# Emily A. Sheveland, D.O

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## Routine Annual Preventative Physical Exam

Patient Name: _____ DOB: _____

Name: Emily A. Sheveland, D.O. Date of Service: _____

An ***Annual Physical Examination, Routine Physical, Wellness Exam, or Check-up*** is a Preventative visit that specifically focuses on promoting health and wellness. The purpose of a routine preventative exam is to identify potential health problems in the early stages when they may be easier and less costly to treat.

A routine preventative exam is technically defined as "periodic comprehensive preventative medicine evaluation and management". This means that the exam is prevention focused and may include the following:

- Review of past medical, social and family history
- Complete physical exam and review of body systems
- Review of medications
- Immunizations
- Counseling on disease prevention
- Review of age/gender appropriate screening test (ex: Mammogram, PAP, DEXA, Prostate Cancer screening, Colon Cancer screening)

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

If time is spent on a new health problem(s) or other chronic condition(s) that need time to address during your physical visit (ex: high blood pressure, diabetes, skin rash, depression, headaches, etc.) your provider may bill separately for this portion of the visit.

Your provider may choose to bill a Sick/Follow-up visit and Physical Exam if appropriate. If your Provider does bill for Physical Exam and Sick/Follow-up visit on the same day it may result in **two** claims for that one date of service/visit. Any copayments for Sick/Follow-up visits would then apply.

Please note that Physicians **will not** change diagnosis codes between Physical Exams and Sick/Follow-ups once the visit is originally filed. We cannot bill a Sick/Follow-up as a Physical if a full Physical Exam was not completed.

If non-preventative services such as labs/imaging are ordered during your preventative service, your insurance may apply charges 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:_____**