**Routine Annual Preventive Physical Exam**
*(Medicare does not cover Routine Annual Exams)*

**Patient Name:** _____ **DOB:** _____

**Physician Name:** _____ **Date of Service:** _____

An “Annual Physical Examination,” “Routine Physical” or “Check-up” is a preventive visit that specifically focuses on promoting health and wellness. The purpose of a routine preventive exam is to identify potential health problems in the early stages when they may be easier and less costly to treat. A routine preventive exam is technically defined as periodic comprehensive preventive medicine evaluation and management.

The exam is prevention focused, not problem focused, and may include the following:

- Past medical, social and family history
- Complete physical exam and review of body systems
- Review of medications
- Immunizations
- Counseling/anticipatory guidance/risk factor reduction interventions
- Review of age/gender appropriate screening tests

If you are having a periodic follow-up to address chronic conditions, then the visit is not considered a routine physical.

If significant time is spent on a new health problem(s) or other chronic condition(s) that need significant time to address during your preventive office visit, e.g. high blood pressure, diabetes, skin rash, or headaches, your provider may bill separately for this portion of the visit. If significant time is spent on an acute problem or chronic conditions, your provider may choose to bill a normal "Sick Visit" in lieu of a "Preventive Physical Exam" or, if appropriate, both may be billed. If your provider does bill for a Preventive Exam and a Sick Visit on the same day, it may result in two out of pocket expenses for that one date of service/visit. This is an acceptable insurance practice.

Please note that physicians will not change diagnosis codes to get claims paid, regardless of what your insurance carrier might suggest. This is considered insurance fraud and is illegal. If non-screening tests, such as labs, are ordered during your preventive service, your insurance may apply to your co-insurance or deductible.

I have read and understand the above policy. I acknowledge that I am responsible for any copay(s), deductible, co-insurance and/or non-covered service(s).

**PATIENT SIGNATURE:** _____ **DATE:** _____