



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.***

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***Patient Name***

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***Date of Birth***

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***Patient or Guardian Signature***

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***Today's Date***



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 15 MONTH VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

### 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 YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs?  No  Yes, describe:

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

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

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes?  No  Yes  Unsure

### YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior?  No  Yes, describe:

**Check off each of the tasks that your child is able to do.**

- Imitate scribbling.
- Use 3 words other than names.
- Crawl up a few steps.
- Drink from cup with little spilling.
- Speak in sounds that seem like an unknown language.
- Run.
- Point to ask for something or to get help.
- Follow directions that do not include a gesture.
- Make marks with a crayon.
- Look around when you say things such as "Where's your ball?" and "Where's your blanket?"
- Squat to pick up objects.
- Drop an object into and take the object out of a container.

## 15 MONTH VISIT

### RISK ASSESSMENT

<b>Anemia</b>	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Hearing</b>	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about how your child speaks?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Vision</b>	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your child's eyes ever been injured?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

### ANTICIPATORY GUIDANCE

#### How are things going for you, your child, and your family?

#### TALKING AND FEELING

Is your child learning new things?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child show any worries or fears when meeting new people?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take time for yourself?	<input type="radio"/> Yes	<input type="radio"/> No
Do you spend time alone with your partner?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child point to something he wants and then watch to see if you see what he's doing?	<input type="radio"/> Yes	<input type="radio"/> No
Does she wave "bye-bye"?	<input type="radio"/> Yes	<input type="radio"/> No
Do you talk to, sing to, and look at books with your child every day?	<input type="radio"/> Yes	<input type="radio"/> No

#### SLEEP ROUTINES AND ISSUES

Does your child have a regular bedtime routine?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child sleep well?	<input type="radio"/> Yes	<input type="radio"/> No
How many hours does your child sleep? ____ Daytime ____ Nighttime		
Does your child have a blanket, stuffed animal, or toy that he likes to sleep with?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a TV or an Internet-connected device in your child's bedroom?	<input type="radio"/> No	<input type="radio"/> Yes

#### TANTRUMS AND DISCIPLINE

Does your child have frequent tantrums?	<input type="radio"/> No	<input type="radio"/> Yes
If your child is upset, do you help distract her with another activity, book, or toy?	<input type="radio"/> Yes	<input type="radio"/> No
Do you set limits for your child?	<input type="radio"/> Yes	<input type="radio"/> No
Do other caregivers set the same limits for your child as you do?	<input type="radio"/> Yes	<input type="radio"/> No
Do you praise your child when he is being good?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about what to do when you become angry or frustrated with your child?	<input type="radio"/> No	<input type="radio"/> Yes

#### HEALTHY TEETH

Has your child been to a dentist?	<input type="radio"/> Yes	<input type="radio"/> No
Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child use a bottle?	<input type="radio"/> No	<input type="radio"/> Yes

Please print.

## 15 MONTH VISIT

### SAFETY

Car and Home Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep cleaners and medicines locked up and out of your child's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep furniture away from windows and use operable window guards on windows on the second floor and higher? (Operable means that, in case of an emergency, an adult can open the window.)	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a gate at the top and bottom of all stairs in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your child away from the stove?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have working smoke alarms on every floor of your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you test the batteries once a month?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a fire escape plan?	<input type="radio"/> Yes	<input type="radio"/> No

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

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

American Academy of Pediatrics

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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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