Attention Medicare Patients:

Every year (365 + 1 days) Medicare encourages an '**Annual Wellness Visit.'**
The focus of these visits is to discuss
Screening and Preventative Recommendations *ONLY*.

What does this mean for *you?*

This visit **includes:**

- Updating your medical history, surgical history, and hospital visit history
- Updating your current medications, over-the-counter supplements, and allergies
- Updating your family history and social history
- Updating a list of all your current medical providers / specialists
- Updating your family history and social history
- Updating your diet and exercise habits
- Obtaining your vital signs including blood pressure, heart rate, height, weight, etc.
- Assessing your safety, mental health, and quality of life
- Hearing and vision screening
- Discuss and answer questions on creating an advanced directive

*At the end of your visit you **will receive a checklist**
known as your '**Personalized Prevention Plan of Service'**.
This list *individualizes* your screening and prevention recommendations.

This visit does **NOT include**:

- A hands-on physical exam
- Discussion of any new or current medical problems, conditions, or medications
- Procedural or laboratory testing

*If you would like to schedule an Annual Physical Examination, including lab work, diagnostic testing, medication management, and full physical exam, please **understand this is not a Medicare covered service and you will be charged for any balance** not covered by any secondary insurance.

Separate visits must be schedule to discuss new or current problems or conditions. Any problems identified during the annual wellness visit will require a separate follow-up visit.

Please allow 1 hour to complete all paperwork. All paperwork must be completed prior to your appointment. Forms are available on our website.

**Please complete all paperwork prior to your appointment. Allow 1 hour to complete.*

THOMPSON PEAK INTERNAL MEDICINE

Annual Wellness Visit – for Patient

Patient Name: _____ DOB: _____ Date:_____

FAMILY HISTORY (i.e. Alcoholism, Bleeding Disorders, Cancer, CAD, Diabetes, Memory Loss, Mental Disorders)	
Father	
Mother	
Siblings	

☐ NA **MEDICAL & SURGICAL HISTORY**

Please ✓ : (past conditions, injuries, operations, hospitalization)

☐ Coronary Artery Disease	☐ CVA (Stroke)	☐ Heart Failure	□ Cancer (specify)
☐ Old Myocardial Infarction	☐ Late effect CVA	☐ Hypertension	□ Amputations (location)
☐ Peripheral vascular disease	☐ Deep Vein Thrombosis	☐ Dyslipidemia	□ Ostomy (location) **Circle**: Active or Reversed
☐ COPD	☐ Pulmonary Embolism	☐ Osteoporosis	□ Major Organ Transplant
☐ Chronic Kidney Disease	☐ Seizure	☐ Pathologic Compression Fx	□ Urinary Incontinence
☐ Renal Dialysis	☐ Chronic Hep B	☐ Major Depression	
	☐ Chronic Hep C	☐ Dementia	
		☐ Diabetes	

OTHER:

__ No Known Allergies	**ALLERGY LIST with REACTION**

☐ NA **MEDICATION LIST with DOSAGE (CPT II CODES: 1159F and 1160F)**

(please include Vitamins and OTC Meds)

1.	7.	13.
2.	8.	14.
3.	9.	15.
4.	10.	16.
5.	11.	17.
6.	12.	18.

□ All Medication Reviewed With Patient (provider must ✓ box)

☐ NA **SPECIALISTS & Durable Medical Equipment SUPPLIERS**

Patient Name: _____ **DOB:** _____ **Date:**_____

SOCIAL HISTORY

Living Arrangements: ☐ Alone With: ☐ Spouse ☐ Family ☐ Caregiver ☐ Assisted Living
Living Will: ☐ YES ☐ NO **DNR:** ☐ YES ☐ NO **Medical POA Designee:** _____

Occupation:	Retired ☐ Yes	Exercise type/frequency

Tobacco ☐ Current ☐ Smoke ☐ Chew Pack/Years: ☐2nd Hand ☐Never ☐Prior Use Quit Date:

Alcohol ☐ Never ☐ Occasional ☐ Daily #of drinks _____ day/ week/ month/ year

CAGE Questionnaire: ☐**1**. Have you ever felt you should **C**ut down ☐**2.** Have people **A**nnoyed you by criticizing your drinking? ☐**3.** Have you ever felt bad or **G**uilty about your drinking? ☐**4**. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye Opener)? ☐**5. NONE OF THE ABOVE**
Score of ≥ 2 considered clinically significant. Further assess for alcohol dependence.

