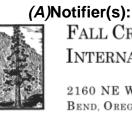
MEDICARE



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)* <u>service(s)</u> 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 <i>ADDITIONAL</i> charges for the following exam/procedures: - Breast / Pelvic (G0101) - Obtaining Pap Smear (G0101)	Women: Medicare will only cover these exams every 2 years.	\$ 91.00 \$106.00
(Female Patients) - 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) <u>service(s)</u> 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) <u>service(s)</u> 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) <u>service(s)</u> 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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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	-	+ -	F
(Healthcare professional: For interpretation of TOTA please refer to accompanying scoring card).	AL, TOTAL:			
10. If you checked off any problems, how difficult		Not diffi	cult at all	
have these problems made it for you to do		Somewhat difficult		
your work, take care of things at home, or get	Very difficult			
along with other people?				

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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 activ	vities of daily living(IADL)
I NEED ASSISTANCE WITH:	
Bathing or Showering	1
Shopping	1
Money Management	1
Transfer	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	<u>د</u>

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: