MEDICARE

***(A)*Notifier(s):**

FALL CREEK
INTERNAL MEDICINE

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

***(B)* Patient Name:** ***(C)* Identification Number: NOT REQUIRED**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)*** the service(s) 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. We expect Medicare may not pay for the ***(D)*** *service(s)* below.

(D) **PHYSICAL**	***(E)*** **Reason Medicare May Not Pay:**	***(F)*** **Estimated Cost:**
*Physical if you don't meet the MC criteria/guidelines as indicated in next column	Effective 1.1.2011 Medicare allows for a preventive physical exam yearly if performed within the required 12 months between exams or if a Welcome to MC Exam is indicated in the FIRST year of MC Part B eligibility enrollment.	$348.00
Potential *ADDITIONAL* charges for the following exam/procedures:	**Women:** Medicare will only cover these exams every 2 years.	
- Breast / Pelvic (G0101)		$ 91.00
- Obtaining Pap Smear (G0101) (Female Patients)		$106.00
- Prostrate Exam (G0102) (Male Patients)		$ 50.00

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)*** service(s) 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)*** service(s) 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)*** service(s) 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)*** service(s) 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:**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 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 figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *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?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PATIENT NAME : _____ DATE _____

Vulnerable Elders Survey (VES) 13 Scale

DOMAIN	Score
75-85	1
>85	3
Self Rated Health	
Good, Very good, and excellent	0
Fair and Poor	1
Activities of daily living(ADL)/ instrumental activities of daily living(IADL)	
I NEED ASSISTANCE WITH:	
Bathing or Showering	1
Shopping	1
Money Management	1
Transfer	1
Light housework	1

I have difficulty in special activities:	
Kneeling, bending, and stooping	1
Performance of housework(example: scrubbing the floor)	1
Reaching out and lifting upper extremities above the shoulder	1
Lifting and carrying 10 lbs	1
Walking ¼ of a mile	1
Writing or handling and grasping small objects	1

Total Score _____

NAME: _____ DOB:_____ DATE:_____

CURRENT LIST OF PROVIDERS AND MEDICAL SUPPLIERS

Physicians/Physician Assistants/Nurse Practitioners involved in my care:

_____

_____

_____

_____

_____

Pharmacies that I use most often:

_____

_____

_____

Therapist for physical therapy, occupational therapy, psychological therapy:

_____

_____

_____

Suppliers for my medical equipment such as oxygen, wheelchair, CPAP device:

_____

_____

_____

Other providers or suppliers not mentioned above:

_____

_____