



Dear Patient:

Please be aware that when you have a physical exam or annual wellness visit there may be two (2) separate charges for that day's service.

The physical exam or annual wellness visit are preventive medicine evaluations and are billed as such. If a new condition or an exacerbation of a pre-existing problem results in additional non-routine workup, an office charge will also be billed.

<p><b>Covered in annual preventive physical</b></p> <ul style="list-style-type: none"> <li>• Age-appropriate history</li> <li>• Age-appropriate physical exam</li> <li>• Status of chronic conditions (minimal additional work required)</li> <li>• Age-appropriate counseling, screening labs or testing</li> </ul>	<p><b>Additional charge added:</b></p> <ul style="list-style-type: none"> <li>➤ Any new or exacerbated condition that is addressed at the appointment that results in: <ul style="list-style-type: none"> <li>○ Change in medication</li> <li>○ Non-routine labs</li> <li>○ X-rays</li> <li>○ Other diagnostic tests</li> </ul> </li> <li>➤ Vaccines</li> </ul>
<p><b>Covered in Annual Wellness Visit (Medicare)</b></p> <ul style="list-style-type: none"> <li>• Health Risk Assessment</li> <li>• Comprehensive history including medication review</li> <li>• Routine minimal measurements (BP, weight) as deemed appropriate based on history</li> <li>• Assessment of cognitive function</li> <li>• Assistance/Referrals with/for routine or screening tests, preventive counseling or programs</li> </ul>	<p><b>Additional charge added:</b></p> <ul style="list-style-type: none"> <li>➤ Any new or exacerbated condition that is addressed at the appointment that results in: <ul style="list-style-type: none"> <li>○ More than a minimal physical exam</li> <li>○ Change in medication</li> <li>○ Non-routine labs</li> <li>○ X-rays</li> <li>○ Other diagnostic tests</li> </ul> </li> <li>➤ Additional workup (labs) for stable chronic conditions</li> <li>➤ Vaccines</li> </ul>

If you have any questions or concerns, please discuss them with your provider during your visit. I acknowledge receipt of this document and accept responsibility for all fees associated with this visit.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

*Cayuga Medical Associates, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.*

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