Medicare Physical Exams

Dear Patient,

Wellness and proactive health management is our collective goal and patient care philosophy. Your health and wellbeing is very important to us. You may not be aware that Medicare does not cover all the costs associated with a complete physical exam. Medicare only covers what they call an "Initial Preventative Physical Exam (IPPE)" and an "Annual Wellness Visit (AWV)".

An Initial Preventative Physical Exam (IPPE) is only covered **once** during the first year of your enrollment of Medicare B benefits. In IPPE includes an EKG, depression check height and weight check and obtaining medical history.

An "Annual Wellness Visit" (AWV) only includes a weight and height check, a blood pressure check, and a depression screening.

Please note neither the IPPE nor an AWV is a complete physical nor do they include clinical laboratory tests or services.

In order to efficiently examine our patients and screen for potential problems, our physicians at Piedmont Internal Medicine encourage all of our patients to schedule an annual physical to ensure all appropriate screening tests are performed.

A full physical includes **ALL** services for both an AWV and IPPE, in depth physical examination, review of medical history, review of medications, and maintenance medication refills. In addition to your exam, your physician will order relevant laboratory tests. Please note Medicare **DOES NOT** pay for a complete physical, nor laboratory testes associated with a "Well Visit".

The fee for a complete physical is $300.00 and is NOT covered or reimbursed by Medicare. The fee will be collected on the day your physical upon check in. In addition, you may also receive a bill from the company that preforms our laboratory services.

Thank you for understanding and if there are any additional questions please do not hesitate to ask. We are here to ensure our patients have complete understanding of the services provided and fees charged.

Thank you,

Piedmont Internal Medicine Physicians

PATIENT INFORMATION

Patient Name: ____ **Today's Date:** ____________________

Social Security Number: (Last 4 Digits) _____________ **Birth Date:** _____________ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Home Address: ____

Phone Numbers: Primary __________________ **Work** ___________________**Email** _______________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other____

Race/Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ Other __________________

Emergency Contact Name: _____________________________**Phone Number:** _______________________________________
Relationship to Patient: ____

Whom may we thank for referring you? ____

EMPLOYMENT INFORMATION

Employer: ____ **Position:** __________________________

Employer's Address: ____

PREFERRED PHARMACY

Pharmacy Name: ____ **Phone:** ___________________________

Pharmacy Address: ____

INSURANCE INFORMATION

Responsible Party: If patient check here: ☐

Name:_________________________________ **Date of Birth:**_____________ **Relationship:**___________________________

Phone Number: ___________________**Address**:____

Primary Insurance Co: _____________________________________ **Group Number:** _____________________________

Subscriber's Name: _______________________________________ **ID Number:** _________________________________

Relationship to Patient: ___________________ **Date of Birth** ______________ **Ins. Phone Number** __________________

Secondary Insurance Co: ___________________________________ **Group Number:** ______________________________

Subscriber's Name: _______________________________________ **ID Number:** _________________________________

Relationship to Patient: ___________________ **Date of Birth:** ______________**Ins. Phone Number:** _________________

(PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID TO ALL APPOINTMENTS)

PIEDMONT
INTERNAL
MEDICINE

Medical History Questionnaire

Name: ___________________________________**Date of Birth**: ______________________________

List main reason for today's visit: ____

____

List any other active problems (include treating physician if applicable): ___________________________
____
____

Allergies and reaction: ____

Medications and dosages (please include supplements): _______________________________________
____
____

Do you feel you have problems with sleep, snoring or day time sleepiness? ___ Yes ___ No
Would you like to speak with us about this? ___ Yes ___ No

Past medical illnesses (Please place a check by all which applies):

___Alcohol/Drug Abuse	___Cancer	___Heart murmur	___STD(type)
___Anemia	___Crohn's disease	___Hepatitis B/C	___Sickle cell disease
___Aneurysm	___COPD/Emphysema	___High cholesterol	___Sleep apnea
___Anxiety disorder	___Depression	___HIV	___Stomach ulcer
___Arthritis	___Diabetes	___Hypertension	___Stroke
___Asthma	___Glaucoma	___Kidney disease	___Thyroid disease
___Blood disorder	___Gout	___Kidney stones	___Tuberculosis
___Blood clot	___Hay fever	___Liver disease	___Positive TB skin test
___Blood transfusion	___Heart disease	___Seizure	___Ulcerative colitis

___Other: (please specify) ____

Past Operations/Procedures and/or Hospitalizations (please include date): _______________________
____
____

Family history (please indicate major medical problems; If deceased, please indicate cause of death):

