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
4 YEAR 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.

- ☐ Go to the bathroom and have a bowel movement by himself.
- ☐ Dress and undress without much help.
- ☐ Play make-believe.
- ☐ Answer questions such as "What do you do when you are cold?" and "When you are sleepy?"
- ☐ Use 4-word sentences.
- ☐ Speak so strangers can understand 100% of what she says.
- ☐ Draw pictures you recognize.
- ☐ Follow simple rules when playing board or card games.
- ☐ Tell you a story from a book.
- ☐ Skip on one foot.
- ☐ Climb stairs, using one foot, then the other, without support.
- ☐ Draw a person with at least 3 body parts.
- ☐ Draw a simple cross.
- ☐ Unbutton and button medium-sized buttons.
- ☐ Grasp a pencil with a thumb and fingers instead of her fist.

PATIENT NAME: _____ DATE: _____

Please print.

4 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	O No	O Yes	O Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	O No	O Yes	O Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child have a dentist?	O Yes	O No	O Unsure
	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
Tuberculosis	Was your child 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 child 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 child infected with HIV?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, 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 enough heat, hot water, electricity, and working appliances?	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
Alcohol and Drugs		
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
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 your child?	O No	O Yes
Safety in the Community		
Do you feel safe in your community?	O Yes	O No
Do you have someone you can turn to if you are concerned about your child's safety?	O Yes	O No
Do you have connections to your community through faith groups, volunteer organizations, or recreational programs?	O Yes	O No
Do you spend time with parents of other children in your community?	O Yes	O No

GETTING READY FOR SCHOOL

Language Understanding and Fluency		
Does your child clearly communicate his wants and needs to you and others?	O Yes	O No
Do you respond to your child's questions with short and simple answers?	O Yes	O No
Do you give your child plenty of time to tell a story or answer a question?	O Yes	O No
Do you talk, sing, and read together every day?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

4 YEAR VISIT

GETTING READY FOR SCHOOL (*CONTINUED*)

Feelings		
Is your child generally happy and active?	O Yes	O No
Do you help your child say, "I'm sorry," for hurting others' feelings?	O Yes	O No
Opportunities to Socialize With Other Children		
Is your child interested in other children?	O Yes	O No
Does your child have a chance to play with other children in playgroups or at preschool?	O Yes	O No
Does your child have a best friend?	O Yes	O No
Do you praise your child when she is good or has finished a task?	O Yes	O No
Early Childhood Programs and Preschool		
Does your child attend preschool?	O Yes	O No
Are you happy with your child care or preschool arrangement?	O Yes	O No
Do you visit your child's preschool and participate in activities there?	O Yes	O No
Readiness for School		
Do you have any concerns about your child starting school in the coming year?	O No	O Yes
Are you doing things to get your child ready for preschool? This could include reading together and going to the library, the park, the zoo, and other places.	O Yes	O No

HEALTHY HABITS

Nutrition		
Does your child drink water every day?	O Yes	O No
How many ounces of milk does your child drink on most days?	_____ oz	
Do you offer your child a variety of foods, including vegetables, fruits, and foods rich in protein, such as meat, eggs, chicken, or fish?	O Yes	O No
Is your child willing to try new flavors and food textures?	O Yes	O No
Do you let your child decide how much to eat and when to stop?	O Yes	O No
Daily Routines That Promote Health		
Does your child sleep well?	O Yes	O No
Do you have a regular bedtime and mealtime routines?	O Yes	O No
Do you brush your child's teeth twice a day with a pea-sized amount of fluoridated toothpaste?	O Yes	O No

LIMITING TV AND PROMOTING PHYSICAL ACTIVITY

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	O No	O Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O No
Does your child play actively for at least 1 hour a day?	O Yes	O No
Does your child play with other children?	O Yes	O No
Are you physically active together as a family, such as going for walks or playing in the park?	O Yes	O No

SAFETY

Car Safety		
Is your child fastened securely in a car safety seat or belt-positioning booster seat in the back seat every time he rides in a vehicle?	O Yes	O No
Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

4 YEAR VISIT

SAFETY (*CONTINUED*)

Outdoor Safety		
Do you watch your child closely when she plays outside, especially near streets and driveways?	O Yes	O No
Are there swimming pools in your neighborhood?	O No	O Yes
Are you planning to have your child learn to swim?	O Yes	O No
Does your child always wear an US Coast Guard–approved life jacket when on a boat?	O Yes	O No
Does your child always use sunscreen when he plays outside?	O Yes	O No
Pets		
Do you own a pet?	O No	O Yes
Have you taught your child how to behave around animals so she does not get bitten or scratched?	O Yes	O No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	O No	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O No
If yes, is the ammunition stored and locked up separately from the gun?	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®