Palouse Heart Center
Palouse Pediatrics
Palouse Psychiatry & Behavioral Health
Palouse Pulmonology & Sleep Medicine
Pullman Family Medicine
Palouse Health Center

Preventive Care Visits
Information for Patients or Legal Guardians

Preventive care is defined as routine care in the absence of symptoms or known disease. It has also been referred to as an "Annual Physical" or "Complete Physical." The extent and focus of the services can depend on the age of the patient. Services that may be considered preventive care can include the following:

- Review and updating past medical and family history*
- Evaluation of risk factors such as smoking and alcohol use*
- Periodic physical examination*
- Glucose testing to screen for diabetes
- Cholesterol screening
- Colon cancer screening (colonoscopy)
- Routine vaccinations (tetanus and influenza)*
- Bone Density testing
- Prostate screening
- HIV screening
- Chlamydia/Gonorrhea testing
- Pap Smear
- Mammogram for women
- Reviewing stable, established problems and renewing medications that do not require changes.*

Preventive Care does <u>not</u> include the following:

- Evaluation of **new** symptoms
- Testing for a **new** diagnosis
- **Significant changes** to patient medical regimen

**National billing standards require these issues to be billed separately. For management of problems not related to preventive health screening there will be a separate charge in addition to the preventive care charge.*

<u>Insurance Coverage for Preventive Services</u>

Insurance companies vary greatly in coverage for "preventive" and/or "routine" services. The variability in coverage extends to other laboratory or diagnostic testing that made be recommended based on your age or personal risk factors. We highly recommend that you contact your insurance company if you have specific questions about your coverage or benefits. We cannot guarantee benefits on behalf of your insurance company and advise you to contact your insurance company prior to receiving any services if you have concerns about potential financial responsibility.

I acknowledge that I have read and understand the information above. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I further acknowledge that additional topics discussed during my preventive visit that are not preventive will result in additional fees such as a co-pay or separate office visit fee.

Printed Name of Patient: _____ Date of Birth: _____

Signature: _____ Date: _____