Maternal Grandmother____

Maternal Grandfather____
Paternal Grandmother____
Paternal Grandfather____
Mother____

Father____
Siblings____
Children____

Social History

Occupation: __________________ Marital Status: ________________ Children: ____________________

Alcohol Use: Yes__ No__ How often: ___________________ Quantity: ____________________

Tobacco Use: Yes__ No__ Pack per day: __________________How many Years: _____________

Former Smoker: Yes__ No__ Pack per day: _________________ Year quit: ___________________

Other Tobacco/Nicotine: Yes__ No__ Type: _______________________Quantity: ___________________

Other Drugs: Yes__ No__ If yes, please specify: ____

Exposure to asbestos or other hazardous material: Yes__ No__ If yes, please specify: _________________

Do you have a living will? Yes__ No__

Healthcare proxy: Yes__ No__ If yes, please indicate Name: __________Relationship: ________________

Health Maintenance

Last known Menstrual cycle: _____________________ Last known Pap Smear: ______________________

Last known Mammogram: _______________________Last known Colonoscopy: ____________________

Last known Prostate Cancer Screening: ____________ Last Bone Density scan: ______________________

Immunizations:

Pneumonia: ________________ Flu: _________________________ Tetanus/TD/Tdap: __________

Hepatitis A: _________________Hepatitis B: _______________

Review of Systems: (Please place a check by all which applies):

	Weight Gain		Weakness		Insomnia		Blood in vomit
	Persistent Cough		Fainting		Mood Swings		Bowel Changes
	Blood in Stool		Frequent urination		Difficulty swallowing		Runny nose
	Headache		Tremor		Nausea		Feeling cold
	Weight loss		Fatigue		Change in vision		Back pain
	Fever		Change in exercise Tolerance		Vaginal discharge/bleeding		Blood in vomit
	Chest Comfort		Penis Discharge		Anxiety		Blood in sputum
	Difficult urinating		Breast pain		Change in hearing		Nipple discharge
	Memory Loss		Leg swelling		Depression		Short of breath
	Night Sweats		Pain with intercourse		Heartburn		Diarrhea
	Breast Lump		Trouble breathing		Skin rash		Nose bleed
	Leg pain		Palpitations		Feeling hot		Constipation
	Dizziness		Numbness/Tingling				

Patient Signature: ____________________________________Date: _________________________________

Reason Patient is Unable to Sign: _________________________Date: _________________________________

PIEDMONT INTERNAL MEDICINE

MEDICARE HEALTH RISK & SCREENING TOOL

In order for Medicare to pay for a wellness visit, the patient MUST complete a Health Risk Assessment Form. Please complete the form. If you need our assistance, please ask and our staff will be happy to help you.

Patient Name:____**Birth Date:** ____________________

EXERCISE: Type: ____

How Often?_______________________________________ How long each time? _______________________

DIET: On average per day, how many servings of the following do you eat?

Fruits: _________ Dairy: _________ Vegetables: _________ Fiber: _________

In an average week, how many servings of the following do you eat?

Red Meat (beef/pork) ________________ servings per week
Chicken ________________ servings per week
Fish ________________ servings per week
Fried Foods ________________ servings per week
Fast Food ________________ servings per week
Restaurant ________________ servings per week

Do you take supplements?

Calcium _____ Yes_____No__________How many units/milligrams
Vitamin D _____ Yes_____No__________How many units/milligrams
Multi-Vitamin _____ Yes_____No
Other (Please list) ____

ALCOHOL: How many drinks per day?__________OR per week? __________

Have you drunk more heavily in the past?__________Yes __________No

TOBACCO: Do you currently smoke?__________Yes___________No If yes, how much? ____________________________

Have you smoked in the past?_____Yes______No If yes, when did you quit? ____________________________

Have you ever chewed tobacco or used snuff?_____Yes______No If yes, when?________how much? _______

AUTOMOBILE: Do you drive? _____Yes _____No

Do you wear a seat belt? _____Yes _____No

Do you drive after drinking or ride with a driver who has been drinking?______Yes _____No

SUN: Do you wear sunscreen? _____ Always _____ Sometimes _____ Never

SELF CARE:

Do you have problems with your vision? _____Yes _____No

Last eye doctor appointment____How often? __________________

Last dental appointment ____

Do you have problems doing things with your hands such as buttoning, cooking, cleaning?______Yes_______No

Are you having problems with your memory?______Yes _____No

Do you have a living will?______Yes _____No

Have you named a Medical Power of Attorney?______Yes _____No

Have you discussed your wished for what happens to you if you can't communicate? (I.e. had a stroke or been in an accident?) _____Yes _____No

SOCIAL: Do you feel safe where you live? _____Yes _____No

Do you feel you can count on family or friends to help you? _____Yes _____No

Sleep:

Do you feel you have problems with sleep, snoring or day time sleepiness? ___ yes ___ no

Would you like to speak with us about this? ___ yes ___ no

LIST OTHER PROVIDERS RENDERING YOU CARE:

____

____

COGNITIVE SCREEN: Draw a clock face, including all the numbers. Place the hands on the clock to read 4:10.

