

North Country Adult Medicine

Patient Name: _____

DOB: _____

MEDICARE ANNUAL WELLNESS VISIT

Please answer the following questions based on your health and daily activities.

1. During the last four weeks how would you rate your health in general?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How have things been going for you for the past 4 weeks?

☐ Very Well, could hardly be better ☐ Pretty well ☐ Good and bad parts about equal ☐ Pretty bad ☐ Very bad, could hardly be worse

3. How confident are you that you can control and manage most of your health problems?

☐ Very confident ☐ Somewhat confident ☐ Not very confident ☐ I do not have any health problems

4. How often do you have trouble taking medication the way you have been told to take them?

☐ I do not have to take medication ☐ I always take them as prescribed ☐ Sometimes I take them as prescribed
☐ I seldom take them as prescribed

5. Do you exercise for about 20 minutes three or more times a week?

☐ Yes ☐ Most of the time ☐ No

6. During the last four weeks what was the hardest physical activity that you could do for at least two minutes?

☐ Very heavy ☐ Heavy ☐ Moderate ☐ Light ☐ Very light

7. During the past four weeks was someone available to help you if you needed and wanted help?

☐ Yes, as much as I wanted ☐ Yes, quite a bit ☐ No

8. Please check off any of the items you need help with:

☐ Eating	☐ Food Preparation	☐ Bathing
☐ Dressing/Grooming	☐ Toileting	☐ Getting around the house
☐ Shopping	☐ Finances	☐ Housework/Laundry
☐ Transportation	☐ Using the telephone	☐ Managing medications

9. During the past 4 weeks, have you had problems with any of the following?

☐ Stress	☐ Anger	☐ Loneliness
☐ Fatigue	☐ None of these	

10. Do you have any concerns about any of the following?

☐ Nutrition or eating	☐ Teeth or oral health
☐ Sexual health	☐ None of these

11. Are you in any pain right now? ☐ YES ☐ NO

If yes, what is your pain level, with 10 being the worst pain of your life:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

North Country Adult Medicine

Patient Name: _____

DOB: _____

12. Have you fallen in the past 12 months? ☐ YES ☐ NO

If yes:

☐ 1 fall with injury in the past year

☐ 1 fall without injury in the past year

☐ 2 or more falls with injury in the past year

☐ 2 or more falls without injury in the past year

13. Do you sometimes skip wearing a seatbelt while in the car? ☐ YES ☐ NO

14. Do you use a cane, walker, or other device to get around? ☐ YES ☐ NO

15. Are you having any trouble with your hearing? ☐ YES ☐ NO

16. Are you worried about your memory? ☐ YES ☐ NO

17. Has anyone told you they are worried about your memory? ☐ YES ☐ NO

18. Do you have access to a phone if you were to fall? ☐ YES ☐ NO

19. Have throw rugs been removed or fastened down? ☐ YES ☐ NO

20. Are non-slip mats in all bathtubs or showers? ☐ YES ☐ NO

21. Do all stairways have a railing or banister? ☐ YES ☐ NO

22. Are doorways, halls, and stairs free of clutter? ☐ YES ☐ NO

23. Do you currently smoke? ☐ YES ☐ NO

24. Have there been any medication changes since your last visit? ☐ YES ☐ NO

Specialists / Other Clinicians

List specialists you currently see. Include medications they prescribe so we know which clinician is responsible for those prescriptions.

Specialty	Provider Name	Reason You See Them	Medications They Prescribe

North Country Adult Medicine

Patient Name: _____

DOB: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble Relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

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

North Country Adult Medicine

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DOB: _____

HOME SAFETY

What is your current housing situation?

☐ I have housing ☐ I do not have housing (staying with others/hotel/shelter/outside) ☐ I choose not to answer

Are you worried about losing your housing?

☐ Yes ☐ No ☐ I choose not to answer

What is the highest level of school that you have finished?

☐ Less than a high school degree ☐ High school diploma or GED ☐ More than high school ☐ I choose not to answer

What is your current work situation?

☐ Unemployed and seeking work ☐ Part time or temporary work ☐ Full time work ☐ Otherwise unemployed but not seeking work ☐ I choose not to answer

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply

☐ Food ☐ Clothing ☐ Utilities ☐ Child care ☐ Medicine or any health care ☐ Phone ☐ Other ☐ I do not have problems meeting my needs ☐ I choose not to answer

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes — medical appointments/medications ☐ Yes — non-medical meetings/work/daily needs ☐ No ☐ I choose not to answer

How often do you see or talk to people that you care about and feel close to?

☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week ☐ More than 5 times a week ☐ I choose not to answer

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ I choose not to answer

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

☐ Yes ☐ No ☐ I choose not to answer

Are you a refugee?

☐ Yes ☐ No ☐ I choose not to answer

What country are you from?

☐ United States ☐ Country other than the United States _____ ☐ I choose not to answer

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I have not had a partner in the past year ☐ I choose not to answer

North Country Adult Medicine

Patient Name: _____

DOB: _____

Tobacco & Vaping

Cigarettes: ☐ Never ☐ Current ☐ Former Age started: ____ Packs/day: ____ Age quit: ____

Other tobacco: ☐ Cigars ☐ Chewing tobacco ☐ Other: _____

Current vaping: ☐ Yes ☐ No What do you vape? _____

Marijuana & Caffeine

Current marijuana use: ☐ Yes ☐ No Method: ☐ Smoked ☐ Vaped ☐ Edible ☐ Tincture ☐ Other: _____

Typical marijuana frequency/amount: _____

Caffeine type & typical amount/day: _____

Alcohol & Drug Screening

Have you ever used drugs other than those required for medical purposes? ☐ Yes ☐ No

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2–4 times/month ☐ 2–3 times/week ☐ 4 or more times/week

How many standard drinks containing alcohol do you have on a typical day?

☐ None, I do not drink ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10 or more

How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Sexual Health

Currently sexually active? ☐ Yes ☐ No

Partners in past 12 months: ☐ Men ☐ Women ☐ Both men and women ☐ Another gender ☐ No sexual partners

Number of partners: ____ Sexual contact includes: ☐ Vaginal ☐ Oral ☐ Anal

Condom/barrier use: ☐ Always ☐ Sometimes ☐ Never ☐ Not applicable

Ever diagnosed with an STI? ☐ No ☐ Yes — Type: _____

Would you like to be tested for HIV? ☐ Yes ☐ No

North Country Adult Medicine

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Remote Patient Monitoring (RPM)

Helping us care for you between office visits

North Country Adult Medicine offers Remote Patient Monitoring (RPM) to eligible Medicare patients. RPM allows our healthcare team to monitor important health information while you are at home and stay connected with you between office visits.

If you participate, you will use a monitoring device that automatically sends your readings to our healthcare team. Our nursing staff reviews your readings, provides regular check-ins, and communicates concerns to your healthcare provider when needed.

Which type of monitoring may be helpful for you?

☐ Blood Pressure

☐ Weight (CHF)

☐ Pulse Oximeter

☐ Glucose

Glucose options: ☐ True Metrix ☐ Dexcom

Your healthcare provider will determine whether RPM is medically appropriate and which device is appropriate. Glucose device options also depend on insurance coverage.

USING YOUR DEVICE

To stay enrolled in our RPM program, your device must transmit readings on at least 2 days every 30 days.

Please use your device regularly as recommended by your healthcare team. If you do not use your device enough to meet program requirements, North Country Adult Medicine may discontinue your RPM enrollment and ask you to return the monitoring device.

How RPM can help

- Monitor your health between visits
- Identify concerning changes earlier
- See how treatment is working
- Support chronic condition management

RPM does not replace regular office visits or emergency medical care.

Medicare coverage

Medicare may cover RPM when Medicare requirements are met and your healthcare provider determines that RPM is medically appropriate for you. Deductibles and/or coinsurance may apply. Secondary insurance may cover some or all of your remaining cost.

Interested in RPM?

- ☐ YES - I am interested.
- ☐ MAYBE - I would like more information.
- ☐ NO - I am not interested at this time.

Electronic Signature: By typing my name in any following signature field, I understand and agree that my typed name constitutes my electronic signature and has the same force and effect as my handwritten signature.

Participation is voluntary. Choosing not to participate will not affect the care you receive at North Country Adult Medicine.

Patient Name: _____ DOB: _____ Date: _____

North Country Adult Medicine

Patient Name: _____

DOB: _____

Introduction to Chronic Care Management

The purpose of this program is to help both you the patient, and us the primary care physicians.

As we age, we tend to have more complicated medical needs, and many times there are questions that you have in between office visits. Medicare recognizes this, and has created this program to compensate primary care offices for the work they do outside of scheduled office visits. By having patients enrolled in this program, we are able to afford to hire an RN to be available to patients for questions outside of office visits.