1.	Have you had any falls in the past year? If "**yes**"; how many falls:	☐ Yes	☐ No
2.	Do you have any weaknesses of the extremities that interfere with your self-care or motility?	☐ Yes	☐ No

3. Do you feel safe in your home? ☐ Yes ☐ No

4. Have you noticed any difficulties with the following? (✓all that apply)
☐ Vision ☐ Hearing ☐ Speech ☐ Urinary: ___ Incontinence ___ High Frequency

5. Do you need any assistance with the following? (✓all that apply)
☐ Dressing ☐ Bathing ☐ Toileting ☐ Transferring ☐ Eating/Feeding

6. Do you need assistance with any of the following? (✓all that apply)
☐ Shopping ☐ Driving ☐ Using the telephone ☐ Meal preparation ☐ Housework ☐ Home repair
☐ Laundry ☐ Taking medications ☐Handling finances

PAIN SCREENING (CPTII CODES: 0521F, 1125F OR 1126F)

Do you have any pain? ☐ Yes ☐ No	If so where?

If pain is present, circle intensity (0=no pain; 10=worst pain): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

What causes or increases the pain?

DEPRESSION SCREENING - PHQ-9

Intended for: screening patients w/o diagnosis of Major Depression or to monitor treatment of Major Depression

Over the past 2 weeks, how often have you been bothered by any of the following problems?) (use "✓" to indicate your answer)	None **0**	Several Days **1**	More Than ½ the Days **2**	Nearly Every Day **3**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people would have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts you would be better off dead, or of hurting yourself in some way				
(If you ✓ any problems) How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people (circle)	Not difficult	Somewhat difficult	Very difficult	Extremely difficult
If there are at least 5 ✓ s in the shaded section of questions 1-9 (one must be question #1 or #2) and a response in the shaded area of the last question, then consider diagnosing Major Depression			**TOTAL SCORE:**	

Patient Name: _____ **DOB:** _____ **Date:**_____

DRUG DEPENDENCE
☐**NA**
Dependence to: ☐Opioids ☐Benzodiazepine ☐Cannabis ☐Cocaine ☐Amphetamine ☐Other: _____
(**MUST** indicate at least 3 criteria: unless in remission)
☐ withdrawal symptoms ☐ longer use than intended ☐unsuccessful efforts to quit ☐excessive time spent to obtain
☐ tolerance ☐ social, occupational, recreational activities affected ☐ continuous use despite adverse consequences
Please ✓ ☐ Continuous ☐ Episodic ☐ In Remission
Please ✓ ☐ Stable ☐ Improving ☐ Worsening

COUNSELING AND REFERRAL OF PREVENTIVE SERVICES	DATE COMPLETED OR SCHEDULED Please fax a copy of reports to 480-502-5761
★ **Mammogram:** Female Age 50 – 74 (MY & prior year)	☐ NA
★ **Colorectal Cancer screening**: Age 50 – 75 (Colonoscopy every 10 years, FIT test yearly, or Sigmoidoscopy every 5 years)	☐ NA
★ **Osteoporosis Management:** Female Age 67 – 85 (Dexa scan or treatment for osteoporosis within 6 months of a fracture)	☐ NA
★ **Diabetic Retinopathy screening (eye exam):** (yearly or negative in the prior year)	☐ NA
★ **Diabetic Nephropathy screening:** (yearly microalbumin or treatment with ACE/ARBs)	☐ NA
★ **Diabetic HbA1c: every 3-6 months** (goal < 9%)	☐ NA
Abdominal Aortic Aneurysm screening: Male ≥65 with h/o 100 cig/lifetime or family h/o AAA (requires prior authorization)	☐ NA
Other Preventive Screening: (Please ☐) ☐ HIV Screening ☐ PAP/Pelvic Exam ☐ PSA Other:_	☐ NA

