RRFM Document #WELPAC2022 Name / Acct #:___________________________

DOB:______/________/__________

Understanding Your Visit Type and Office Copays

Wellness exams, chronic care, sick visits…If you are confused about the differences among these terms, you are NOT alone!

At Rocky Run Family Medicine, our goal is to help you understand the different types of office visits so that you will know what to expect in terms of any out of pocket costs. Please understand that these are just guidelines in an effort to help you understand charges. Your insurance plan may process different services uniquely, and it is very important for you to know your benefits before you schedule an appointment. Take the time to familiarize yourself with what your insurance plan offers. Check your insurance company's website for more details.

Wellness Exams

This is an exam to evaluate previously undiagnosed disease and/or provide guidance for healthy living. Getting appropriate preventive services at the right time can help you stay healthy by preventing disease or by detecting a health problem at an early stage when it may be easier to treat.

Many insurances cover one wellness/preventive care visit each year. However, if new issues are discussed, chronic problems are reviewed and managed, or medications are refilled or modified, there will be an office visit charge in addition to your comprehensive preventive exam charge. Copays, deductibles, and coinsurances will be applied per your insurance plan.

As we have found that a majority of adult wellness visits also result in simultaneous office visits (as noted above), **all** adult wellness visits are initially assumed to include an office visit, and an office visit copay will be applied for the visit.[1] Should the visit result in only a wellness/preventive care visit, and should your insurance have no associated copay, any copays made will be credited to your account.

Follow Up/Chronic Care/General Office Visits

These include any visit to review chronic problems, adjust medications, review labs, refill prescriptions, or address other medical concerns. The frequency of required visits will depend on the patient and specific concerns or issues. Copays, deductibles, and coinsurances will be applied per your insurance plan guidelines.

If you have questions regarding our services and associated charges, please contact our billing department.

I understand the purpose of my visit today is for a wellness/preventive exam. I understand that any new acute health problems, chronic medical conditions or office procedures that I may request today are not considered part of the wellness exam and that an additional copay or deductible will apply. I understand that I will be responsible for payment in full.

Printed Name: ____ DOB: __________________________

Signature: ____ Date: ___________________________

[1] For your convenience, and when schedules permit, we try to address any added problems as part of your wellness exam. In this situation, as per the guidelines developed by the AMA, we will bill for the added office visit. The wellness portion of your visit may or may not be processed at 100% coverage by your insurance but the management of other issues will require us to collect your copay and possibly bill you as these additional charges may apply to your yearly deductible.

By combining these services into one time slot, we feel that we may have saved you another trip to the office to address any chronic issues. If that is not convenient for you, we can also schedule a separate appointment to address any additional health concerns. Our goal is to deliver the very best care to you and your family – comprehensive, convenient, and fairly priced.

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Patient Medical History

Please indicate if you currently have or have had any of the following:

	Yes	No	Details		Yes	No	Details
Headaches, Migraines				Abdominal Pain			
Epilepsy, Seizures				Bowel Irregularity			
Depression				Rectal Bleeding			
Anxiety				Hemorrhoids			
Mental Health Issues (list specifics)				Hernia			
				Gallbladder Disease			
Insomnia				Bladder Infections			
Sleep Apnea				Incontinence			
Hearing Loss				Prostate Problems			
Ringing in Ears				Kidney Disease			
Glaucoma/ Cataracts				STD			
Fatigue				HIV/AIDS			
True Food Allergies				Hepatitis			
Stroke				Sexual Dysfunction			
Eating Disorders				Menstrual Dysfunction			
Thyroid Disease				Infertility			
Dizziness/Fainting				Arthritis			
Weakness				Osteoporosis			
Chest Pain				Neck Pain			
Heart Murmur				Back Pain			
Heart Palpitations				Bursitis/Tendonitis			
Heart Disease				Hives			
Elevated Cholesterol				Chronic Rash			
High Blood Pressure				Diabetes			
Low Blood Pressure				Cancer			
Circulation Problems				Weight Loss			
Bleeding Tendency				Weight Gain			
Anemia				Measles			
Blood Transfusion				Mumps			
Leg Pain/Swelling				Chickenpox			
Shortness of Breath				Whooping Cough			
Wheezing				Polio			
Asthma				Tetanus			
Pneumonia				Erectile Difficulties			
Tuberculosis (TB)				Any Other Illnesses/Diseases			
Indigestion/Heartburn							
Ulcer							

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Social History

	Yes	No	Details		Yes	No	Details
Smoke (list # per day and for how many years)				Caffeine Use (how much)			
Alcohol (list frequency and amount)				Exercise Outside of Daily Activities (what/how often/how long)			
Use Drugs				Employed (list occupation)			
Live Alone				Under Stress			
Have Children (how many/sex/birth year)							

Surgical History

	Yes	No	Details		Yes	No	Details
Tympanostomy (ear tubes)				Hysterectomy			
Appendectomy				Hip Replacement			
Gallbladder Surgery				Knee Surgery			
Heart Surgery (indicate what type)				Cataract Repair			
Tonsillectomy				Sinus Surgery			
Bunionectomy				Any Surgeries Not Listed (include only date and year or surgery)			
Back Surgery							

Family History

If yes to any below, please include which family member

	Yes	No	Details		Yes	No	Details
Asthma				Epilepsy			
Heart Disease (note age of first event)				Bleeding Disorder			
High Blood Pressure				Kidney Disease			
High Cholesterol				Thyroid Disease			
Stroke				Mental Illness			
Cancer (type, age)				Osteoporosis			
Glaucoma				Arthritis			
Diabetes				Any Other Illness/Disease Not Listed			

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Females Only

	Yes	No	Details		Yes	No	Details
Age Periods Began				Premature			
Cycle Length (average # days from first day of period to first day of next period)				Stillbirths			
Period Length				Miscarriages			
Flow				Abortions			
Discomfort				Tubal Pregnancy			
PMS (pre-menstrual syndrome)				Pregnancy Complications			
Number of Pregnancies				Vaginal Deliveries (what year/s)			
Full term				Cesarean Sections (what year/s)			

Medications

Please list any medications you are currently taking:

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____

____

Please list any known drug allergies you have and your reaction to them:

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Printed Name: ____ Date: _________________________________