Physical Exam & Office Visit Policy

Dear Patient,

Our goal is to provide you with the best medical care possible. Annual physical exams give us a chance to address your overall physical and emotional health. The **preventative** care we provide during a physical also includes an *assessment of dietary and exercise habits, review of vaccinations, discussion of screening tests, lifestyle behaviors, etc.* We often look in on chronic stable problems such as high blood pressure, arthritis, and/or other ongoing medical conditions, though we don't always charge for that, depending on the degree of difficulty of amount of time spent.

Regular office visits differ from the **preventative** and wellness care provided at a physical because they address *other new ongoing or poorly controlled medical problems.* These types of problems need to be addressed in an appointment separate from a **preventative** or physical exam. If, however, we adequately cover required preventative and wellness care during the physical, sometimes we will have time to address other issues. You OR your doctors may identify an issue that may need to be addressed during a physical, **separate from preventative care.**

We would like to attempt to correct a misperception that is occurring at time regarding "double charges". Our goal is to address as much as we can in a quality manner during visits. Please note that the insurance companies do allow providers to address additional complaints beyond a physical examination, if there is time. If additional problems are found or addressed, an additional office evaluation code will be generated in addition to a preventative physical examination code. We are required to submit billing in this fashion, if we address care beyond preventative care at the physical examination. *This essentially generates an extra charge to the insurance company for issues addressed beyond preventative care, which in turn may require you to pay an additional copay, coinsurance or deductible charge.*

The coding rules set by the health care industry, specifically state, "*If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventative medicine evaluation service, then the appropriate visit code should also be reported."* We can actually fail an audit if we violate these rules.

You have entrusted us with your medical care. Please also trust that we practice the highest integrity with our billing practices. Our goal is to provide excellent care and take appropriate time doing it. Please speak with your provider if you have any questions regarding the charges from your preventative care/physical today.

Sincerely,

Your physicians at Bowling Green Internal Medicine & Pediatric Associates

I have read the Physical Exam and Office Visit Policy and understand that I may be billed an additional charge from my insurance company. This charge may be a copay, coinsurance or deductible amount and I will be responsible for payment of this additional charge.

Patient Name	***Date of Birth***
Patient or Guardian Signature	***Today's Date***

The CRAFFT Screening Questions - Appendix A

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:

	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? "Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff".	☐	☐

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1, to A3) answer **B1 to B6** below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:
The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

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Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number ____________________

Score ____________________

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	_____	_____	_____	_____
2. I did not feel like eating, I wasn't very hungry.	_____	_____	_____	_____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	_____	_____	_____	_____
4. I felt like I was just as good as other kids.	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	_____	_____	_____	_____
7. I felt like I was too tired to do things.	_____	_____	_____	_____
8. I felt like something good was going to happen.	_____	_____	_____	_____
9. I felt like things I did before didn't work out right.	_____	_____	_____	_____
10. I felt scared.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	_____	_____	_____	_____
12. I was happy.	_____	_____	_____	_____
13. I was more quiet than usual.	_____	_____	_____	_____
14. I felt lonely, like I didn't have any friends.	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that they didn't want to be with me.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	_____	_____	_____	_____
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	_____	_____
19. I felt people didn't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	_____

PATIENT NAME: ______________________ DATE: __________
Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
11 THROUGH 14 YEAR VISITS FOR PATIENTS

To give you the best possible health care, we would like to know how things are going. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. **Depression screening (beginning at age 12) and Tobacco, Alcohol, or Drug Use assessment are also part of this visit.** Thank you for your time.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOURSELF.

What are you most proud of about yourself?

Have there been major changes lately in your family's life? ○ **No** ○ **Yes,** describe:

Have any of your relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Do you live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

GROWING AND DEVELOPING

Check off all the items that you feel are true for you.

☐ I do things that help me have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping myself safe.
☐ I have at least one adult in my life who I know I can go to if I need help.
☐ I have a friend or a group of friends that I feel comfortable to be around.
☐ I help others.
☐ I am able to bounce back when life doesn't go my way.
☐ I feel hopeful and confident.
☐ I am becoming more independent and I make more of my own decisions.

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PATIENT NAME: ______________________________ **DATE:** ____________

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS

RISK ASSESSMENT

Anemia	Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	O Yes	O No	O Unsure
	For girls: Do you have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	For girls: Does your period last more than 5 days?	O No	O Yes	O Unsure
Dyslipidemia	Do you smoke cigarettes or use e-cigarettes?	O No	O Yes	O Unsure
Vision	Do you have concerns about how well you see?	O No	O Yes	O Unsure

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ANTICIPATORY GUIDANCE

How are things going for you and your family?

