



Today's Date \_\_\_\_\_

Chart # \_\_\_\_\_

Name: \_\_\_\_\_

MRN # \_\_\_\_\_

### INDICATE WHICH APPLY TO YOU

**GENERAL**

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>Yes</b>               | <b>No</b>                |
| 1. Frequent infections                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Weight change                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Appetite/thirst change                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Excessive fatigue/nervousness         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Difficulty sleeping                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Enlarged/tender lymph nodes or glands | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other _____                           |                          |                          |

**EYES**

- |                                 |                          |                          |
|---------------------------------|--------------------------|--------------------------|
|                                 | <b>Yes</b>               | <b>No</b>                |
| 1. Do you wear glasses/contacts | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Vision changes               | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Red/itchy, watery eyes       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Eye pain                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Glaucoma                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Dry eyes                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other _____                  |                          |                          |

**EARS**

- |                      |                          |                          |
|----------------------|--------------------------|--------------------------|
|                      | <b>Yes</b>               | <b>No</b>                |
| 1. Infections        | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hearing loss      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Earaches          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ear drainage      | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Buzzing/ringing   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Feel "stopped up" | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other _____       |                          |                          |

**NOSE AND THROAT**

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>Yes</b>               | <b>No</b>                |
| 1. Nasal stuffiness/drainage                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Frequent nosebleeds                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sore throat  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Mouth sores/ulcers                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Hoarseness   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Changes in taste                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Teeth/gum problems                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Snoring  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Sleep apnea ( <i>stop breathing while sleeping</i> ) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Other _____   |                          |                          |

**PULMONARY**

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>Yes</b>               | <b>No</b>                |
| 1. Shortness of breath/difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Cough-dry/productive                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Asthma/wheezing                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Night sweats                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Fever/chills                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____                              | <input type="checkbox"/> | <input type="checkbox"/> |

**CARDIOVASCULAR**

- |                                |                          |                          |
|--------------------------------|--------------------------|--------------------------|
|                                | <b>Yes</b>               | <b>No</b>                |
| 1. Heart attack/failure/angina | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chest pain/tightness        | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Irregular heartbeat         | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. High blood pressure         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Swelling of feet/ankles     | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Leg cramps with walking     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Mitral Valve/Murmur         | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other _____                 |                          |                          |

**GASTROINTESTINAL**

- |                                       |                          |                          |
|---------------------------------------|--------------------------|--------------------------|
|                                       | <b>Yes</b>               | <b>No</b>                |
| 1. Heartburn /indigestion             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Difficulty swallowing              | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Stomach pains/ulcers               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Nausea/vomiting                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Vomiting blood                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Loose stools/diarrhea              | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Constipation                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hemorrhoids                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Rectal bleeding                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Black/bloody stools               | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Changes in bowel habits           | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Frequent laxatives                | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Liver problems/jaundice/hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Gallstones                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Other _____                       |                          |                          |

**BREAST**

- |                |                          |                          |
|----------------|--------------------------|--------------------------|
|                | <b>Yes</b>               | <b>No</b>                |
| 1. Lumps       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Pain        | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Discharge   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Other _____ |                          |                          |

**MALES ONLY**

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>Yes</b>               | <b>No</b>                |
| 1. Prostate problems                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Sexual difficulties                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Testicle pain/lumps/swelling           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Impotent                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Discharge                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you do regular testicle exams       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Date of last prostate exam / PSA _____ |                          |                          |
| 8. Venereal disease                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Genital concerns                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Other _____                           |                          |                          |

**FEMALES ONLY**

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>Yes</b>               | <b>No</b>                |
| 1. Excessive menstrual flow                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Excessive menstrual pain                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Vaginal discharge/odor                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Vaginal dryness                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. PMS symptoms                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Menopause/symptoms                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Trouble conceiving                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Problems with pregnancies                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Sexual difficulties                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Venereal disease                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Genital concerns                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Self breast exams per year _____             |                          |                          |
| 13. Do you use birth control _____<br>Type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Date of last pap _____                       |                          |                          |
| 15. History of Abnormal Pap Treatment _____      | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Date of last mammogram _____                 |                          |                          |
| 17. Age at onset of periods _____                |                          |                          |
| 18. Frequency of periods _____                   |                          |                          |

