PREVENTIVE CARE

Prevention is the Best Medicine.

Good health begins with preventive care, and establishing a partnership with the right primary care doctor empowers you to achieve good health for a lifetime.

At Carolinas HealthCare System, your health is our top priority. In addition to caring for you when you're sick, our primary care doctors focus on preventive care that puts you in top form to fight off disease and illness so you can live the best life possible.

The preventive services included in this handout are covered by most health plans.

Coverage for Preventive Services

Adult Preventive

Exams:
Preventive office visits including well woman exams*

Screening Tests:
- Blood pressure screening for adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease

Immunizations:
Doses, recommended ages and populations vary
- Influenza (flu)
- Pneumonia
- Hepatitis A
- Hepatitis B
- Tetanus, Diphtheria, Pertussis (Td/Tdap)
- Varicella (chicken pox)
- Measles, Mumps, Rubella (MMR)
- Meningococcal
- Zoster (shingles)
- Human Papillomavirus (HPV)

Child Preventive

Exams:
Preventive office visits including well-child care*

Screening Tests:
- Hearing
- Vision
- Phenylketonuria (newborns)
- Sickle cell disease (newborns)

Immunizations:
Vaccines for children, birth to age 18 – doses, recommended ages and populations vary
- Influenza (flu)
- Pneumonia
- Hepatitis A
- Hepatitis B
- Tetanus, Diphtheria, Pertussis (Td/Tdap)
- Varicella (chicken pox)
- Measles, Mumps, Rubella (MMR)
- Polio
- Rotavirus
- Meningococcal
- Human Papillomavirus (HPV)
- Hib (Haemophilus influenza type b)

Newborn Preventive Treatment:
Ocular medication against gonorrhea for all newborns

Certain history of symptoms or certain screenings, such as a colonoscopy, may identify health conditions that require further testing or treatment. If a condition is or has been identified through a preventive screening, any testing, diagnosis, analysis or treatment are not considered preventive services and are subject to any related copays and deductibles within your health plan.

Bring this handout with you to your next preventive exam appointment to discuss with your doctor what preventive screenings are right for you or your child.

* During an annual preventive exam, your physician may address new or pre-existing health conditions or concerns not considered part of your preventive service benefit. Should this occur, the additional services may not be considered part of your preventive services benefit, therefore, your insurance carrier may subject these additional services to your deductible and co-insurance provisions.

The services listed are subject to change as federal guidelines are issued. A full list of covered preventive services can be found at www.healthcare.gov/what-are-my-preventive-care-benefits/

Carolinas HealthCare System

Carolinas HealthCare System

Thank you for choosing Carolinas HealthCare System for your healthcare needs. You are scheduled for an Annual Preventive Exam today and we want to provide you with some information regarding your visit.

What is part of preventive care?

Preventive care means that you and your doctor work together to lower your chance of getting certain health problems. During your visit, your doctor will choose what tests or health screenings are right for you. The tests chosen depend on your age, sex, past health record and your health now. As part of your visit you may have physical exams, immunizations, lab tests and other tests. Most health plans pay for these tests.

What is <u>not</u> part of preventive care?

New or current health problems are not part of preventive care. Your doctor can diagnose or treat any new or current health problem during your visit. Tell your doctor if you want that done. You may be charged for extra office or lab fees. This is a Carolinas HealthCare System policy. You will need to pay for some or all of the fees not covered by your health plan. Check your health plan to know what it will pay for.

You may want to keep your annual preventive exam apart from new or current health problems. We can set up a separate visit for you. You will still be charged for care and tests that are not covered by your health plan.

Thank you for letting us help you stay healthy.

Annual Preventative Exam Visit

Request for Additional Services

During your visit today, your provider will complete an Annual Preventative Exam. In addition to this exam, please let us know if you wish to have any of the following health services performed today. These additional services may result in extra office or lab charges.

