INTERNAL MEDICINE

with ***MUSC Health***

Patient Name:______________________________ DOB:____________

Annual Wellness Visit (AWV). Did you know?

At Brio Internal Medicine we pride ourselves in offering the best healthcare possible to our patients. By doing this, our providers, in keeping with Medicare guidelines, are requiring all Medicare patients at Brio Internal Medicine to partake in an AWV.

What are the benefits to an Annual Wellness Visit?

1. The AWV is a benefit of Medicare.
2. The AWV helps to provide preventative care to our Medicare patients.
3. The AWV allows you to spend more time with your provider.

What am I to expect during my Annual Wellness visit?

1. Collection of personal medical and surgical history, as well as a list of current medications, vitamins, and supplements taken, and the doctors who are involved in your care.
2. Depression and mood disorder screening.
3. Review of functional abilities and level of safety (ie. fall risk, hearing loss)
4. Lab draw for you to discuss at the follow up appointment with your provider.

I acknowledge that, as a Medicare patient of Brio Internal Medicine, I am required to participate in an Annual Wellness Visit each year. The AWV will better help my provider to care for me and to meet my medical needs. I understand that by failing to participate in a yearly AWV will result in my dismissal as a patient from Brio Internal Medicine.

____   ________________________

Patient Signature   Date

INTERNAL MEDICINE

with MUSC Health

ANNUAL WELLNESS VISIT

PLEASE COMPLETE THE QUESTIONS PRIOR TO SEEING YOUR MEDICAL ASSISTANT OR NURSE. YOUR RESPONSES WILL HELP US GIVE THE BEST HEALTHCARE POSSIBLE.

PATIENT NAME: ______________________________ DATE OF BIRTH: ________________

ANSWER THE FOLLOWING QUESTIONS:

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

IN A RELATIONSHIP WITH A MALE PARTNER ☐ IN A RELATIONSHIP WITH A FEMALE PARTNER ☐

HOW MANY BIOLOGICAL CHILDREN DO YOU HAVE? __________

EMPLOYED ☐ **OR** RETIRED ☐

RISK

DO YOU CURRENTLY USE TOBACCO PRODUCTS? YES ☐ NO ☐

HAVE YOU EVER? YES ☐ NO ☐

HOW OFTEN DO YOU EXERCISE? ______________________________

HOW OFTEN DO YOU WEAR YOUR SEATBELT? ______________________________

ARE YOU SEXUALLY ACTIVE? YES ☐ NO ☐

DO YOU EXPERIENCE SEXUAL PROBLEMS? YES ☐ NO ☐

DO YOU EXPERIENCE BLADDER CONTROL/LEAKAGE PROBLEMS? YES ☐ NO ☐

GENERAL HEALTH

IN THE PAST MONTH, HAVE YOU EXPERIENCED PAIN? YES ☐ NO ☐

HOW WOULD YOU DESCRIBE THE EASE WITH WHICH YOU CAN: (CHECK THE OPTION THAT APPLIES)

PREPARE YOUR FOOD?	EASY ☐	SOMEWHAT DIFFICULT ☐	VERY DIFFICULT ☐	I CAN'T ☐
BATHE/CLEAN YOURSELF?	EASY ☐	SOMEWHAT DIFFICULT ☐	VERY DIFFICULT ☐	I CAN'T ☐
DRESS YOURSELF?	EASY ☐	SOMEWHAT DIFFICULT ☐	VERY DIFFICULT ☐	I CAN'T ☐
USE RESTROOM BY YOURSELF?	EASY ☐	SOMEWHAT DIFFICULT ☐	VERY DIFFICULT ☐	I CAN'T ☐
DO YOUR OWN SHOPPING?	EASY ☐	SOMEWHAT DIFFICULT ☐	VERY DIFFICULT ☐	I CAN'T ☐
PAY YOUR OWN BILLS?	EASY ☐	SOMEWHAT DIFFICULT ☐	VERY DIFFICULT ☐	I CAN'T ☐
DO ROUTINE HOUSEWORK?	EASY ☐	SOMEWHAT DIFFICULT ☐	VERY DIFFICULT ☐	I CAN'T ☐

FALL RISK AND HOME SAFETY

HOW MANY TIMES HAVE YOU FALLEN WITHIN THE PAST YEAR? ______________________________

DO YOU FEEL SAFE IN YOUR CURRENT HOME? YES ☐ NO ☐

HOW OFTEN DO YOU SPEND TIME WITH OTHERS?

NONE, I PREFER ISOLATION ☐ OCCASIONAL ☐ FREQUENT ☐

DOES A PARTNER OR ANYONE AT HOME, HURT, HIT, OR THREATEN YOU? YES ☐ NO ☐

DO YOU WEAR HEARING AIDS? YES ☐ NO ☐

DO YOU WEAR GLASSES? YES ☐ NO ☐

WHO DO YOU LIVE WITH: ____

WHEN WAS YOUR LAST...

