
4 Vanderbilt Park Drive, Suite 100, Asheville, NC 28803-1700
(828) 258-0397 FAX (828) 258-3390
www.carolinaim.com

# PREVENTIVE HEALTH CONSENT

(Please read, sign below, and bring with you to your appointment)

Patient Name: _____MR#_____

You are scheduled for a comprehensive exam. During this evaluation, there are a number of services provided that may be unrelated to a specific diagnosis. These are commonly referred to as Preventive or Wellness services.

Preventive Health Exams are frequently done in conjunction with a disease management visit and/or an acute problem. Disease management or acute problems will result in a separate fee.

We will file your insurance for you and you will be responsible for any portion of this exam that your insurance does not cover, whether it is for uncovered preventive services or disease management.

Not all insurance companies include Preventive Coverage. Our office has no way to know what each patient's individual plan will cover. You may wish to check with your insurance company prior to your exam to see what coverage your policy allows.

Routine labs such as Lipid Panel, General Health Panel (CBC, TSH, CMP, BMP), and Urinalysis may not be included in your insurance company's preventive coverage. If your physician recommends these test and you elect to have them performed you will be billed for these services if they are not covered under your insurance plan.

The goal of Preventive Screening is to prevent illness and identify the problems in their early stages. The program is designed to detect disease before it is clinically apparent- that is, for individuals with "no problems" or who feel they are in "good health." Early detection can lead to improved outcomes. If you have a family history that makes one of these diseases more likely, screening on a more frequent basis is advisable. Any individual circumstances should be discussed with your provider to determine a visit interval appropriate for you.

I understand that I will be responsible for all charges not covered by my insurance policy.

Patient Signature _____

Date _____ **(Revised 9-7-17)**