Check all that apply:

- ☐ Evaluation and/or care for new health issues or concerns
- ☐ Care for a disease or illness you have already been diagnosed with
- ☐ A change in your prescription medication(s)
- ☐ Renewal of any prescription medication(s)
- ☐ Other: _____

☐ **No, I do not wish for any extra services to be provided.**

Patient name (print): _____ Date: _____

Patient Signature: _____

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 _____

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Review of Symptoms Questionnaire

Have you been feeling any of these symptoms today?

Patient Name _____ DOB _____

Today's Date _____

Constitutional	Yes	No
Feeling tired or poorly		
Fever (as symptom)		
Chills (as symptom)		
Recent weight loss (lbs_____)		
Recent weight gain (lbs_____)		

Chest	Yes	No
Difficulty swallowing		
A cough		
Shortness of breath		
Palpitations		
Chest pain or discomfort		

Ear, Nose, Throat	Yes	No
Nasal Congestion		
Post-nasal drip		
Sore throat		
Earache (right)		
Earache (left)		

Hemo/Endocrine	Yes	No
An easy brusing tendency		
Excessive sweating		
Sweating heavily at night		
Excessive thirst		
Temperature intolerance		

Urinary	Yes	No
Pain during urination		
Increased urination		
Blood in urine		
Urinating more than 1x night		

Neuro/Eyes	Yes	No
Headaches		
Dizziness		
Ringing in ears		
Numbness		
Decreased in strength		
Red eyes		
Sleep disturbances		
Depression		
Anxiety		

GI	Yes	No
Decreased appetite		
Abdominal pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Heartburn		
Blood in stool		

Gynecological (women)	Yes	No
Unexplained vaginal bleeding		
Vaginal discharge		
Vaginal pain		
Vaginal itching or burning		

Skin/Musculoskeletal	Yes	No
Skin rash		
Neck pain		
Back pain		
Joint pain		

Preventive Care Risk Assessment

Name:_____ DOB _____ Date _____

Lung Cancer (please check all that apply)

- ☐ You currently smoke cigarettes, cigars, or pipes.
- ☐ You have a history of second-hand smoke exposure.
- ☐ You have been exposed to radon or asbestos in the workplace.
- ☐ You have a history of tuberculosis.
- ☐ You have a personal history of lung cancer.
- ☐ You have a chronic persistent productive cough with colored or blood-tinged sputum.
    - Consider chest xray or low dose chest ct if patient answers yes to more than one of these questions and has a persistent productive cough, fevers and chills, unexplained weight loss, or other clinical findings

Colorectal Cancer (please check all that apply)

- ☐ You have a personal history of colorectal cancer prior to age 50.
- ☐ You have a personal history of colorectal polyps prior to age 40.
- ☐ You have a family history of colorectal, endometrial, ovarian, or stomach cancer.
- ☐ You have more than two first-degree relatives with colorectal cancer or adenomatous polyps.
- ☐ You have a history of long-standing inflammatory bowel disease such as ulcerative colitis or Crohn's disease.
- ☐ You consume a high-fat diet.

Immunizations (please check all that apply)

Tdap

- ☐ Have you had a tetanus shot in the last 10 years? ☐ Y ☐ N When?_____

Shingles

- ☐ You are older than 60 years?

Pneumococcal

- ☐ You are older than 65 years?
- ☐ You have any of the following: chronic lung disease (COPD, emphysema, asthma), chronic cardiovascular disease, diabetes, chronic liver disease, alcoholism, cochlear implants, cerebrospinal leak, asplenia
- ☐ You live in a nursing home?
- ☐ You smoke?
- ☐ Your first pneumococcal vaccination was more than 5 years ago?

Influenza

- ☐ You have a severe allergic reaction to egg?
- ☐ You have a fever?
- ☐ You had a severe reaction to the influenza vaccine?
- ☐ You have had Guillain-Barre′ Syndrome?

HPV

- ☐ Are you between the ages of 19-26 years?

