

HEALTH MAINTENANCE SCREENING TESTS:

Colonoscopy _____ Date: _____ Abnormal Yes No
Women: Mammogram _____ Date: _____ Abnormal Yes No
Pap Smear _____ Date: _____ Abnormal Yes No
DEXA Scan (osteoporosis) _____ Date: _____ Abnormal Yes No
Men : PSA (prostate) _____ Date : _____ Abnormal Yes No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following problems

- | | | |
|----------------------------------------------|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Asthma/Lung disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other: _____ |

SURGICAL HISTORY: Please list all prior operations

FAMILY HISTORY:

Alcoholism: _____	High cholesterol: _____
Cancer, specify type: _____	High blood pressure: _____
Heart disease: _____	Stroke: _____
Depression/suicide: _____	Bleeding or clotting disorder: _____
Diabetes: _____	Asthma/COPD: _____
	Other: _____

SOCIAL HISTORY

Tobacco Use

Cigarettes: Never Quit Date _____
 Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? No Yes

Safety:

Is violence at home a concern for you? Yes No
Have you fallen or currently sustaining falls at home? Yes No
Have you ever been abused? Yes No

Alcohol use

Do you drink alcohol? No Yes #drinks/week _____
Is your alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreational drugs? No Yes
Have you ever used needles to inject drugs? No Yes

**AGREEMENT TO RECEIVE MEDICARE ADVANCED PRIMARY CARE MANAGEMENT
(APCM) SERVICES**

Medicare covers Advanced Primary Care Management (APCM) services provided monthly by physician practices. I understand that my primary care physician is assuming responsibility for all my primary care services and will be a continuing focal point for all my needed health care. In agreeing to receive APCM, I understand that my physician and Getwell internal medicine team are willing to provide such services to me, including the following.

Access and continuity of care

- 24/7 access to the care team for urgent needs.
- The ability to get successive, routine appointments with a member of the care team.
- Alternatives to traditional office visits (for example, home visits or expanded clinic hours)

Comprehensive Care Management

- Needs assessment, including medical and psychosocial
- Helping ensure I receive recommended preventive services.
- medication management and support.
- A personalized care plan that outlines my health goals and needs and is regularly reviewed and updated.
- A copy of my care plan is accessible to me, my caregivers, and members of my care team.

Care Coordination

- Coordinating my care across settings, such as:
 - Referrals to other physicians and health care providers.
 - Communicating with home-and community-based providers, community-based service providers, hospitals, and skilled nursing facilities others.
- Follow-up care after emergency department visits or discharge from a hospital, skilled nursing facility, or other health care facility.

Enhanced Communication Opportunities

- Additional ways for me and my caregivers to communicate with my physician and care team, such as patient portals, secure messaging, and e-visits.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me APCM services within a given calendar month.

I understand these APCM services are subject to the usual Medicare deductible and coinsurance applied to physician services.

My signature authorized my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in APCM.

This designation is effective as of the date below and remains in effect until revoked by me

Patient Name: _____ **Signature:** _____ **Date:** _____