CONNER CLINIC
COMPLETE FAMILY HEALTH CARE

Please be aware of the recent changes affecting CFHC procedure for physical exams.

Preventive Services Covered under the Affordable Care Act

If your plan is subject to these new requirements, you may not have to pay a copayment, co-insurance or deductible to receive recommended preventive health services, such as screenings, vaccinations and counseling.

Some Important Details

- This preventive services provision applies to people enrolled in job-related health plans or individual health insurance policies created after March 23, 2010. If you are in such a health plan, this provision will affect you as soon as your plan begins its first new "plan year" or "policy year" on or after September 23, 2010.
- If your plan is "grandfathered," these benefits **may not be available** to you.
- ***Be aware that additional changes resulting from the Affordable Care Act indicate that some significant conditions cannot be discussed in a physical exam. If the preventive service is not the primary purpose of the appointment, a separate office visit will be billed*** *and your plan can require you to pay some costs* ***of the office visit.*** *For example: any existing condition such as hypothyroid, high cholesterol, etc a copay, coinsurance or deductible may by applied by your insurance.* If you have questions about whether these new provisions apply to your plan, contact your insurer.

_____ I understand I will be financially responsible for any service performed, but not covered by my insurance.
(Initial)

_____ I understand it is ultimately my responsibility to know what is covered by my insurance during a physical.
(Initial)

CFHC will no longer be able to draw labs prior to your physical. If necessary, we will order these on the day of your exam. You may want to consider fasting 6-8 hours prior to your appointment (water is ok to drink.) Additionally, your Provider may ask you to schedule a follow up appointment to review the results if there are any abnormal findings. PLEASE SELECT ONE OF THE FOLLOWING:

- _____ I choose to receive the best preventive care that is offered & agree to pay any copayment, coinsurance, or deductible that my insurance may apply to the services I receive during my preventive exam. **OR**
- _____ I choose NOT to receive any additional labs or testing during my preventive exam that may incur additional cost at my responsibility.

My signature acknowledges that I have reviewed and agreed with the above information.

_____ _____
Patient Name (Print) (Date of Birth)

_____ _____
(Signature) (Today's Date)