Hello!

The attached forms are required from patients scheduled for a Medicare Annual Wellness Visit in our office. You may download and complete these forms prior to your scheduled visit.

If you prefer, we are happy to provide you a copy of these forms when you arrive. Please arrive at least 20 minutes prior to your scheduled appointment to allow time to complete your forms.

If you choose to print or download these forms now, please note the following:

- Medicare Annual Wellness Vision Consent**—REQUIRED**
- Medicare Health Risk Assessment**—REQUIRED**
- Advance Directive**—NOT REQUIRED**
  (If you choose to complete your Advance Directive, we are happy to notarize it for you at our office. You may elect not to complete an Advance Directive if you wish not to have one or if you have already completed one.)

We look forward to seeing you!

BOWERS
Family Medicine

R. Edward (Ted) Bowers, II, MD
Taylor F. Elliott, FNP-C
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3824 South Highway 27 | PO Box 606
LaFayette, GA 30728

Medicare Annual Wellness Visit Consent

Medicare now offers an annual wellness visit once every 12 months for its patients. This benefit includes many preventative screenings that Dr. Bowers recommends for our patients. These screenings are covered by Medicare at no cost to the patient once every 12 months.

If you are due for evaluation of any ongoing health problems or you would like us to evaluate any new health problems, our providers will address these issues today as planned while also performing the medicare annual wellness visit. The evaluation of these chronic or new health problems is separate from the medicare wellness visit and remains subject to any applicable medicare deductibles and copays.

I would like to have a medicare wellness visit today as part of my office visit. I understand that any chronic or acute medical problems that are evaluated today are not part of the wellness visit and are subject to any applicable medicare deductible or copay charge.

Signature Date

Office: 706-639-9055 • Fax: 706-639-9057
www.bowersfamilymedicine.com

Medicare Health Risk Assessment

BOWERS Family Medicine

Patient Name: _____ Date of Birth: _____ Date: _____

BEHAVIORAL RISK FACTORS

Smoking Tobacco Use: Do you currently smoke cigarettes or use other types of tobacco? (Choose one)

☐ None ☐ Occasional ☐ Daily ☐ Prior use

Alcohol Use: In a typical week, how many days do you drink alcohol?

☐ None ☐ Occasional ☐ Daily ☐ Prior use

Illicit Drug Use:

☐ None ☐ Occasional ☐ Daily ☐ Prior use

DIET Are you on a special diet? ☐ Yes ☐ No Comments:

SELF ASSESSMENT OF HEALTH STATUS

General Well-Being: In general, would you say that your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Exercise: How intense is your typical exercise? (choose one)

☐ Light (stretching or slow walking) ☐ Moderate (brisk walking) ☐ Heavy (jogging or swimming) ☐ Very Heavy (fast running) ☐ I am currently not exercising

PSYCHOLOGICAL RISK FACTORS

	Over the last 7 days 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 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 family down	0	1	2	3	
7	Trouble concentrating on things such as reading the newspaper or watching TV	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 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	

FUNCTIONAL ABILITY AND LEVEL OF SAFETY

Do you need help from others to perform everyday activities such as:

Eating	☐ Yes	☐ No
Getting Dressed	☐ Yes	☐ No
Grooming	☐ Yes	☐ No
Bathing	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Using the toilet	☐ Yes	☐ No

Do you need help from others to take care of such things as:

Laundry	☐ Yes	☐ No
Housekeeping	☐ Yes	☐ No
Shopping	☐ Yes	☐ No
Banking	☐ Yes	☐ No
Transportation	☐ Yes	☐ No
Taking Medicine	☐ Yes	☐ No
Preparing Meals	☐ Yes	☐ No
Using the Telephone	☐ Yes	☐ No

HOME SAFETY

Do you live alone?	☐ Yes	☐ No
Does your home have any of the following?		
Throw Rugs	☐ Yes	☐ No
Poor Lighting	☐ Yes	☐ No
Slippery bathtub or shower	☐ Yes	☐ No
Does your home lack any of the following?		
Grab Bars in Bathrooms	☐ Yes	☐ No
Handrails on Stairs or Steps	☐ Yes	☐ No
Functioning Smoke Alarms	☐ Yes	☐ No

FALL RISK

Have you had two or more falls in the past year?	☐ Yes	☐ No
Any fall with injury in the past year?	☐ Yes	☐ No
Are you worried about falling or feel unsteady when standing or walking?	☐ Yes	☐ No
Do you have urinary leakage?	☐ Yes	☐ No

ADVANCED CARE PLANNING

Do you have an Advance Directive (Living Will)?	☐ Yes	☐ No

HEARING LOSS SCREENING

Do you have trouble hearing the television or radio when others do not?	☐ Yes	☐ No
Do you have to strain or struggle to hear/understand conversations?	☐ Yes	☐ No

Provider Signature: _____ Date: _____

ADVANCE DIRECTIVE

An advance directive is a document that allows a principal to select someone else to make health care decisions if they are not able to for themselves. In addition, it will enable a principal to choose their end-of-life treatment options on whether to prolong their life. Depending on State law, this document must be signed in the presence of a notary public and/or two (2) witnesses.

