



# INTERNAL MEDICINE WEST



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**To:    Our Medicare Patients**

**Subject:    Medicare Annual Wellness and Other Preventive Visits**

Beginning January 1, 2011, Medicare covers an “Annual Wellness Visit” in addition to the one-time “Welcome to Medicare” exam. The “Welcome to Medicare” exam occurs only once during the first twelve months as a Medicare patient. You may receive your Annual Wellness Visit after you have been with Medicare for more than one year, or it has been at least one year since your “Welcome to Medicare” exam.

Initial Preventive Physical Exam (IPPE)	“Welcome to Medicare” is only for <i>new</i> Medicare patients. This must be done in the 1 <sup>st</sup> year as a Medicare patient.
Annual Wellness Visit, Initial	At least 1 year after the “Welcome to Medicare” exam.
Annual Wellness Visit, Subsequent	Once a year (more than 1 year + 1 day after the last Wellness Visit).

The Annual Wellness Visit is *not* the same thing as what many people refer to as their yearly physical exam. Medicare is very specific about what the “Annual Wellness Visit” includes and excludes.

At the Annual Wellness Visit, your doctor will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. The visit does *not* include a hands-on exam or any testing that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. You may schedule another visit to address those issues *or* your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Annual Wellness Visit.

If you would like to schedule an annual physical, including any lab work or other diagnostic testing, medication management, vaccinations, and other services, please understand that these services will be charged and covered according to Medicare’s usual coverage guidelines. However, you may still develop a care plan based on the Annual Wellness Visit criteria.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this new benefit to work with your provider in creating a personalized prevention plan. We are dedicated to the promotion of good health for our patients and look forward to discussing your health at your wellness visit.

*See the attached list to bring with you to your appointment.*

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*What you should bring to your Annual Wellness Visit:*

The names of all your doctors:

Name	Speciality

A list of all your medications, vitamins and supplements:

Name of Medicine and Dose	

Have any of your close relatives had any health changes?  Yes     No

Has your mood changed?  Yes     No

If yes – Do you have little interest in doing things?  Yes     No

Do you experience apathy (times when you just don't care?)  Yes     No

When was your last flu or pneumonia immunization?  Flu     Pneumonia

Do you have a living will advance directive?  
(If you have one, *please bring it with you.*)  Yes     No

Do you have trouble hearing?  Yes     No

Does your home:

A) Have rugs in the hallway?  Yes     No

B) Have grab bars in the bathroom?  Yes     No

C) Have handrails on the stairs?  Yes     No

D) Have poor lighting?  Yes     No

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do you need any help with:

- |                    |                              |                             |
|--------------------|------------------------------|-----------------------------|
| A) Phone Calls     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B) Transportation  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C) Shopping        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D) Preparing meals | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E) Housework       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F) Laundry         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G) Medications     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| H) Managing Money  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you smoke?  Yes  No

Do you exercise regularly?  Yes  No  
If so, how much? \_\_\_\_\_

When was your last colonoscopy? \_\_\_\_\_  
Mammogram? \_\_\_\_\_

Please detail your family history by listing the health of your mother, father, siblings, and grandparents. If deceased, please explain why. Please include any health problems they have including cancer, hypertension, diabetes, etc.

Has anyone been concerned about your drinking of alcohol?  Yes  No  
If so, please explain.

Have you had sex with more than one partner within the past year?  Yes  No

Nutrition Assessment:  
Typical Breakfast:

Lunch:

Dinner:

Snacks/beverages:

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_