



Rochelle L. Collins, DO  
Board Certified Family Physician  
701 Cottage Grove Road, Suite B10, Bloomfield, CT 06002  
Phone: (860) 243-3315 Fax: (860) 243-3820  
Email: [info@livingwellprimarycare.com](mailto:info@livingwellprimarycare.com) Website: [www.LivingWellPrimaryCare.com](http://www.LivingWellPrimaryCare.com)

**What is a Preventative Exam?**

Prevent Health Exams, also called “physicals”, “wellness exams” or “annual exams”, are prescheduled medical evaluations for an individual that focuses on preventive care. This includes an age and gender appropriate history and physical exam, a review or risk factors and a plan to help reduce those health risks. In addition, “screening” lab tests, x-rays or diagnostic procedures will be ordered and the results reviewed when they are available.

**What does this mean?**

Your preventative health exam covers all health maintenance and prevention issues that are appropriate for your age, sex, and family history; it is a “**WELL VISIT**”. This preventative visit is **NOT** a follow up visit for a chronic condition or a new problem-based visit. A preventative exam cannot be expected to address everything that has been bothering you since your last visit.

**What are the costs associated with this?**

Depending on the judgement of the provider and if time allows, new problems or chronic disease management may be addressed as a **SECOND SERVICE** during the preventive visit. Examples of chronic issues are: hypertension, diabetes, elevated cholesterol, cardiac issues, arthritis, etc. New problem issues might include: abdominal pain, headaches, rashes, joint or muscle pain, fatigue. Most insurance plans cover the cost of the preventative exam; however the cost of the second service will likely incur a copay or visit charge.

**NOTE: YOUR insurance plan may require a copay or apply charges to your deductible for a SECOND SERVICE provided during a Preventative Exam visit. Please consult with your insurer or HR department to understand your insurance coverage requirement.**

\_\_\_\_\_  
Patient Signature (Patient’s Representative, if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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