RECENT SYMPTOM QUESTIONNAIRE

Patient Name: _____ Date: _____

Have you had any of the following symptoms in the past two months? Write comments if you like.

GENERAL

fatigue	☐ Yes	☐ No
unexplained recurring fever	☐ Yes	☐ No
night sweats	☐ Yes	☐ No
unexplained weight gain	☐ Yes	☐ No
unexplained weight loss	☐ Yes	☐ No

EYES, EAR, NOSE & THROAT

vision problems	☐ Yes	☐ No
hearing difficulty or deafness	☐ Yes	☐ No
ringing in ears	☐ Yes	☐ No
frequent nose bleeds	☐ Yes	☐ No
nasal congestion/sinus problems	☐ Yes	☐ No
bleeding gums	☐ Yes	☐ No
chronic hoarseness	☐ Yes	☐ No
chronic sores in mouth or throat	☐ Yes	☐ No
seasonal or year long allergies	☐ Yes	☐ No

HEART (CARDIOVASCULAR)

chest pains or pressure	☐ Yes	☐ No
pains in the lower legs from walking	☐ Yes	☐ No
trouble breathing with walking	☐ Yes	☐ No
irregular heart beats	☐ Yes	☐ No
trouble breathing laying flat	☐ Yes	☐ No
lower leg swelling	☐ Yes	☐ No
racing heart	☐ Yes	☐ No

LUNGS (PULMONARY)

chronic cough	☐ Yes	☐ No
shortness of breath	☐ Yes	☐ No
coughing up blood	☐ Yes	☐ No
pain in chest with breathing	☐ Yes	☐ No
wheezing	☐ Yes	☐ No

GASTROINTESTINAL

abdominal pain	☐ Yes	☐ No
poor appetite	☐ Yes	☐ No
bloating or swelling of the abdomen	☐ Yes	☐ No
difficulty or pain with swallowing	☐ Yes	☐ No
constipation	☐ Yes	☐ No
diarrhea	☐ Yes	☐ No
indigestion or heartburn	☐ Yes	☐ No
blood in stools	☐ Yes	☐ No
chronic nausea or vomiting	☐ Yes	☐ No
stool caliber change	☐ Yes	☐ No

GENITOURINARY

pain or burning while urinating	☐ Yes	☐ No
genital lesions	☐ Yes	☐ No
blood in urine	☐ Yes	☐ No
difficulty controlling bladder	☐ Yes	☐ No
frequent nighttime urination	☐ Yes	☐ No
difficulty passing urine	☐ Yes	☐ No
sexual issues	☐ Yes	☐ No
breast lumps/changes	☐ Yes	☐ No
low sex drive	☐ Yes	☐ No

MUSCULOSKELETAL

painful joints	☐ Yes	☐ No
chronic back pain	☐ Yes	☐ No
chronic pain in arms or legs	☐ Yes	☐ No
muscle aches	☐ Yes	☐ No

SKIN

changing shape or size of moles	☐ Yes	☐ No
rash	☐ Yes	☐ No
easy bruising	☐ Yes	☐ No
easy bleeding	☐ Yes	☐ No
swollen glands	☐ Yes	☐ No

NEUROLOGIC

balance problems	☐ Yes	☐ No
dizzy spells	☐ Yes	☐ No
fainting	☐ Yes	☐ No
frequent headaches	☐ Yes	☐ No
memory loss	☐ Yes	☐ No
tremor	☐ Yes	☐ No
weakness in arms or legs	☐ Yes	☐ No

PSYCHIATRIC

anxiety	☐ Yes	☐ No
crying spells	☐ Yes	☐ No
depression	☐ Yes	☐ No
feeling stressed	☐ Yes	☐ No
loss of interest in fun activities	☐ Yes	☐ No
personality changes	☐ Yes	☐ No
poor concentration	☐ Yes	☐ No
sleeping problems	☐ Yes	☐ No
suicidal thoughts	☐ Yes	☐ No

Other _____

Name _____ Date of Visit _____

Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half 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 asleep, 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're 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

_____

AUDIT-C Questionnaire

1. How often do you have a drink containing alcohol?

a. Never b. Monthly c. 2-4 times a month d. 2-3 times a week e. 4+ times a week

2. If you drink, how many drinks do you have on one occasion?

a. 1 or 2 b. 3 or 4 c. 5 or 6 d. 7 to 9 e. 10 or more

3. How often do you have six or more drinks on one occasion?

a. Never b. Less than monthly c. Monthly d. Weekly e. Daily or almost daily

A. Notifier: SCOTTSDALE FAMILY PHYSICIANS

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), PAP, **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. This includes: 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.

Male Physical Exam
An annual physical exam for men might also include: Testicular exam; Hernia exam; Penis exam; Prostate exam
Female Physical Exam
A woman's annual exam might include: Breast exam; Pelvic exam
Laboratory Tests
There are no standard laboratory tests during an annual physical. However, some doctors will 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.

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 _____

Financial Policy
Scottsdale Family Physicians, PLLC

Please carefully read each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered so that we may continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our staff will be glad to discuss these policies with you.

_____ initial

I understand that if I do not have my insurance card, referral, and/or co-payment that my appointment may be rescheduled until such time that I can provide the required documents or payments.

_____ initial

I understand that reminder appointment calls from the office are a courtesy only, and that I am responsible for keeping track of my appointment and being on time.

_____ initial

I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges which are not covered by my insurance. ***I understand that verification of coverage is not a guarantee of payment of benefits.*** My insurance company determines benefit payments. I understand I will be responsible for the portion not covered by my insurance.

_____ initial

I understand that if I am unable to make a scheduled appointment I need to contact the office at least 24 hours prior to my scheduled appointment. A $25-$75 FEE MAY BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 1 BUSINESS DAY WITH A 24 HOUR NOTICE.

_____ initial

I understand there is a $25 charge for a Non-Sufficient Funds (NSF) check.

_____ initial

I understand there may be a $10-$40 charge for all forms deemed appropriate, filled out by the Physician (e.g. Disability, FMLA, etc.). When dropping forms off, I must allow 5-7 days for completion.

_____ initial

I understand if my account is not paid in full within 90 days, I may be turned over to a collection agency for further processing and incur an additional 35% fee. Legal action fee will be 50%. In addition, I will be discharged from the practice.

_____ initial

I have read and I understand the above Financial Policy and I agree to abide by its terms.

_____ _____

Signature of the Patient or the Patient's Legal Representative Date

_____ _____

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

Name _____ DATE_____

☐ OPT-OUT: I do not wish to answer these questions at this time

As your healthcare provider, we recognize the profound impact that non-medical factors can have on your ability to live a healthy and well rounded lifestyle. Conducting these screening questions allows us to uncover potential barriers and develop a more personalized approach to improving your health outcomes.

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, has 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 withbeen unable to get utilities (heat, cooling, 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 abused in other ways 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

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