North Spokane Women's Health

# Annual Preventive Exam Acknowledgment

Patient Name: _____ DOB: _____

Provider: _____ Date of Visit: _____

*You are scheduled today for your Annual Preventative Exam; this will include an age-appropriate physical exam and screening to identify and reduce risk factors.*

*You may already have issues or conditions that are being managed by your Provider, but today's focus will be on how to avoid future health issues.*

| **What's typically considered preventative, and what's included in your Annual Preventative Exam?** | **What's typically NOT included in your Annual Preventative Exam?** |
|---|---|
| Review your medical history and health risk assessment. | Evaluation and diagnosis of new health issues/ concerns. |
| Discussion of how to lower any current health risks, if applicable. | Treatment of existing health conditions and medication management. |
| Making sure you are up to date on your health screening tests, i.e., colonoscopy, mammogram, diabetic eye exam, and immunizations. | Lab tests or imaging of existing or new conditions or illnesses. |
| Counseling on health-related behaviors, i.e., diet, physical activity, alcohol use, and safety. | Chronic disease management for ongoing conditions, this includes any referrals to other providers and/or care plans. |
| | Prescribing new or adjustments of medication. |

Services not typically included in your annual preventative exam as listed above, would not be covered by your insurance's preventative service benefit, and are also not covered if you are a self-pay patient. If any of these services are provided today, they will be for a **NON-PREVENTATIVE VISIT.** If we are billing insurance for this visit, the non-preventative charges are subject to your insurance plan's coverage and a copay, coinsurance, or deductible will apply. Please note a medication check is required yearly if you are on medications prescribed by this office. If you would like to schedule these visits separately, we would be happy to schedule another appointment on a different day.

*I have read and understand the financial policy regarding Annual Preventative Exams, and I agree to pay for all services not covered by my insurance plan.*

Signature of patient/responsible party: _____

Printed Name: _____ Date: _____