Vaccinations with Date:	**Flu** **Date:**	**Pneumovax 23** **Date:** **Date:** **Prevnar 13** **Date:**	**Tetanus** **Date:**	**Shingles** **Date:**

★ **Rheumatoid Arthritis present** ☐ Yes ☐ No	**Patient on DMARD** ☐ Yes ☐ No
★ **Hypertension** ☐ Yes ☐ No	**Pt BP controlled:** ☐ Yes ☐ No (**Ages 18-59, 60 – 85 w/DM: <140/90, Ages 60 – 85: <150/90)**

I certify that the information provided on this assessment form is accurate, complete and current as of the date of exam noted on this page. I have personally examined the patient and indicated the patient's condition by noting the relevant diagnoses and supporting information. The diagnoses have been derived through: patient history, face-to-face patient examination, and completion of diagnostic studies. I understand this document will become a permanent part of the patient's medical record.

Provider Signature: _____ **M.D. D.O. N.P. P.A.** (circle one)

Provider Name: **Gary Betz, II, M.D. / Stacey Hopper, A.N.P.**

Date: _____

1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?
    a. Yes
    b. No
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?
    a. Yes
    b. No
3. Do you have housing?
    a. Yes
    b. No
4. Are you worried about losing your housing?
    a. Yes
    b. No
5. Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?
    a. Yes
    b. No
6. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?
    a. Yes
    b. No
7. Do you feel physically and emotionally safe where you currently live?
    a. Yes
    b. No
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?
    a. Yes
    b. No
9. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
    a. Yes
    b. No

A. Notifier: THOMPSON PEAK INTERNAL MEDICINE

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. Service listed** below, you may have to pay. *Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.*

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
AWV- Annual Wellness Visit.	**Medicare does not allow for procedures, tests and services to be covered during the Annual Wellness Visit.**	**$40.00 - $250.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Annual Wellness Visit** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. AWV** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. AWV** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D. AWV** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

NOTICE TO PATIENTS REGARDING PHYSICALS/WELL EXAMS

If you have scheduled an Annual Wellness Visit (AWV) **or** physical exam for today, your insurance company may call this visit "preventative", "yearly" or "annual". Please take a moment to read the remainder of this letter:

FOR COMMERCIAL HEALTH INSURANCE PATIENTS (NOT MEDICARE):

Due to national coding laws, we must bill your insurance company for your exam today as a preventative care visit, which may include: History; Vital Signs – Blood Pressure, Heart Rate, Respiration Rate, Temperature; General Appearance; Heart Exam; Lung Exam; Head and Neck Exam; Abdominal Exam; Neurological Exam; Dermatological Exam; Extremities (Arms and Legs) Exam.

Laboratory Tests

There are no standard laboratory tests during an annual physical. However, the doctor may order certain tests routinely:

- Complete blood count
- Chemistry panel
- Urinalysis (UA)

A screening lipid panel (cholesterol test) is recommended every 4 to 6 years.

Physicals Should Emphasize Prevention

The annual physical exam is a great opportunity to refocus your attention on prevention and screening:

- At age 50, it's time to begin regular screening for colorectal cancer or other risk factors.
- For some women, age 40 marks the time to begin annual mammogram screening for breast cancer.

If during your visit you have additional concerns that require diagnosis and treatment, or chronic conditions that need to be managed, you may incur additional office or lab charges - including a copay and/or deductible. Additionally, if your Physician finds a medical issue that needs immediate care, they are required to address the concern, which may result in an office visit charge. These additional charges will be submitted to your insurance company, as well as the preventative visit. If your insurance company does not cover some or all of the charges, you will be billed for the balance your insurance company indicates as patient responsibility. Please do not ask us to re-bill by changing a procedure or diagnostic code. By asking this of your physician, you are asking her to commit insurance fraud. You may also schedule a separate follow up appointment with the doctor to address your additional concerns instead of having them addressed today.