PATIENT TO LEAVE THE BELOW BLANK. TO BE COMPLETED BY THE PROVIDER. RECALL 3 UNRELATED ITEMS

1. ____
2. ____
3. ____

PROVIDER SIGNATURE:____DATE: _______________

PATIENT FINANCIAL AGREEMENT

Welcome to Piedmont Internal Medicine. We are dedicated to making sure that our patients are provided with exceptional medical care. **We strongly encourage each patient to contact their insurance company to confirm their doctor is a participating provider in their plan.**

As a service to our patients, we are currently enrolled in numerous Managed Care plans. However, it is impossible for the practice to know all the requirements of each individual plan. **It is the patient's responsibility to be aware of the parameters of your individual plan and to notify the office of any changes or restrictions.** Any charges which are accrued because of failure of notification will be the responsibility of the patient. If insurance cannot be verified prior to each appointment, payment will be due at the time of service.

Patients who have a HMO policy must ensure their physician is listed on their insurance card. If not, the insurance provider will not cover the services provided. Any unpaid charges will be the patient's responsibility.

At Piedmont Internal Medicine, PC we provide diagnostic procedures, examinations and medical treatment including laboratory work. As a courtesy, we file charges directly to your insurance. At times, it is required that we send medical records to assist with payment of these charges.

Please be aware some of the services billed to your insurance may result in charges to you depending on your individual insurance plan coverage. Please take the time to acquaint yourself with your insurance policy.

Please note Piedmont Internal Medicine, PC follows all Federal laws. We are not able to rebill due to services not being covered by your insurance policy. If you receive a bill from an outside facility such as LabCorp, Quest, or Piedmont Hospital, you will need to contact them directly.

Self-pay patients are required to pay at the time services are rendered. An initial deposit of 150.00 will be required at Check In. Upon check out charges will be reconciled. As a courtesy, Piedmont Internal Medicine, PC offers a self-pay rate on same date services provided, including most laboratory services, only if charges are paid the day of services.

We contact every patient to remind them of their appointment. We ask all patients to give at least 24 business hour advanced notice in canceling or rescheduling an appointment. Failure to do so will result in a fee of $75.00 for an Office Visit, $150.00 for a Physical Exam/Annual Wellness Visit and $150.00 for an Echocardiogram. This will be your responsibility to pay.

Any **returned check** will incur a $35.00 charge to cover bank charges associated with the returned check in addition to the amount of the check. NSF checks must be redeemed with certified funds and check will no longer be accepted as payment.

An upfront fee of $35.00 will be collected for administrative tasks such as completing disability forms, FMLA, biometric screening form, medication prior authorizations and some medical records request. These tasks may require up to ten days to complete.

If any bills are acquired, it must be paid within 30 days of receipt. If you are unable to pay your balance, please contact the billing office to make payment arrangements. Any balance left unpaid nor under arrangements may be sent to a collection agency. If your account is sent to collections, there will be a $30.00 collection fee added to the total outstanding balances.

I acknowledge I have read and understand the policies above. I accept the rights and responsibilities outlined within them.

Patient/Guardian Signature:____Date: _______________

CONSENT AND RELEASES

Consent for Treatment

I,____, hereby voluntarily consent to outpatient care at Piedmont Internal Medicine, PC encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribe by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including nurse practitioners, physician assistants, medical assistants, or their designees as is necessary in the physician's judgment.

Patient/Authorized Signature:____Date_________
If Patient is a Minor (under 18), Authorized Signature:____

Notice of Patient Privacy Consent (HIPAA)

I have been provided with a copy (electronic and/or printed copy) of the practice's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. (The Notice of Patient Privacy Consent is posted on our website at www.PiedmontInternalMed.com for your convenience.)

