you if you needed and wanted help?
*For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

Yes, as much as I wanted ☐
Yes, quite a bit ☐
Yes, some ☐
Yes, a little ☐
No, not at all ☐

11. How often in the past 4 weeks, have you had trouble eating well?

Never ☐
Seldom ☐
Sometimes ☐
Often ☐
Always ☐

12. How often in the past 4 weeks, have you been bothered by your teeth or dentures?

Never ☐
Seldom ☐
Sometimes ☐
Often ☐
Always ☐

13. How often in the past 4 weeks, have you had problems using the telephone?

Never ☐
Seldom ☐
Sometimes ☐
Often ☐

Patient Name:_____DOB:_____Date: _____

Always ☐

14. Have you been given any information to help you identify hazards in your house that might hurt you?

Yes ☐

No ☐

15. Do you always fasten your seatbelt when you are in a car?

Yes, Usually ☐

Yes, Sometimes ☐

No ☐

16. Have you had sex in the past 12 months (vaginal, oral or anal)?

Yes ☐

No ☐

17. Have you ever had a sexually transmitted disease?

Yes ☐

No ☐

18. During the past 4 weeks, how much bodily pain have you generally had?

No pain ☐

Very mild pain ☐

Mild pain ☐

Moderate pain ☐

Sever pain ☐

19. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?

Very heavy ☐

Heavy ☐

Moderate ☐

Light ☐

Very light ☐

20. During the past 4 weeks, how would you rate your general health?

Excellent ☐

Very good ☐

Good ☐

Fair ☐

Poor ☐

21. How have things been going for you in the past 4 weeks?

Very well – could hardly be better ☐

Pretty good ☐

Good and bad are about equal ☐

Pretty bad ☐

Very bad – could hardly be worse ☐

22. How confident are you that you can control and manage most of your health problems?

Very confident ☐

Somewhat confident ☐

Not very confident ☐

I do not have any health problems ☐

23. Over the past 2 weeks, have you experienced having little interest or pleasure in doing things?

Yes ☐

No ☐

24. Over the past 2 weeks, have you been feeling down, depressed or hopeless?

Yes ☐

No ☐

25. Are you a smoker?

No ☐

Yes, and I might quit ☐

Yes, but I am not ready to quit ☐

Patient Name:_____ DOB: _____ Date:_____

26. Did you have a drink containing alcohol in the past year?

Yes □

No □

27. Have you fallen two (2) or more times in the past year?

Yes □

No □

28. Were you injured in any falls in the past year?

Yes □

No □

29. Do you have an Advanced Directive?

Yes □

No □