FOR MEDICARE PATIENTS:

Please be aware that the Medicare Annual Wellness Visit (AWV) consists of a history, medication review, fall risk screening, depression screening and vital signs. An EKG may be done and will be billed separately. Laboratory testing and a Physical are not part of the service and is ordered and billed separately. Coverage of the AWV visit is provided as a Medicare Part B benefit. The Medicare deductible is waived for the AWV. If you are here for the Annual Wellness Visit, please be sure to tell your provider. ***If during your visit you have additional concerns or conditions that require diagnosis and treatment, you may incur additional office or lab charges. Additionally, if your Physician finds a medical issue that needs immediate care, they are required to address the concern, which may result in an office visit charge.***

Thank you for your understanding in this matter. Your cooperation is greatly appreciated.

Print Name _____ Date of birth _____

Signature _____

Date _____

Thompson Peak Internal Medicine - Gary A. Betz,II MD PC- Please complete in ink.

Name	Date of Birth	Gender (circle one) Male · Female
Address City State Zip Code		
Home Phone	Cell Phone	Social Security #
Marital Status (circle one) Single · Married · Divorced · Widow · Legally separated · ♢Partner	E-mail Address*	
Employer	Work Phone	
Emergency Contact Relationship	Emergency Contact Phone	
Referral Source (circle one) Family/Friend · Web Site · Insurance Company · Radio/TV · Physician · Newspaper/Magazine · Electronic Newsletter · Search Engine		

Responsibility Party Name (if patient is under 18 OR other than patient)		
Address/City/State/Zip		Social Security No.
Phone	Date of Birth	Employer Name & Phone No.

Pharmacy Location	Phone

Name of individuals who we may speak to on your behalf (scheduling, medical results, etc) 1. 2.	Phone
Messages may be left at: (circle one or more) HOME WORK CELL	

Primary Insurance Carrier		
Policyholder Name (if other than patient)		Social Security no Date of Birth (of policy holder)
ID/Policy No	Group No	Primary carrier Phone

Secondary Insurance	Phone
Policy holder name(if other than patient)	SSN
ID/Policy No	Group #

Please allow us to copy your insurance cards

I authorize my insurance company to pay directly any and all claims submitted from Thompson Peak Internal Medicine, Gary A. Betz, II MD. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner.

* My signature on this document allows Thompson Peak Internal Medicine to communicate to me via my e-mail address.

** My signature on this document allows Thompson Peak Internal Medicine to request copies of any and all medical records from any source pertinent to my medical care.

*** To ensure confidentiality and privacy for our patients, any type of electronic recording is prohibited at this office.

I acknowledge that the office's Notice of Privacy Practices has been made available to me

Signature** _____ Date _____

_____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

THOMPSON PEAK
INTERNAL
MEDICINE

Patient Insurance-Financial Responsibilities Notification

To all patients:

Thompson Peak Internal Medicine the office of Dr. Gary Betz, commonly requests blood work or consultation with other specialists regarding your care. For those of you who have limitations in terms of managed care programs, or insurance contracts with laboratories or imaging facilities, it is your responsibility to make sure that the laboratory or imaging facility which is used is proper for your coverage, or make sure that necessary insurance authorization is obtained before your consultation, lab work or diagnostic testing.

Although we make an effort to try to make sure our referrals and orders are in accordance with the individual patient's health plan, we cannot take responsibility for this.

For those who have Medicare and other insurances, we attempt to provide the coding necessary for Medicare and insurances to cover your blood work, but it is not always possible that blood work ordered is covered by Medicare or insurance. We make no representation that we can guarantee insurance coverage, and will not accept any responsibility for payment of laboratory or diagnostic imaging charges. If you decide that you do not wish to have diagnostic studies or laboratory tests performed which are recommended by our physicians, because of insurance coverage, that responsibility is yours, including responsibility for failure to diagnose a disease which otherwise would have been found.

It is regrettable that we have to issue this letter, but "circumstances" with today's complex insurance / Medicare rules and regulations require this. Please contact the office if you have any questions.

Sincerely,

The office staff of Thompson Peak Internal Medicine

I have read and understand the above.

Patient: _____ Date: ____/____/____

THOMPSON PEAK
INTERNAL
MEDICINE

GARY A. BETZ, II, MD
Board Certified
Internal Medicine

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Thompson Peak Internal Medicine and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by Dr. Betz and his staff.

