B·G·I·M·P
BG Internal Medicine
& Pediatric Associates

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***

CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
1 MONTH VISIT

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. **Maternal Depression screening is also part of this visit.** 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 BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs? ○ **No** ○ **Yes,** describe:

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

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

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

YOUR GROWING AND DEVELOPING BABY

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

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

- ☐ Look at you.
- ☐ Follow you with her eyes.
- ☐ Comfort himself by doing things such as bringing his hands to his mouth.
- ☐ Start to get fussy when she is bored.
- ☐ Calm when he is picked up or spoken to.
- ☐ Look briefly at objects.
- ☐ Make short sounds such as "ooh" and "ah."
- ☐ Become alert when she hears unexpected sounds.
- ☐ Become quiet or turn when he hears your voice.
- ☐ Show signs she is sensitive to her surroundings (such as crying or startling) or need extra support to handle daily activities.
- ☐ Use different cries for hunger and tiredness.
- ☐ Move both arms and legs together.
- ☐ Hold his chin up when he is on his stomach.
- ☐ Open her fingers a little when at rest.

PATIENT NAME: _____ DATE: _____

Please print.

1 MONTH VISIT

RISK ASSESSMENT

Tuberculosis	Was your baby or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your baby had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your baby infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Is permanent housing a worry for you?	O No	O Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	O Yes	O No
Does your home have enough heat, hot water, and electricity?	O Yes	O No
Do you have health insurance for yourself?	O Yes	O No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Do you need help in finding community support services, such as WIC or food stamps?	O No	O Yes
Have you had any problems with mold or dampness in your home?	O No	O Yes
If your home has a basement, has it been checked for radon? O NA	O Yes	O No
Do you use pesticides inside or outside your home?	O No	O Yes
Intimate Partner Violence		
Do you always feel safe in your home?	O Yes	O No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	O No	O Yes
Maternal Alcohol and Substance Use		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Family Support		
Do you feel comfortable returning to work or school after the baby's birth?	O Yes	O No
Have you made arrangements for child care?	O Yes	O No

MOTHER'S HEALTH AND FAMILY RELATIONSHIPS

Have you had a post-birth checkup?	O Yes	O No
Does your partner or do other family members help care for the baby and help around the house?	O Yes	O No
If you have older children, are they getting along with the baby? O NA	O Yes	O No

CARING FOR YOUR BABY

Is your baby sleeping well?	O Yes	O No
Does your baby use a pacifier?	O Yes	O No
Can you tell what your baby wants by how she cries?	O Yes	O No
Are you able to calm your baby?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room?	O No	O Yes
Do you put your baby on his tummy for short periods of time when he is awake and with you?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

1 MONTH VISIT

CARING FOR YOUR BABY (*CONTINUED*)

Medical Home After-hours Support		
Do you know how to take your baby's temperature rectally?	O Yes	O No
Do you know when to call your baby's doctor?	O Yes	O No
General Information		
Does your baby feed well?	O Yes	O No
Do you give your baby any supplements, herbs, special teas, or vitamins?	O No	O Yes
Can you tell when your baby is hungry?	O Yes	O No
Can you tell when your baby is full?	O Yes	O No
Do you ever prop the bottle rather than holding it or put your baby to bed with a bottle?	O No	O Yes
Are you able to burp your baby?	O Yes	O No
If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	O No	O Yes
Do you eat foods high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	O Yes	O No
Are you continuing to take prenatal vitamins?	O Yes	O No
Do you take medications (either over-the-counter or prescription) or herbal supplements?	O No	O Yes
Are you giving your baby vitamin D drops?	O Yes	O No
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	O Yes	O No
Do you have any questions about using formula, such as how much it costs or how to prepare it?	O No	O Yes

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	O Yes	O No
Are you having any problems with your car safety seat?	O No	O Yes
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	O Yes	O No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	O Yes	O No
Safe Sleep		
Does your baby sleep on his back?	O Yes	O No
Does your baby sleep in a crib?	O Yes	O No
Does your baby sleep in your room?	O Yes	O 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

DEDICATED TO THE HEALTH OF ALL CHILDREN®