THIS FORM CONTAINS 2 PARTS (EACH PART IS OPTIONAL):

PART I. MEDICAL POWER OF ATTORNEY

PART II. LIVING WILL

PART I. MEDICAL POWER OF ATTORNEY

A medical power of attorney allows you the right to name someone else to make health care decisions on your behalf

I choose to: (initial and check) (choose one)

_____☐ - Have a medical power of attorney

_____☐ - Not have a medical power of attorney Part I of this form is intentionally left blank.

A. PRINCIPAL. I, _____, with a mailing address of _____, City of _____ _____, State of _____, Zip Code _____ ("Principal") hereby designate:

B. AGENT. _____, with a mailing address of _____, City of _____, State of _____, Zip Code _____ ("Agent").

AGENT'S TELEPHONE (CELL) (_____) _____ - _____

I select the above-named person as my Agent to act in all matters relating to my health care (including my mental health care) and including, without limitation, the power to give or refuse consent to all medical and surgical treatments, hospitalizations, and all related health care. This power of attorney is effective at the point when I am no longer able to communicate my health care wishes. My Agent's decisions under this power of attorney, during any period when I am unable to make and/or

communicate my health care decisions or when there is uncertainty as to whether I am dead or alive, are binding on my heirs, devisees, and personal representatives.

C. ALTERNATE AGENT. If my Agent is unable or unwilling to serve or make a decision in a timely manner, I select _____, with a mailing address of _____, City of _____ _____, State of _____, Zip Code _____ to act as my alternate agent ("Alternate Agent")

ALTERNATE AGENT S TELEPHONE (CELL): (_____) _____- _____

I intend for my Agent to receive any and all of my health records and information as if I were the one requesting such information This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 14200, and 45 CFR 160-164.

PART II. LIVING WILL

A living will allows a principal to select end-of-life treatment options in the chance of incapacitation with no viable cure.

I choose to: (initial and check) (choose one)

_____☐ - Have a living will.

_____☐ - Not have a living will. Part II of this form is intentionally left blank.

A. PRINCIPAL. I, _____, with a mailing address of _____, City of _____, State of _____, Zip Code _____, with the last four (4) digits of my social security number (SSN) being XX- XXX -_____ ("Principal") desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

B. LIFE SUPPORT.
I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below, and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

_____☐ - Chronic coma or persistent vegetative state

_____☐ - No longer able to communicate my needs

_____☐ - No longer able to recognize family and friends

_____☐ - Total dependence on others for daily care

_____☐ - Other:_____

(initial and check) (choose one)

_____☐ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV)

_____☐ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

C. CERTAIN LIFE-SUSTAINING TREATMENT.
Some people do not wish to have certain life-sustaining treatments under any circumstance, even if recovery is a possibility. Check the treatments below, if any, that you do not wish to have under any circumstances.

(initial and check) (choose one):

_____☐ - Cardiopulmonary Resuscitation (CPR)

_____☐ - Ventilation (breathing machine)

_____☐ - Feeding tube

_____☐ – Dialysis

_____☐ – Other: _____

A. END OF LIFE WISHES (hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that _____

_____

I have signed this document on this _____ day of _____, 20_____.

Principal's Signature: _____

Print Name: _____

Depending on your State's laws, you either need two (2) witnesses and/or notary public may be required for signing this form.

WITNESSES/NOTARY ACKNOWLEDGEMENT

On this date set forth above, I hereby state as follows:

The above-named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am not an Agent or successor Agent named in this document. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

WITNESS 1

Signature: _____ Date: _____

Print Name: _____

WITNESS 2

Signature: _____ Date: _____

Print Name: _____

NOTARY ACKNOWLEDGEMENT

State of _____}

County of _____}

Signed and sworn to me on the _____ day of _____, 20_____.

I, the undersigned authority in and for said County in said State, hereby certify that the Principal, ___ _____, whose name is signed above in this living will, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily on the day the same bears date.

Given under my hand this _____ day of _____, 20_____.

Notary Public Signature: _____

Printed Name: _____

My commission expires: _____