My signature certified that I read and understand the scope of this consent and that I authorize the access

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

7010 E. Chauncey Lane, Suite 145 • Phoenix, AZ 85054
Phone 480-502-5533 • Fax 480-502-5761 • www.thompsonpeakinternalmedicine.com

Thompson Peak Internal Medicine
FINANCIAL POLICY 2015

We appreciate that you have entrusted Thompson Peak Internal Medicine (TPIM) with your health care. Our office is dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. Because healthcare benefits and coverage options have become increasingly complex, we have developed this policy which details our financial requirements to help you better understand your responsibilities as a patient.

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, precertifications, preauthorizations, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and/or coinsurance. This applies to all payors regardless of whether or not our physicians participate. It is your responsibility to notify the office of any changes in your coverage prior to service.

Our office understands the value of insurance benefits, as a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. Payment of fees for the Provider's services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. We will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

Due to increased insurance company demands, we ask you to read and agree to the following TPIM provisions:

Private Pay Patients: If you have no insurance coverage, full payment is expected at the time of service.

Services not covered by your insurance plan: Services not covered by your insurance plan are your responsibility. You will receive a statement from us for the amount due. We advise you to contact your insurance company in advance to verify coverage for specific benefits such as well checks, immunizations, behavioral visits and lab services.

Patients with contracted insurance plans: Your copayments and/or coinsurance are due at the time of your visit. As a courtesy, our office will submit your claim to your insurance carrier.

Patients with private insurance/out of network plans/out of state plans: Payment in full is due at the time of your visit. A paid receipt will be provided to you to submit to your insurance company.

Payment options: We accept Cash, Check, Visa, Master Card, Discover Card (sorry, no American Express)

Statements: Statements will be mailed to the address that we have on file for you.

Outside Collections: If your outstanding balance has not been paid to TPIM within 120 days, your account will be turned over to RSKM, LLC, our outside collection agency, (phone number 602u 395u 0718). Thereafter, within 60 days of receipt by RSKM, LLC, if your balance has not been paid or payment arrangements have not been made, dismissal from TPIM will occur.

Laboratory Fees: You will receive a separate laboratory fee for their services. Any lab services that are not covered by your insurance will be your responsibility.

Address and Insurance Changes: Please let us know if your address, phone numbers, insurance, etc. change, so that your information is always current and accurate in your records. It is your responsibility to make sure we have the most up to date information for you.

Payment Policy Schedule*:	
Co-payments	Full payment is due at time of service
Deductible and coinsurance	Full payment is due at time of service
Non-covered services	Full payment is due at time of service

Non-participating insurance plan	Full payment is due at time of service
Other charges/fees*:	
Missed Appointment Fee	The office requires at least 24 hours notice when cancelling an appointment. - Failure to provide this notice will result in a charge of: $50 for routine or problem-focused visits $100 for physical exams or extended visits
Blocked Call fee:	When paging the Provider after hours, your phone must be "unblocked" in order to reach you. Failure to do so will result in a delayed response and a $25 charge.
Returned Check Fee:	$25 (only cash, debit cards and credit cards are accepted in the office)
Statement Fee:	After your initial statement, each subsequent mailed statement with a balance showing, will incur a $25 Processing fee
Collection Fee:	Any outstanding balances after 120 days will be sent to collections. A collection service fee of $50 will be incurred. Legal interest on the indebtedness and related attorney fees will be added. Delinquent accounts will result in discharge from practice, at which time, 30 days from time of notice, only emergent care will be provided while you establish with another physician
Medical Records:	A fee of $25 is due prior to receipt of records
Special Paperwork:	A $25-$75 fee for completing medical forms or other health related paperwork

* subject to change at any time

We realize that medical care can often become very expensive. If you have concerns about your ability to pay for service, we recommend that you contact us for assistance in management of your account.

Should you have any questions with regard to our financial policy we encourage you to ask. It is our goal, not only to provide the best quality of medical care, but to help you by answering any questions you might have.

I have read and understand TPIM's Financial Policy and agree by its terms. I understand that I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by Thompson Peak Internal Medicine. I understand that my insurance is an arrangement between myself and my insurance company, and that it is my responsibility to understand my benefits.

Patient Name & Date of Birth (Please print) _____

Responsible Party Name (Please Print) _____

Your Signature _____ Date _____