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

9 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 items that are true for your child.

- ☐ Shows the ability to get along with others and control his emotions
- ☐ Chooses to eat healthy foods and participate in physical activity every day
- ☐ Forms caring, supportive relationships with family members, other adults, and peers

PATIENT NAME: _____ DATE: _____

Please print.

9 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
	Does your child eat a vegetarian diet (does not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If your child is a vegetarian (does not eat red meat, chicken, fish, or seafood), does your child take an iron supplement?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
	Do you have concerns about how your child speaks?	O No	O Yes	O Unsure
Oral health	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
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Has your child ever failed a school vision screening test?	O No	O Yes	O Unsure
	Does your child tend to squint?	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

Neighborhood and Family Violence		
Are there frequent reports of violence in your community or school?	O No	O Yes
Has your child ever been bullied or hurt physically by someone?	O No	O Yes
Has your child felt excluded or not a part of any group of friends?	O No	O Yes
Has your child ever told you she was touched in a way that made her uncomfortable or on her private parts?	O No	O Yes
Food Security		
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
Tobacco, E-cigarettes, Alcohol, and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Yes
Do any of your child's friends smoke, use or vape e-cigarettes, drink alcohol or beer, or use drugs?	O No	O Yes
Harm From the Internet		
Do you know about your child's Internet use?	O Yes	O No
Do you have rules for the Internet?	O Yes	O No
Have you installed an Internet safety filter on your computers, tablets, and smartphones?	O Yes	O No
Emotional Security and Self-esteem		
Does your child usually seem happy?	O Yes	O No
Are there things your child is really good at doing or is proud of?	O Yes	O No
Does your child have the chance to help others at home, at school, or in your community?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

9 YEAR VISIT

YOUR FAMILY'S HEALTH AND WELL-BEING (*CONTINUED*)

Connectedness With Family and Peers		
Do your family members get along well with each other?	O Yes	O No
Does your family do things together?	O Yes	O No
Does your child have chores or responsibilities at home?	O Yes	O No
Does your child have friends at school or in your neighborhood?	O Yes	O No

YOUR GROWING CHILD

Temper Problems, Setting Reasonable Limits, and Friends		
Has your child experienced any recent stresses at home or in school?	O No	O Yes
Do you have clear rules and expectations for your child?	O Yes	O No
When your child breaks the rules, are you consistent with consequences and discipline?	O Yes	O No
Do you help your child control his anger, deal with worries, and solve problems?	O Yes	O No
Have you and your child talked about how to say no to smoking, alcohol, and drug use?	O Yes	O No
Onset of Puberty and Sexual Safety		
Have you talked with your child about the body changes that occur during puberty?	O Yes	O No
Have you discussed privacy and body safety with your child?	O Yes	O No
Have you and your child talked about sex?	O Yes	O No
Does your child know to tell a trusted adult if someone touches her private parts or if someone encourages her to do other things that make her uncomfortable or she knows are wrong?	O Yes	O No

SCHOOL

Do you have concerns about your child's school experience?	O No	O Yes
Has your child missed more than 2 days of school in any month?	O No	O Yes
Does your child have any difficulties at school or get extra help in any subjects?	O No	O Yes
Does your child participate in activities outside of school?	O Yes	O No

STAYING HEALTHY

Healthy Teeth		
Does your child have a dentist?	O Yes	O No
Does your child brush and floss his teeth every day?	O Yes	O No
Does your child use a mouth guard when playing contact sports?	O Yes	O No
Does your child regularly drink soda, juice, or other sugar-sweetened drinks?	O No	O Yes
Nutrition		
Do you have any concerns about your child's weight?	O No	O Yes
Do you have any concerns about her eating? This includes drinking enough milk and eating vegetables and fruits.	O No	O Yes
Do you eat family meals together?	O Yes	O No
Do you hear your child talking about how he looks or dieting?	O No	O Yes
Physical Activity		
Is your child physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	O Yes	O No
Do you have any concerns about your child's physical activity level, such as it being either too much or too little?	O No	O Yes
Does your child have trouble going to sleep or does she wake up during the night?	O No	O Yes
How much time every day does your child spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	O No	O Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

9 YEAR VISIT

SAFETY

Car Safety		
Does your child always sit in a belt-positioning booster seat or lap and shoulder seat belt in the back seat every time he rides in a vehicle?	O Yes	O No
Does everyone in the vehicle always use a lap and shoulder seat belt?	O Yes	O No
Outdoor Safety		
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	O Yes	O No
Does your child know how to swim?	O Yes	O No
Does your child know to always have an adult watching him in the water and never to swim alone?	O Yes	O No
Does your child always use sunscreen when playing outside?	O Yes	O No
Knowing Your Child's Friends and Their Families		
Do you know your child's friends and their families?	O Yes	O No
Does your child know how to get help in an emergency if you are not there?	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
Have you talked with your child about gun safety?	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®