**FEMALES ONLY (continued)**

- |                                  |  |  |
|----------------------------------|--|--|
| 19. Last menstrual period _____  |  |  |
| 20. Pregnancies _____            |  |  |
| 21. Live births _____            |  |  |
| 22. Miscarriages/abortions _____ |  |  |
| 23. Other _____                  |  |  |

**MUSCULOSKELETAL**

- |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|
|                          | <b>Yes</b>               | <b>No</b>                |
| 1. Joint pain/tenderness | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Joint swelling/warmth | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Joint stiffness       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Joint deformity       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Muscle pain           | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Back/neck pain        | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Weakness              | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Prone to falls        | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other _____           | <input type="checkbox"/> | <input type="checkbox"/> |

**SKIN**

- |                        |                          |                          |
|------------------------|--------------------------|--------------------------|
|                        | <b>Yes</b>               | <b>No</b>                |
| 1. Rashes              | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dry/itchy skin      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Bruising            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sweats              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mole/lesion changes | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Skin color changes  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Skin growths        | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hair/nail problems  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other _____         |                          |                          |

**NEUROLOGIC**

- |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|
|                          | <b>Yes</b>               | <b>No</b>                |
| 1. Headaches/migraines   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dizziness/nausea      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Fainting/blackouts    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Numbness/tingling     | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Paralysis             | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Seizures/convulsions  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Coordination problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Memory loss           | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other _____           |                          |                          |

**PSYCHIATRIC**

- |                                 |                          |                          |
|---------------------------------|--------------------------|--------------------------|
|                                 | <b>Yes</b>               | <b>No</b>                |
| 1. Mental illness               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Anxiety                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Depression                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Suicidal thoughts            | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Overly emotional/mood swings | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Hallucinations               | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Phobias                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other _____                  |                          |                          |

**URINARY**

- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
|                                    | <b>Yes</b>               | <b>No</b>                |
| 1. Pain/burning on urination       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Urinary frequency               | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Difficulty starting urine       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Incontinence ( <i>wetting</i> ) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Bloody urine                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____                     |                          |                          |

Provider Review: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Review: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Review: \_\_\_\_\_ Date: \_\_\_\_\_



# Carolinus Physicians Network

## Carolinus HealthCare System

### PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

#### TO OUR VALUED PATIENTS:

**THANK YOU** for choosing Carolinus Physicians Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

**FOR YOUR CONVENIENCE** we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

**PAYMENT (such as co-pays, deductibles & co-insurance)** is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

**INSURANCE CARDS must be presented at each visit.** You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card,** you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

**MEDICARE PLANS** are more numerous and complicated. Carolinus HealthCare System and Carolinus Physicians Network participate with **Traditional Medicare (Part A & Part B)** and a limited number of Private Fee-for-Service (PFFS) Medicare Advantage Plans. We do not accept any Non Private Fee-for-Service Plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and co-insurance are expected at the time of service. As a participating provider with Medicare and a limited number of PFFS, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

**MANAGED CARE PLANS** have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co-pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

**OTHER INSURANCES** are those plans we do not participate in. You may be responsible for payment in full at the time of service. As a courtesy, we will file your claim.

**WORKER'S COMPENSATION** may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

**MEDICAID** may not be accepted by your provider. Please check with your provider's office before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Identification Card to each visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

**HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS** are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

**SELF PAY PATIENTS** are those patients who **do not have insurance coverage.** Self pay patients will be given a 25% discount off the charges for services provided and are expected to pay a minimum of \$50.00 at the time of service. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

**MEDICAL FORMS/MEDICAL LEAVE/DISABILITY FORMS** will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

**I understand my responsibilities as outlined above and will abide by them.**

Patient/Guardian Name \_\_\_\_\_

Patient/Guardian  
Signature \_\_\_\_\_ Date \_\_\_\_\_



# Carolinan Physicians Network

## ACKNOWLEDGEMENT FORM

Medical Records # \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Authorized Representative)

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

Reason Patient Unable/Unwilling to Sign: \_\_\_\_\_  
\_\_\_\_\_

## ACKNOWLEDGEMENT FORM

### DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK

Numero de Registro Medico \_\_\_\_\_

Nombre del Paciente \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_/\_\_\_\_/\_\_\_\_  
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_  
(Paciente o Representante Autorizado)

Relacion al Paciente: \_\_\_\_\_ Mismo \_\_\_\_\_ Esposo (a) \_\_\_\_\_ Otro \_\_\_\_\_

Razon Por la Cual El Paciente No Puede/No Desea Firmar: \_\_\_\_\_

**One Patient Per Authorization Form**

**Carolinas HealthCare System - CPN Ongoing Communications Authorization for Release of Health Information Form**

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations once it is disclosed.