EXAMS

EXAM	DATE
DENTAL	
EYE	

SCREENINGS: CHECK THIS BOX IF THERE ARE NO CHANGES SINCE YOUR LAST VISIT ☐

SCREENING	DATE
COLONOSCOPY	
COLOGUARD	
ABDOMINAL AORTIC ANEURYSM	
FEMALES ONLY:	
PAP SMEAR	
MAMMOGRAM	
BONE DENSITY	
MALES ONLY:	
PSA	

VACCINES: CHECK THIS BOX IF THERE ARE NO CHANGES SINCE YOUR LAST VISIT ☐

VACCINE	DATE
PNEUMONIA	
INFLUENZA (FLU)	
HEPATITIS B (SERIES OF 3)	
SHINGRIX	
TDAP	
COVID	

LIST CURRENT SPECIALIST:

____

____

____

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 "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Total Score: ☐

SBIRT (2018 Edition)

Patient Name : ______________________________ Date: ______________________

Patient refused/declined SBIRT screening at this time?					
☐ Yes					
☐ No					
ALCOHOL USE	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	☐ Never	☐ Monthly or less	☐ 2-4 times a month	☐ 2-3 times a week	☐ 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 1 or 2	☐ 3 or 4	☐ 5 or 6	☐ 7 or 9	☐ 10 or more
3. How often do you have five or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
				SCORE	
				Interpretation	
DRUG USE					
How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?				☐ 0	☐ 1 or more
				Total Count	
				Interpretation	

Responsible Party Signature Form

RESPONSIBLE PARTY

The Responsible Party is the person who is FINANCIALLY responsible for the patient's account and who will receive all account statements to their address. By signing, I understand that I am the responsible party and will adhere to the requirements outlined in the policies provided to me for the following patient as well as future patients registered in my name at Brio Internal Medicine with MUSC Health (Brio Internal Medicine). If you are 18 or older, you are your own responsible party.

First Name	Last Name	Date of Birth
______________________	______________________	______________________

WAIVER OF LIABILITY

______________ I understand that the treatment/service from the providers and physicians at Brio Internal Medicine for the patient listed above may not be a covered treatment/service or may not be covered at 100%. I agree to be personally and fully responsible for any balance due.

PAYMENT POLICY

______________ Brio Internal Medicine is committed to providing the best treatment for our patients. Our pricing structures are representative of the usual and customary charges for our area. Thank you for adhering to our payment policy. Signing below indicates that you are the responsible party which means you are financially responsible for this patient and have read and understand the payment policy and agree to abide by its guidelines.

RESPONSIBLE PARTY ACKNOWLEDGEMENT

______________ I understand that I am the responsible party for the patient listed above and any future patient(s) registered in my name at Brio Internal Medicine and I agree to the terms of the Waiver of Liability and Payment Policy. I have been given a copy for review and I am aware of the availability of these documents in the office of Brio Internal Medicine as well as online at www.briointernalmedicine.com.

NEW PATIENT APPOINTMENTS

______________ I understand that the typical new patient visit is a consultation in which your new provider will take the time to get to know you personally as well as your medical issues. Devoting this extra time at your initial visit allows us to gain a solid foundation of your health information that will result in us providing you with the highest quality care. After your initial consultation, we will together determine when lab work, additional testing, and/or a physical are needed.

______________________________ Responsible Party Signature

______________ Date

Lab Services Payment Policy

First Name ______________________ Last Name ______________________ Date of Birth ______________________

Our goal is to provide the most comprehensive healthcare for you. In order to achieve this goal, your provider may order labs for your preventative and/or diagnostic care.

In the event that labs are not covered by your insurance company, you will receive a bill from Brio Internal Medicine with MUSC Health, LabCorp, and/or both. For any lab bill you receive from Brio Internal Medicine that is not covered by insurance, you will be given a discount (this does not include invoices from LabCorp).

By signing this form, you are accepting responsibility for any uncovered expenses associated with your labs.

______________________________ ______________

Patient Signature Date

Patient Update Form

Patient Information

Patient First Name ____________ Patient Last Name ____________ Patient Date of Birth ____________

Mailing Address ____________ City ____________ State ____________ Zip Code ____________

Email Address ____________

Activate my patient portal with this email address

☐ Yes ☐ No ☐ Already activated

Primary Phone Number ____________ Secondary Phone Number ____________

Emergency Contact ____________ Relationship ____________ Phone Number ____________

Primary Insurance Information

Insurance Company ____________ Subscriber Name ____________

Subscriber ID ____________ Claims Address on Back of Card ____________

Secondary Insurance Information

Insurance Company ____________ Subscriber Name ____________

Subscriber ID ____________ Claims Address on Back of Card ____________

Communication Preferences

Leaving Messages: ☐ ALL Information (Appointments, Billing, Referrals, etc.) ☐ Appointments only

Messages can be left on: ☐ Primary Phone Number ☐ Secondary Phone Number

Email Updates: I authorize Brio Internal Medicine with MUSC Health to email me about available **Brio Aesthetics** specials, offers, and updates. ☐ Yes ☐ No

How Are We Doing?

You are an important part of the Brio Internal Medicine with MUSC Health Family! Please share your thoughts and ideas about your experience with us:

____

____________ Patient Signature ____________ Date