Patient Signature:____ Date: _______________________

Authorized Release of Medical Information

There are times where the physicians and employees of Piedmont Internal Medicine need to contact you. Our primary method is through our "My Chart" patient portal, however, circumstances may require us to contact you via email, telephone, voice mail, and/or text messaging. Please check the additional approved methods of how we may contact you regarding your personal and private health information. Please note, you may change or revoke your authorization approvals at any time. ***Check all that apply:***

_____ Home Voice Mail/Answering Machine _____ Text Message _____ Work Voice Mail
_____ Cell Phone Voice Mail _____ Personal Email _____ Work Email
_____ Other: ____

I authorize the release of medical information to the following:____
____
Name and Relationship Name and Relationship

Patient Signature:____Date: _______________________

Lifetime Medicare Authorization & Consent for Medicare Patients Only

I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance, we will bill your secondary insurance after Medicare pays the requested amount.

I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Signature:____Date: ______________________

Medigap Authorization Statement

I authorize any holder or other information about me to release Piedmont Internal Medicine, P.C. any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Patient Signature:____Date:________________________

Consent for Use, Disclosure of Patient Information for the purposes of Treatment, Payment, and Healthcare Operations

I hereby consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Patient Signature:____Date: ______________________

Health Information Exchange

Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Practice for treatment, the physicians and/or their staff may get a copy of my medication history and other health care information electronically through various health information exchange connections with other health care providers. **I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in the Practice's Notice of Patient Privacy Practices.**

Terminating Services

All the providers and staff at Piedmont Internal Medicine value a meaningful and productive relationship with our patients. Unfortunately, there are occasions when this is no longer feasible. Please be advised that the Practice reserves the right to terminate the provider/patient relationship for the following reasons:

1. Multiple cancellations or missed appointments.
2. Medical Non-Compliance, including violation of Therapeutic Drug Agreement.
3. Failure to comply with practice policies, including yearly physical exams.
4. Rude, abusive behavior, use of obscene language, mistreatment of staff in person or on the phone.
5. Failure to pay a debt/account sent to collections

In such cases where the practice terminates the relationship, you will be notified in writing. Your provider will provide emergency medical care for 30 days following the date of the written notice, and will send medical records to your new provider with a written release. I have read and understand the reasons Piedmont Internal Medicine and my Provider may terminate the patient/provider relationship.

Patient Signature:____Date: _____________________

MEDICARE AUTHORIZATION STATEMENT

I, ____, authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

____ ____________________
Patient Signature **Date**

Only complete the Medigap Authorization Statement if you have secondary insurance to Medicare that pays for deductibles and co-insurance after Medicare has paid their portion.

MEDIGAP AUTHORIZATION STATEMENT

I, ____, authorize any holder of medical or other information about me to release to Piedmont Internal Medicine, P.C. any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

____ ____________________
Patient Signature **Date**

Policy Number: ____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Date: ____________________________

Patient Name: ____ **Birth Date:** _______________________

Medicare requires that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items provided. Therefore, Piedmont Internal Medicine is requesting that the information below be completed so that a determination can be made if Medicare is your primary insurance, please answer all the questions.

	Please check all that apply:	Yes	No
1.	Is the illness/injury due to an automobile accident, liability accident, or Workman's Compensation?	◯	◯
2.	Is illness covered by the Black Lung Program or Veterans Administration program?	◯	◯
3.	Are the services to be paid by a government research/ grant program?	◯	◯
4.	Is the patient covered by an employer group health plan (EGHP), including Federal Employees?	◯	◯
5.	Is this patient or his/her spouse actively employed by an employer of 20 or more employees?	◯	◯
6a.	If under age 65, is your Medicare coverage due to disability? *If "yes" go to #6b, if "no", go to #7.*	◯	◯
6b.	Is the patient or his/her spouse or parent actively employed by, or is the patient considered an employee of an employer having 100 or more employees? *If "yes", please complete information below.*	◯	◯
7a.	Is the patient entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)? *If "yes", go to #7b*	◯	◯
7b.	Has the patient completed the ESRD coordination period? *If "no", enter information below.*	◯	◯

If you answered "Yes" to any of the above questions, please complete the following:

Name of Insurance Company: ____

Street Address of Insurance Company: ____

City, State, Zip Code: ____ Telephone: ______________________

Name of Policy Holder: ____

Street Address of Insurance Company: ____

City, State, Zip Code: ____ Telephone: ______________________

Relationship to Patient: ___________________________________ Date of Birth of Policy Holder: _________________________

Insurance I.D. Number: ____ Group Number: ______________________

If Accident/Injury, Date of Accident/Injury: _____________________________ Do you have an attorney? _____ Yes _____ No

Attorney Name and Contact: ____

Name of Research/Grant Study: ____

Patient Signature: ____