MIPS Quality Measures

Patient Name: _____ Today's Date: ____/____/_____

Date of Birth: _____ Phone Number: (_____) _____ - _____

Primary Care Physician: _____ Pharmacy/Location: _____

Email address: _____

We sincerely apologize for the additional paperwork. As of January 2017, physicians are being penalized if they are not compliant with reporting quality measures to the government.

Tobacco/VAPE use (circle one, if you are between 12-20 years old):
Never Smoked / Current smoker/ Former smoker

Have you had an INFLUENZA vaccine (flu shot) within the last year? ☐ Yes ☐ No

If yes, when (date): _____

Have you had a PNEUMONIA vaccine (pneumococcal)? ☐ Yes ☐ No

If yes, when (date): _____

Advanced Care Plan, Living Will, Health Care Proxy:
Please check the box that applies**:**

- ☐ **I have, with me today, an advance care plan (living will) and/or documentation of a surrogate decision maker. I will supply this information for inclusion in my medical record at the completion of this visit.**
- ☐ **I have an advance care plan (living will) and/or documentation of a surrogate decision maker but I did not bring it today. I will supply this information for inclusion in my medical record on my next visit.**
- ☐ **I do not wish or am not able to name a surrogate decision maker or provide an advance care plan.**

COMPLETE THIS SECTION *ONLY IF*:
You are giving another person (spouse, family member, caregiver, etc.) authorization for our office to speak with them regarding your medical care.

Name of the person **(OTHER THAN YOURSELF)** you're authorizing with your medical care.

Print Name: _____ Relationship: _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient or Representative Signature: _____ **Date:** _____