The following examples are things that our RN is able to provide to patients enrolled in the program.

1. Calling patients with test results instead of having to log onto the patient portal
2. Speaking to your pharmacy and insurance company on your behalf to figure out why a medication wasn't covered, or getting a prior approval for a medication.
3. Speaking with your specialists to ensure you understand the plan and are up to date on their recommendations.
4. Help get tests scheduled.
5. Help coordinate home care, or durable medical equipment
6. Checking in with you before and after doctor appointments to make sure you understand the plan the doctor discussed with you.
7. Check in with you on a monthly basis or more frequently depending on your needs to make sure you are doing okay.
8. Being on standby in the office to answer any questions you may have, allowing you to get answers to your health questions much faster.

Our goal is to keep your healthcare costs down, make access to care easier, and keep you as healthy as possible.

Patients in this program have LESS hospital and emergency room visits and overall saves Medicare money by KEEPING YOU HEALTHIER.

Your insurance carrier will be billed monthly for this care management service. Medicare deductibles and/or coinsurance may apply. If you have secondary insurance, it may cover some or all of your remaining cost.

Only one healthcare practitioner can provide and bill Medicare for Chronic Care Management services for you during a calendar month.

You may stop Chronic Care Management services at any time. Your decision will become effective at the end of the calendar month.

None of the above services replace urgent or emergency care.

Our goal is to keep your healthcare costs down, make access to care easier, and keep you as healthy as possible.

Patient Agreement

I consent to participate in Chronic Care Management (CCM) services as described above.

Electronic Signature: By typing my name in any following signature field, I understand and agree that my typed name constitutes my electronic signature and has the same force and effect as my handwritten signature.

Patient Name: _____

Signature: _____ Date: _____

North Country Adult Medicine

Patient Name: _____

DOB: _____



Care between office visits.

Primary Care Enrollment Agreement

Thank you for being part of our primary care family! We're so grateful for the trust you place in us to support your health and well-being.

Over the years, our team has gone above and beyond to provide services like:

- Coordinating your care with specialists and other healthcare providers.
- Creating personalized care plans to address your unique health needs.
- Keeping in touch between visits to manage your ongoing health concerns.

We've always done these things as part of our commitment to you, without additional reimbursement. Now, Medicare recognizes the value of these extra services and has introduced specific codes (G0556, G0557, and G0558) that reimburse us for the work we're already doing.

We're asking our Medicare patients to participate in this program so Medicare can recognize and support the care coordination services our practice provides between office visits. Here's what this means for you:

- **No changes to your care:** You'll continue receiving the same attentive, personalized care you always have.
- **Covered by Medicare:** Medicare covers Advanced Primary Care Management services. Medicare deductibles and/or coinsurance may apply. If you have secondary insurance, it may cover some or all of your remaining cost.
- **Helps us help you:** Participating in this program ensures we can continue dedicating the time and resources needed to give you the best care possible.
- **One APCM provider:** Only one healthcare provider can provide and be paid by Medicare for APCM services for you during a calendar month.
- **Your choice:** You may stop APCM services at any time.

By signing below, you're simply agreeing to allow Medicare to reimburse us for the care coordination and management services we already provide.

If you have any questions or need more details, please don't hesitate to ask. We're here to help!

Thank you for trusting us to care for you,

North Country Adult Medicine

Electronic Signature: By typing my name in any following signature field, I understand and agree that my typed name constitutes my electronic signature and has the same force and effect as my handwritten signature.

Patient Agreement

I consent to participate in the Medicare Advanced Primary Care Management (APCM) program as described above.

Patient Name: _____

Signature: _____ Date: _____

North Country Adult Medicine

Patient Name: _____

DOB: _____



Care between office visits.

APCM - OFFICE USE ONLY

Qualified Medicare Beneficiary: ☐ YES ☐ NO

Number of Chronic Conditions: ☐ 0-1 ☐ 2 or more

CCM patient: ☐ YES ☐ NO

PCP on record:

- ☐ Dr. Neil Cichetti
- ☐ Dr. Joanne Cichetti
- ☐ PA Laura Goldhar
- ☐ PA Camryn Peets

APCM billing level:

G0556 - patients with 0-1 chronic condition

G0557 - patients with 2 or more qualifying chronic conditions

G0558 - patients with 2 or more qualifying chronic conditions who are a Qualified Medicare Beneficiary

For G0557/G0558: qualifying chronic conditions are expected to last at least 12 months or until death and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.