HOW YOU ARE DOING

Interpersonal Violence (Fighting and Bullying)			
Have you been part of a gang or a group that has gotten or could get into trouble?	O No	O Sometimes	O Yes
Have you been in a fight in the past 6 months?	O No	O Sometimes	O Yes
Do you know anyone in a gang?	O No	O Sometimes	O Yes
Do you have ways that help you deal with feeling angry?	O Yes	O Sometimes	O No
Do you feel safe at home?	O Yes	O Sometimes	O No
Have you ever been bullied in person, on the Internet, or through social media?	O No	O Sometimes	O Yes
Have you been in a relationship with a person who threatened you physically or hurt you?	O No	O Sometimes	O Yes
Have you ever been touched in a way that made you feel uncomfortable?	O No	O Sometimes	O Yes
Has anyone touched your private parts without your agreement or against your wishes?	O No	O Sometimes	O Yes
Have you ever been forced or pressured to do something sexually that you didn't want to do?	O No	O Sometimes	O Yes
Connectedness With Family and Peers			
Do you spend time talking with your parents every day?	O Yes	O Sometimes	O No
Do your parents praise you when you do something good or learn something new?	O Yes	O Sometimes	O No
Do you get along with your family?	O Yes	O Sometimes	O No
Does your family do things together?	O Yes	O Sometimes	O No
Do you have an adult you feel connected to?	O Yes	O Sometimes	O No
Do you have rules at home and know what happens when you break the rules?	O Yes	O Sometimes	O No
Connectedness With Community			
Do you have activities or things you like to do after school or on the weekends?	O Yes	O Sometimes	O No
Do you help others at home, in school, or in your community?	O Yes	O Sometimes	O No
School Performance			
Are you doing well at school?	O Yes	O Sometimes	O No
Do you have things you enjoy doing at school?	O Yes	O Sometimes	O No
Are you having any problems in school? Are there things you need help figuring out?	O No	O Sometimes	O Yes
Do you get extra help or support in any subjects at school?	O No	O Sometimes	O Yes
Coping With Stress and Decision-making			
Do you worry a lot or feel overly stressed out?	O No	O Sometimes	O Yes
Do you have things you do to feel better when you are stressed?	O Yes	O Sometimes	O No

PATIENT NAME: ______________________________ **DATE:** ____________

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS

YOUR GROWING AND CHANGING BODY

Healthy Teeth				
Do you brush your teeth twice a day?		O Yes	O Sometimes	O No
Do you see the dentist twice a year?		O Yes	O Sometimes	O No
If you play contact sports, do you wear a mouth guard?		O Yes	O Sometimes	O No
Body Image				
Do you have any concerns about your weight?		O No	O Sometimes	O Yes
Are you teased about your weight?		O No	O Sometimes	O Yes
Are you currently doing anything to try to gain or lose weight?		O No	O Sometimes	O Yes
Healthy Eating				
Do you have healthy food options at home and in school?		O Yes	O Sometimes	O No
Do you eat fruits and vegetables every day?		O Yes	O Sometimes	O No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?		O Yes	O Sometimes	O No
Do you drink juice, soda, sports drinks, or energy drinks?		O No	O Sometimes	O Yes
Do you ever skip meals?		O No	O Sometimes	O Yes
Do you eat meals together with your family?		O Yes	O Sometimes	O No
Physical Activity and Sleep				
Are you physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.		O Yes	O Sometimes	O No
How much time every day do you spend watching TV, playing video games, or using computers, tablets or smartphones (not counting schoolwork)?			_____ hours	
Do you get 8 or more hours of sleep each night?		O Yes	O Sometimes	O No
Do you have trouble sleeping?		O No	O Sometimes	O Yes

EMOTIONAL WELL-BEING

Do you and your parents argue a lot about what your culture expects of you and what your friends are doing?		O No	O Sometimes	O Yes
Have you talked with your parents about dating and sex?		O Yes	O Sometimes	O No
Do you have questions or concerns about how your body is changing (puberty)?		O No	O Sometimes	O Yes
For girls: Have you started your period?		O No	O Sometimes	O Yes
For girls: If yes, do you have any concerns about your period (such as not regular, heavy bleeding, or bad cramping)?		O No	O Sometimes	O Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships				
Have you ever been in a romantic relationship?		O No	O Sometimes	O Yes
If yes, have you always felt safe and respected?	O NA	O Yes	O Sometimes	O No
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs				
Have you ever smoked cigarettes or used e-cigarettes?		O No	O Sometimes	O Yes
Have you ever drunk alcohol?		O No	O Sometimes	O Yes
Have you ever been offered any drugs?		O No	O Sometimes	O Yes
Have you ever used drugs (including marijuana or street drugs)?		O No	O Sometimes	O Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?		O No	O Sometimes	O Yes
Acoustic Trauma				
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?		O Yes	O Sometimes	O No
Do you often listen to loud music?		O No	O Sometimes	O Yes

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11 THROUGH 14 YEAR VISITS FOR PATIENTS

STAYING SAFE

Seatbelt and Helmet Use				
Do you always wear a lap and shoulder seat belt?		O Yes	O Sometimes	O No
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?		O Yes	O Sometimes	O No
Do you always wear a life jacket when you do water sports?		O Yes	O Sometimes	O No
Sun Protection				
Do you use sunscreen?		O Yes	O Sometimes	O No
Do you visit tanning parlors?		O No	O Sometimes	O Yes
Substance Use and Riding in a Vehicle				
Have you ever ridden in a car with someone who has been drinking or using drugs?		O No	O Sometimes	O Yes
Do you have someone you can call for a ride if you feel unsafe riding with someone?		O Yes	O Sometimes	O No
Gun Safety				
Have you ever carried a gun or knife (even for self-protection)?		O No	O Sometimes	O Yes
If there is a gun in your home, do you know how to get hold of it?	O NA	O No	O Sometimes	O Yes

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

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DEDICATED TO THE HEALTH OF ALL CHILDREN®

The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit,* 2nd Edition.

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