**PURPOSE OF RELEASE:**  Ongoing Communication regarding your healthcare.

**RELEASE FROM:** The facility/practice/individual listed below is authorized to release the requested health information:

**Facility/Practice Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

**DATES OF SERVICE, RANGE OF TIME OR EVENT(S):** The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or events(s):

From: (MM/DD/YY) Beginning of treatment To: (MM/DD/YY) End of Treatment

This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied.

**CHECK THE SPECIFIC INFORMATION TO BE RELEASED:**

All Records & Details  Other (Please Specify) \_\_\_\_\_

*I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).*

**NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:**

**Patient Name:** \_\_\_\_\_  
First Middle/Maiden Last

**Patient Address:** \_\_\_\_\_  
(Street Address/PO Box, City, State, Zip)

**Social Security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Medical Record/Chart #** \_\_\_\_\_

**Please provide phone numbers where you are authorizing CHS to leave patient information as described above:**

**Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**RELEASE TO:** This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

Name	Address	Telephone/Fax #	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PATIENT'S RIGHTS AND SIGNATURE:**

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices/Policy.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

**PRINT NAME (Patient/Authorized Representative):** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

If Authorized Representative, please indicate relationship to patient:  Spouse  Parent  Guardian  Executor of Estate  Power of Attorney

**MINOR'S SIGNATURE:** Please note, if the minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

**NAME OF MINOR:** \_\_\_\_\_ **SIGNATURE OF MINOR:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## **Important** **Your Physical & Your Insurance Company**

**Weddington Family Medicine** practices comprehensive medical care focused on prevention, as well as evaluation and management of your diseases, complaints and concerns.

Insurance companies now dictate how physicians bill for these services.

There are two definitions that you need to be aware of that define office encounters.

### **A. Preventive Physical Exams (PE, Physician Exam, Preventive PE)**

This visit is designed to educate you on changes you can make to live a healthier life and to identify new health problems. This encounter is **NOT** designed to address specific complaints or to manage known medical problems. This is usually an encounter to review preventive health issues, such as:

- Past medical history
- Interim medical history since your last physical exam
- Immunizations
- Health habits
- Diet
- Sleep pattern
- Health maintenance issues, such as last colonoscopy, last mammography
- Pertinent family history
- Review of systems
- Thorough physical exam

### **B. Office Visits (Evaluation and Management Encounters, E&M Services)**

This encounter is designed for the evaluation and management of single or multiple complaints or diseases, such as:

- Headaches
- Chest pain
- High blood pressure
- Diabetes mellitus

During your preventive physical exam, your physician will include management of your existing and/or any new medical problems. You will be charged for both the preventive physical exam and the office visit. The additional services may not be considered part of your preventive service benefit; therefore, these services may be non-covered by your insurance carrier or your carrier may apply the charges towards your deductible/coinsurance.

You will be responsible for any services rendered today that are not covered by your insurance carrier. It is important for you to understand your individual insurance benefit coverage because each carrier processes claims differently.

\*Please refer to the reverse side for examples of the definitions outlined above.

**Example 1:** A patient with multiple known medical problems presents to discuss these problems, as well as to have a preventive physical exam. The multiple medical problems are addressed and treatment is delivered. The charge to your insurance carrier would include the preventive physical exam, plus a charge for an office visit.

**Example 2:** A patient presents for a preventive physical exam. The patient has no complaints and no known problems, but is found to have high blood pressure. This problem is addressed and treatment started. The charge to your insurance carrier would include the charge for the preventive physical exam, plus a charge for an office visit.

**Example 3:** A patient with no health problems presents for a preventive physical exam. Patient has no complaints and no problems are found. The charge to your insurance carrier would be for the preventive physical exam only.

**Your out-of-pocket expense will be determined by your co-pay, deductible and individual insurance benefit coverage.**

**Thank you,**

*Weddington Family Medicine  
Physicians and Staff*

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_