

Dear Patient:

Our records indicate that you have been scheduled today for a "Routine Physical Examination" or a Routine Physical Exam with a "Well Woman Exam". These exams are also known by, but not limited to, the following terms:

**Routine Physical Examination Only  
(Male or Female)**

Annual Exam or Annual Check Up  
Yearly Exam or Yearly Check Up  
Complete Physical Exam (CPE)  
Healthcare Maintenance Exam (HCM)  
Well Adult Exam  
Physical  
Preventive Maintenance Exam

**Well-Woman Examination (to be  
done in addition to a Routine  
Physical Examination)**

Annual Pap and Pelvic Exam  
Pap  
Pap/Pelvic/Breast Exam  
WWE  
A Female Exam  
Yearly, routine, Female Exam

This service will be coded by our office as a "Routine Physical Examination" or a "Routine Physical Examination with a Well Woman Examination". Your insurance benefits **MAY** or **MAY NOT** cover this exam.

If you, or the healthcare provider you are seeing today, decide to have Lab Work done, please note that the reference lab contracted by your insurance company will bill your insurance company for all labs done by them. These lab services MAY or MAY NOT be covered by your insurance plan as a part of a "Routine Physical Examination" or "Routine Physical Examination with a Well Woman Examination".

It is your responsibility to know if you are covered for wellness, preventive, well woman or health screening benefits. All services for today's visit, whether billed by this office or the reference lab, not paid by insurance, are your financial responsibility.

The physicians at Aspen Creek Medical Associates feel that a periodic, routine physical exam with certain diagnostic labs or other age-appropriate procedures, are an integral part of providing excellent healthcare to their patients.

By signing below you acknowledge and accept financial responsibility for all non-covered services associated with today's visit.

Thank you

*This office **DOES NOT PERFORM** "New-to-Medicare" IPPE Physical Examinations. If an IPPE Physical Examination is the service you are expecting to receive at this visit, do not sign this form and advise your provider's assistant. Your signature below indicates you understand you are not receiving a Medicare IPPE, and you wish to receive a CPE/WWE under the provisions outlined above on this form.*

**Date of Physical Exam:** \_\_\_\_\_

\_\_\_\_\_  
**Patient Printed Name**

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

\_\_\_\_\_  
**Signature of Patient or Legal Guardian  
(patient is own guarantor if age is > 18)**