Sexually Transmitted Diseases (please check all that apply)

1. How many people have you had sex with during your lifetime? If you answer 0 (zero), go to question #10
   □ 0 □ < 5 □ > 6
2. Have you had an STD? □Y □ N
   (If YES, check all that apply)
   □ Syphilis □ Genital/Sex Warts □ Gonorrhea (clap) □ Herpes □HIV
   □ Chlamydia □ Trichomonas(trich) □ Hepatitis A □ Hepatitis B □ Hepatitis C
   □ Women –infection in your tubes/womb (PID)
   □ Men-burning or drip from penis (not gonorrhea or chlamydia)
3. Have you ever used non-injecting drugs like marijuana? □Y □ N
4. Have you ever injected drugs? □Y □ N
   -If YES, did you ever share needles, syringes, or "works"? □Y □ N
5. Have you ever snorted drugs (i.e., cocaine, speed, heroin, ecstasy, meth.)? □ Y □ N
6. Have you ever been in jail, prison, or a detention center? □Y □ N
7. Did you ever have a blood transfusion before 1992? □Y □ N □ Unsure
8. Have you ever had a tattoo? □Y □ N □ Unsure
9. Have you ever had body piercing (other than your ears)? □Y □ N
10. Have you ever been tested for HIV? □Y □ N □ Unsure
11. Have you ever received (check all that apply):
    □ Hepatitis A vaccine □ Hepatitis B vaccine □ Hepatitis A & B

Heart Disease (please check all that apply)

- □ You smoke.
- □ You have high blood pressure.
- □ You have diabetes.
- □ You are overweight.
- □ You are physically inactive.
- □ If male, you are older than 45.
- □ If female, you are older than 55.
- □ People in your family have early heart disease (before age 45 in men or before age 55 in women)

Osteoporosis (please check all that apply)

- □ You are on treatment for osteoporosis.
- □ You are a current smoker.
- □ You drink more than 3 alcoholic drinks a day.
- □ You have been on prolonged courses of steroids.
- □ You have rheumatoid arthritis.
- □ You have a fragility fracture after age 45 (any fall from standing height that has caused fracture.)
- □ You have a parent who has had a hip fracture.
- □ You have secondary osteoporosis (osteoporosis resulting from another medical problem.)
- □ Gender: □ male □ female
- □ Ethnicity: □ white □ Asian □ Black □ Hispanic

Sleep Apnea (please check all that apply)

- ☐ You have been told that you snore loudly on most nights.
- ☐ You have been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep.
- ☐ You are tired, fatigued or sleepy on most days.
- ☐ You have acid reflux or high blood pressure (or use medicines to treat either of these conditions.)
- ☐ You are overweight.

Website for Frax score: http://riskcalculator.fore.org **Office Use Only**
BMD-Femoral Neck T-Score: _____
Calculated Risk: _____

Men

Prostate Cancer (please check all that apply)

- ☐ You have a family history of prostate cancer.
- ☐ You have a first-degree relative with prostate cancer.
- ☐ Define your race _____ and ethnicity_____.
- ☐ You consume a high-fat diet.

Testosterone (please check all that apply)

- ☐ You have a decrease in libido (sex drive).
- ☐ You have a lack of energy.
- ☐ You have a decrease in strength and/or endurance.
- ☐ You lost height.
- ☐ You have noticed a decrease enjoyment of life.
- ☐ You are sad and/or grumpy.
- ☐ Your erections are less strong.
- ☐ During sexual intercourse, it has been more difficult to maintain your erections to completion of intercourse.
- ☐ You fall asleep right after dinner.
- ☐ There has been a recent deterioration in your work performance.

Abdominal Aortic Aneurysm (please check all that apply)

- ☐ You currently smoke or have smoked.
- ☐ You are between 65 and 75 years of age.

Breast Cancer

- ☐ You have a history of any of the following: male infertility, testicular abnormalities (cryptorchidism, orchitis, orchiectomy, testicular trauma), or Klinefelter's syndrome.

