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Dear Medicare Patient,

We are currently scheduling ***Annual Wellness Visits*** for our Medicare patients. This visit is covered by Medicare and is at no cost to you. This is **NOT** a PHYSICAL EXAM. Physical examinations are NOT covered by Medicare. The *Annual Wellness Visit* is a **PAPERWORK VISIT,** which provides the framework for health promotion and disease prevention, the foundation of a Patient-Centered Medical Home**.**

This visit is conducted by the physician or physician's assistant to help you create a **healthcare prevention and screening plan**. The ***Annual Wellness Visit***, reviewed and approved by a provider, is a personalized healthcare directive to identify age related problems early and initiate treatment sooner.

Does this replace the Welcome to Medicare Exam?
No, when you become eligible for Medicare, you may receive the *Welcome to Medicare Exam* within 12 months of your eligibility date. Twelve months later, and each year after, you will have an *Annual Wellness Visit*. This is **NOT** a physical exam, but rather an opportunity to organize your medical history to make sure that your healthcare screening and safety is addressed and documented.

What should I expect during my visit?
During the visit, the provider will review the packet of medical history forms, questionnaires and screening tools that you were given and ask to complete prior to the *Annual Wellness Visit*.

A medical assistant will check your blood pressure, height and weight, and will calculate your body mass index. Body mass index (BMI) is a measure of body fat based on height and weight that applies to both adult men and women.

The provider will check to make sure you are up to date with preventive screenings and Medicare offered services, such as cancer screening and immunizations. The provider may also order or suggest further tests, labs, or health programs depending on your general health and medical history. If multiple areas of concern are identified you may require further evaluation by your physician and asked to schedule an additional appointment to discuss treatment. Note: Diagnostic visits are subject to Medicare Deductibles and Co-insurance.

At the completion of your *Annual Wellness Visit* you will receive a copy of your customized prevention plan letting you know which screening and other preventive services you should have. You will also receive information regarding Patient Advanced Directives.

What should I bring to my first Wellness visit?
It is important that you complete all pages of the Annual Wellness packet as these are mandatory elements required by Medicare. Please bring the **COMPLETED** Annual Wellness Packet along with a list of any prescriptions and over-the-counter drugs you currently take, how often you take them, and why.

What if I have other health problems or medication refills that I want to discuss?
The *Annual Wellness Visit* is **NOT** designed to be a visit to discuss your chronic conditions.

Where can I get more information about the free preventive services Medicare offers?
You can also contact Medicare at (800) 623-4227 or visit www.medicare.gov if you have questions about the *Annual Wellness Visit.*

Doctors of Internal Medicine

Medicare Annual Health Risk Assessment

Name: _____ Date of Birth: _____

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible

<table>
<tr>
<td>1. During the <u>past 4 weeks</u>, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
□ Not at all
□ Slightly
□ Moderately
□ Quite a bit
□ Extremely</td>
<td>6. Can you get to places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?
7. Can you shop for groceries or clothes without help?
8. Can you prepare your own meals?
9. Can you do your own housework without help?
10. Can you handle your own money without help?
11. Do you need help eating, bathing, dressing, or getting around your home?</td>
<td>Yes

□
□
□
□
□</td>
<td>No

□
□
□
□
□</td>
</tr>
<tr>
<td>2. During the <u>past 4 weeks</u>, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
□ Not at all
□ Slightly
□ Moderately
□ Quite a bit
□ Extremely</td>
<td colspan="3">12. During the <u>past 4 weeks,</u> how would you rate your health in general?
□ Excellent
□ Very good
□ Good
□ Fair
□ Poor</td>
</tr>
<tr>
<td>3. During the <u>past 4 weeks</u>, how much bodily pain have you generally had?
□ No Pain
□ Very Mild Pain
□ Mild Pain
□ Moderate Pain
□ Severe Pain</td>
<td colspan="3">13. How have things been going for you during the <u>past 4 weeks</u>?
□ Very well – could hardly be better
□ Pretty good
□ Good and bad parts about equal
□ Pretty bad
□ Very bad – could hardly be worse</td>
</tr>
<tr>
<td>4. During the <u>past 4 weeks</u>, 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, a little
□ No, not at all</td>
<td colspan="3">14. Are you having difficulties driving your car?

□ Yes, always
□ Sometimes
□ No
□ Not applicable, I do not use a car</td>
</tr>
<tr>
<td>5. During the <u>past 4 weeks,</u> what was the hardest physical activity you could do for at least 2 minutes?
□ Very heavy
□ Heavy
□ Moderate
□ Light
□ Very light</td>
<td colspan="3">15. Do you always fasten your seat belt when you are in a car?
□ Yes, always
□ Yes, sometimes
□ No</td>
</tr>
</table>

Doctors of Internal Medicine

Medicare Annual Health Risk Assessment

Name: _____ Date of Birth: _____

16. During the past 4 weeks, how often have you been bothered by any of the following problems	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up	□	□	□	□	□
Sexual problems	□	□	□	□	□
Trouble eating well	□	□	□	□	□
Teeth or dentures	□	□	□	□	□
Using the telephone	□	□	□	□	□
Tired or fatigued	□	□	□	□	□

22. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?
□ Yes □ No

Keeping track of your medications?
□ Yes □ No

17. Have you fallen 2 or more times in the past year?

□ Yes □ No

23. 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

18. Are you afraid of falling?

□ Yes □ No

24. 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

19. Are you a smoker?

□ Yes □ No

25. Have you ever had deafness or trouble hearing with one or both ears?
□ No □ Yes

If yes, did you ever see a doctor about it?
□ No □Yes

20. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
□ 10 or more per week
□ 6-9 per week
□ 2-5 per week
□ 1 drink or less per week
□ No alcohol at all

26. Do you have an advance directive (living will)?

□ No □ Yes

21. Do you exercise for about 20 minutes 3 or more days a week?
□ Yes, most of the time
□ Yes, some of the time
□ No, I usually do not exercise this much

Doctors of Internal Medicine

Medicare Annual Health Risk Assessment

Name: _____ Date of Birth: _____

UPDATE MEDICAL HISTORY

List physicians/practitioners you currently see outside of our practice

Name	Specialty	Phone Number

UPDATE MEDICATIONS

List any medication that you currently take, including over the counter medications and herbal supplements.

Name	Strength	Direction	Prescribed by

PHARMACY

List the names and locations of your pharmacies.

Name	Location	Phone Number

Patient Signature: Date:

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Advance Directives Act (see §166.033, Health and Safety Code)

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preference. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides two other types of directives that can be important during a serious illness. These are the Medical power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisors. You may also wish to complete a directive related to the donation of organs and tissues.

DIRECTIVE

I, _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____I request that I be kept alive in this terminal condition using available life-sustaining treatment.
(THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently a possible; OR

_____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment.

(THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____

_____

_____

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:

1. _____
2. _____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed _____ _____ Date _____

City, County, State of Residence _____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness 1 may not be a person designated to make a treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____ Witness 2 _____

Definitions:
"**Artificial nutrition and hydration**" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).
"**Irreversible condition**" means a condition, injury, or illness:
(1) that may be treated, but is never cured or eliminated;
(2) that leaves a person unable to care for or make decisions for the person's own self; and
(3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.
"**Life-sustaining treatment**" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pin.
"**Terminal condition**" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.
Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.