Jupiter Family Healthcare

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Jupiter Family Healthcare Concierge

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Dear Patient:

To ensure that your physical examination is of the highest quality and comfort, please observe the following:

PHYSICAL EXAM NOTES

Please bring the Physical Exam forms completely filled out with you on the day of your scheduled exam.

Use an ink pen to fill out the Physical Exam forms writing your name and the date on top of each page.

On the day of your examination:
PLEASE DO NOT USE BODY LOTIONS.
PLEASE DO NOT USE PERFUME OR COLOGNE AFTER YOUR BATH.
WEAR LOOSE FITTING CLOTHING.
PLEASE DO NOT WEAR PANTYHOSE.

It is advisable to leave small children at home so that the physician has your complete attention during the examination.

Please call the member services number on the back of your insurance card and ask if the physical examination will be covered and what tests may or may not be covered during the physical examination,
i.e. blood work, EKG, chest x-ray, etc.

If you have not eaten or drank any liquid (except for sips of water) for at least 8 hrs on the day of your examination, your laboratory studies can be done on the same day. If you are unable to wait that long for a meal, then your laboratory studies can be scheduled for another day.

If you decided to go without food or drink until your visit, you may take your medications at the normal time with small sips of water.

There will be a $100 charge for any physical not cancelled within 24 hours prior to your appointment.

Thank you,

Staff at Jupiter Family Healthcare

[1/26]

Important Information Regarding Your Physical

Jupiter Family Healthcare providers practice comprehensive medical care that is based on prevention as well as evaluation and management of your diseases, complaints and concerns.

Today you are scheduled for your ***PHYSICAL EXAM,*** often called an annual wellness exam, annual health maintenance exam or yearly check-up. According to insurance coding guidelines, this visit is designed to educate you on changes you can make to live a healthier life and to provide screening tests appropriate for your age and gender. It includes a review of your personal medical and social history, family medical history, counseling on immunizations, a review and discussion of your diet and exercise habits. It will also include the potential need for additional screenings based on age and personal history. Preventative services generally include the following:

-Immunizations	-Health habits
-Nutrition/ education review	-Sleep patterns
-Medication review	-STDs
-Preventative screenings: labs, mammograms, colonoscopy	

Many insurance plans today now cover preventative services at 100%. This Physical Exam/ Wellness exam encounter is NOT designed to address specific complaints or to manage known medical conditions.

Today you may receive services that could be applied to your plan's deductible, coinsurance or copay. ***OFFICE VISITS*** for new problems and/or management of an existing condition(s) are designated for the evaluation, management and treatment of single or multiple concerns or conditions. In some cases, throughout the course of your exam, your provider may identify a new medical concern. If this occurs, your routine physical will expand to include an office visit and perhaps additional condition specific testing will be ordered. These additional service(s) are NOT considered part of your physical exam by your insurance company. If this occurs, you will be billed for your physical exam AND an office visit. Billing for both services is compliant with insurance billing guidelines. If your plan charges copays for the office visits, you will be asked for that co-payment by a member of our team. Examples include but are not limited to:

-Headaches	Hypertension	Diabetes	Cough/ Cold/ Allergy
-Chest pain	Asthma	Joint pain	GYN concerns
-Arthritis	Fatigue	Weight loss/ gain	Back/ Joint pain
-Abnormal labs	Medication monitoring	Any Prescription or REFILL	

It is important to understand your individual benefit coverage as benefits differ from plan to plan and in some cases from year to year. If you have questions, please contact your insurance company.

Your signature below indicates that you have read and understand that you will be financially responsible for the portion of the visit provided today that may not be covered in full by your insurance company.

_____	_____	_____
Signature	Printed name	Date

JUPITER FAMILY HEALTHCARE

NAME_____ Date ___/___/___

Tobacco Use Assessment and Cessation Intervention:

You currently smoke or chew tobacco or smoked in past 2 years	**Yes**	**No**
If Yes, Do you have any desire to quit?	**Yes**	**No**
Do you wish assistance on quitting?	**Yes**	**No**

Do you have any problems with urinary leakage/ incontinence: **Yes** **No**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

	Not at all	Several days	More than 1/2 the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns:

TOTAL SCORE

minimal 1-4 *mod-severe 15-19*

mild 5-9 *severe 20-27*

moderate 10-14

ONLY ANSWER IF YOU ARE ON MEDICARE:

Medicare Wellness Exam Questionnaire ****(only for Medicare patients)****

Based on Medicare requirements, please answer the questions to the best of your ability. These are a requirement of the Medicare Wellness Program.

Activities of Daily Living:

Are you Independent *(If yes, skip to next section Fall Risk)*	**Yes**	**No**
Patient needs full help with all daily activities	**Yes**	**No**

If No, Patient needs help with the following:

Dressing:	**Yes**	**No**	Grooming	**Yes**	**No**
Shopping:	**Yes**	**No**	Bathing:	**Yes**	**No**
Housework	**Yes**	**No**	Feeding:	**Yes**	**No**
Toilet Use	**Yes**	**No**	Preparing Meals	**Yes**	**No**

Fall Risk Assessment:

Have you fallen 2 or more times in the last 12 month or have you fallen with injury in the past 12 months	**Yes**	**No**

If Yes:

Do you have a walker/cane or other ambulatory assistance	**Yes**	**No**
Have you seen a Specialist or Physical Therapy?	**Yes**	**No**

AUDIT-C (Alcohol Use Disorders Identification Test) *(M>=4, F>=3)*

1. How often did you have a drink containing alcohol in the past year?
   (0) Never
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

JUPITER FAMILY HEALTHCARE

WOMEN ONLY:

NAME_____ Date ___/___/___

1. WOMEN ONLY:		Yes	No
Date of last period	_____		
Was your last period normal?		___	___
Have you passed menopause?	___	___	
If so, what year?	_____		
Date of last Pap smear	_____		
Was your last Pap smear normal?		___	___
Date of last mammogram	_____		
Was your last mammogram normal?		___	___
Did you have any pregnancies?		___	___
How many?____			
Premature_____ Full Term_____ Abortions_____ Miscarriages_____			
Do you know how to examine your breasts?		___	___
How often do you examine your breasts?	_____		
Do you have any:			
any lumps in your breasts?		___	___
discharge from your nipples?		___	___
vaginal drainage?		___	___
prolapse ("falling out") of the vagina or uterus?		___	___
any abnormal bleeding from the vagina in the past year?		___	___
Have you had herpes?		___	___

CONSENT FOR PELVIC EXAMINATION (if having one done)

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation.

By signing this consent, I_____ _authorize and direct
[Print Patient's Name]

Jupiter Family Healthcare PA, its Practitioners, and Students who will performing the examination.

To perform a pelvic examination as described above. By my signature below I acknowledge that I read and understand the contents of this form.

_____

Patient/Legal Representative Signature Print Name and Date

_____

Witness Signature