Women

Breast Cancer (please check all that apply)

- ☐ What was your age at your first period? _____
- ☐ What is your current age?_____
- ☐ You have a first-degree relatives with breast cancer.
- ☐ Have you had previous breast biopsies in the past? _____ How many?_____
- ☐ You had at least one biopsy consistent with atypical hyperplasia.
- ☐ You had diethylstilbestrol (DES) exposure.
- ☐ You have more than two drinks of alcohol daily.

Cervical Cancer (please check all that apply)

- ☐ How old were you at your first sexual encounter? _____
- ☐ You had or have any of the following: genital warts, HIV infection, herpes, gonorrhea, Chlamydia.
- ☐ You have any history of abnormal vaginal bleeding.
- ☐ You smoke cigarettes.

Ovarian Cancer (please check all that apply)

- ☐ You older than 60.
- ☐ Your mother or sister has a history of ovarian cancer.
- ☐ You have been diagnosed with cancer of the breast, colon, or endometrium.
- ☐ You have taken any fertility drugs.
- ☐ You are currently using hormone replacement drugs.
- ☐ You put talcum powder in the area between your vagina and rectum.

Endometrial Cancer (please check all that apply)

- ☐ You are older than 50?
- ☐ You were previously on estrogen-only hormone replacement therapy.
- ☐ You have a history of colon, rectal, or breast cancer.
- ☐ You have taken tamoxifen in the past for breast cancer prevention.
- ☐ You have been diagnosed with endometrial hyperplasia?
- ☐ You are white?
- ☐ You began menopause after age 59?
- ☐ You have diabetes.
- ☐ You have hypertension.

REQUEST FOR TREATMENT AND AUTHORIZATION FORM
Carolinas HealthCare System Medical Group

REQUEST FOR TREATMENT. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("CHS") maintains certain providers, personnel and facilities needed in providing me medical care, and I authorize CHS, those providers and personnel to perform on me the care ordered by my providers. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed treatment or procedure and any available alternative methods of treatment, together with an explanation of the likely risks and benefits associated with them. This form is not a substitute for such explanations. I acknowledge that CHS and its providers and personnel are not responsible for providing me this information for non-CHS providers. I consent to receive services by interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications benefiting a patient if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so. I choose to receive the services even if my insurance plan may not cover or continue to cover specific services, including the specific services rendered during medical treatment.

ASSIGNMENT OF INSURANCE BENEFITS. I/we hereby assign all my rights to CHS under any policy of insurance, including but not limited to, major medical insurance, hospital or outpatient benefits, sick benefits, injury benefits due to me because of liability of a third party, such as auto insurance or Workers' Compensation insurance, and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient up to the full amount of the medical bill, and hereby authorize direct payment to CHS and/or my providers of all benefits to which I am entitled. This assignment includes payment of hospital, outpatient, surgical, and medical benefits to any professional group contracted by CHS for professional services they may perform for me. In addition, I/we further warrant and represent that any insurance which I/we assign is valid insurance and in effect and that I/we have the right to make this assignment. I understand that I am financially responsible to CHS, my providers, and those professional groups or entities included in this assignment for amounts due that are not covered by this assignment. For example, I know that sometimes insurance companies will not pay for services ordered by my providers and which I have authorized. I understand that these payment denials occur for a variety of reasons. My insurance policy may not include the particular service as a benefit. In other cases, a service will not be covered by my insurance company because it decides the service is not necessary, despite my provider's decision to order the service. In any event, even if a service is not covered by insurance, I agree to pay for all charges for all services rendered, including the specific services rendered as part of medical treatment. I further agree that in the event benefits paid under this assignment or any other amounts paid by me/us or on my/our behalf exceed the amounts due CHS, my providers, or those professional groups or entities for services in connection with this medical treatment, any such excess amount may be applied to any other indebtedness that I or my spouse or any child for whom I am financially responsible may have to CHS or any other facility or entity related to CHS, my providers, or other professional groups or entities included in this assignment.

NOTICE OF INDEPENDENT CONTRACTORS. I understand that CHS has contracted with certain independent professional groups for such groups to exclusively provide certain medical services at CHS facilities, including but not limited to radiology, anesthesiology, pathology, radiation oncology, and emergency medicine services. I understand that professional groups providing those services are independent contractors, are not employees or agents of CHS, and are not subject to control or supervision by CHS in their delivery of professional services.

USE OF MEDICAL INFORMATION AND COMMUNICATION. I understand that CHS, my providers and independent professional groups providing medical services can use my information for treatment, payment, and health care operations, as further outlined in the CHS Notice of Privacy Practices. As clarification, I understand that CHS and my providers may give any medical information relating to my medical treatment to my insurance company, governmental or charitable agencies and their agents, and professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my medical treatment. I also understand that CHS and my providers may release any medical information to any health care provider or medical facility to which I may be referred or transferred for further medical care. I authorize CHS and my provider to take and produce pictures, recordings, and/or video of me for treatment and health care operation purposes. I can object to, or rescind my permission for, pictures, recordings, and video being taken or produced for reasons other than treatment and health care operations at any time. In addition, I authorize CHS and my providers to release any medical information necessary to prove CHS's damages in any legal proceeding brought to enforce any unpaid balance on any of my accounts. I consent and authorize CHS and third party agents of CHS to contact me by telephone at any number associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

AUTHORIZATION TO RELEASE MEDICARE AND MEDICAID INFORMATION. I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Request for Treatment and Authorization
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PATIENT
LABEL

I understand that health care services paid for under the Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend denial of payment if my medical condition does not warrant continued medical care. I authorize those agencies responsible for determining eligibility under these programs to provide to CHS any information relating to the determination of my eligibility. I request payment of benefits under these programs be made to CHS and my health care providers on my behalf.

PAYMENT GUARANTY. I (patient and/or responsible party/ies) agree to pay all charges for services rendered by CHS and my physicians or other providers for my medical treatment. This guaranty includes charges for services not covered by my insurance, regardless of the reason that insurance coverage is denied. If I fail to pay all charges and CHS or my providers use an attorney to collect unpaid charges, I agree to pay the reasonable cost of the attorney's services in addition to the unpaid charges. I consent and authorize CHS and its agents and subcontractors to contact outside data sources of its choosing, including credit reporting agencies, for purposes related to my account, including evaluating and assessing my credit worthiness, my charity eligibility, and the viability of collecting any amounts due for the treatment I receive, whether at this time or on subsequent visits. I understand and agree that CHS may assign my accounts as it deems necessary for purposes of collecting any amounts I owe, including to collection agencies and attorneys.

PERSONAL PROPERTY. I understand that CHS is not responsible for money, valuables and other personal property in my possession and has no liability for their loss.

ADDITIONAL AUTHORIZATION AND CONSENT: I authorize the Financial Counseling staff of CHS to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the Patient within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department of Social Services to provide such information to the Financial Counselor. I authorize and consent to referral to the County for benefits by use of any appropriate referral form. I request that if my benefits are approved or denied, a copy of the approval or denial be attached to and returned with the referral form. I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken. This consent shall remain valid and enforceable until it is revoked or replaced by a new form of consent, signed by me.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. The undersigned hereby consents to such medical treatment as my provider(s) order and indicate the same by my (our) signature below.

Name of Patient: _____

_____
Patient/Responsible Party Signature

_____
Date Time

Relation, if not Patient:
____Spouse
____Parent/s
____Other (Specify:_____)

_____
Witness Date Time

○ I have been provided access to CHS's Notice of Privacy Practices

_____
Patient/Authorized Representative Signature

_____
Date Time

Relation, if not Patient:
____Spouse
____Parent/s
____Other (Specify:_____)

Reason Patient Unable/Unwilling to sign _____
_____

REQUEST FOR TREATMENT AND AUTHORIZATION FORM

PATIENT LABEL