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Dear Parent or Guardian:

Thank you for bringing your child for a well visit today. We recommend regular well visits (also known as preventive exams or physicals) based on the American Academy of Pediatrics guidelines. We are providing this document to help you understand the difference between what is covered within a well visit versus a problem-oriented visit.

Screening – During well visits we perform recommended screenings appropriate to your child's age and seek to uncover any conditions that may lead to suboptimal health in the years to come. These screenings are also required for school, sports, camp, scouts and other activities. In our experience, some insurance plans cover these screenings and some do not. Because there are so many different insurance companies and plans, we do not know in advance what will and will not be covered. It is your responsibility to understand what screening services are covered by your insurance plan.

Insurance Coverage for Well Visits vs. Problem-Oriented Visits - Well visits may uncover or revisit problem-oriented issues that require evaluation or management (ex. ear infection, allergies, warts). When possible, we strive to address such problem-oriented issues at the same office visit. This is also an additional convenience so that families do not have to return to the office for another appointment. In compliance with insurance company billing policies, these issues then prompt charges for both categories. While preventive services may not require a co-pay/deductible, problem-oriented services do prompt a co-pay/co-insurance/deductible.

If you need further explanation about incurring additional fees for services provided during your visit today, please ask to speak with our biller.

Acknowledgement of Wellness Services Billing Procedures
I acknowledge that during my well visit, there may be a problem-oriented service performed in addition to the wellness services. In this case, I understand that two separate charges may be submitted to my insurance company and that, when applicable, a co-pay/deductible/co-insurance may be required for charges generated pertaining to problem-oriented services. Alternatively, I understand I may choose to return for a separate visit to address problem-oriented issues, at which time, my co-pay/deductible would still apply.

Patient name: _____ DOB: _____

Parent/guardian signature: _____ Date: _____

Tuberculosis and Lead Screening Questions

Casa Verde Pediatrics, Inc.

Name of Child _____ DOB _____ Date _____

Tuberculosis (TB) is an infection of the lungs and many other parts of the body that can cause death if undetected and untreated. It is contagious. California wants to treat and protect children who have been exposed to TB and are at risk of the infection.

The following questions help determine testing for tuberculosis. These questions and TB testing are required for childcare, school, and many jobs. These questions are used only to decide who needs TB testing.

Ask the doctor or nurse practitioner if you need more information to answer the questions.

Where was the child born? ***Please circle one***

United States
Africa
Asia
Middle East
Northern/Western Europe
Eastern Europe
New Zealand/Australia
Latin American: Central or South America

Please answer the following questions by circling **yes** or **no**

1. **Has the child traveled to or lived in a country with a high rate of TB and stayed for *one month* or more? YES/NO**

   Where did they travel or live? ***Please circle all areas below***

   Africa
   Asia
   Middle East
   Northern/Western Europe
   Eastern Europe
   New Zealand/Australia
   Latin American: Central or South America

2. **Has the child even been around anyone who has ever had TB or a positive TB test? YES/NO**

This includes anyone with a positive TB test or was treated for TB at any time in the past including family, friends, nannies, babysitters and childcare providers, especially if they were born outside of the United States.

3. **Is your child being treated for a condition that suppresses the immune system? YES/NO**
   This includes: oral steroids for more than a month, infection with HIV, an organ transplant or other medications that suppress the immune system.

For **children under 5**, please continue to the following lead screening questions:

5. Does your child live in or regularly visit a house that was built before 1950? YES NO
Is there chipped, peeling or damaged paint? YES NO
6. Does your child live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the past 6 months?) YES NO
7. Does your child have a sibling or playmate who has or did have lead poisoning? YES NO

Reviewed on: _____ _____ _____ _____ _____

Patient Name: _____ DOB:_____ Date of Visit: _____

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

	YES	NO
1. Have you used drugs other than those required for medical reasons?	___	___
2. Have you abused prescription drugs?	___	___
3. Do you abuse more than one drug at a time?	___	___
4. Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5. Are you always able to stop using drugs when you want to?	___	___
6. Do you abuse drugs on a continuous basis?	___	___
7. Do you try to limit your drug use to certain situations?	___	___
8. Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9. Do you ever feel bad about your drug abuse?	___	___
10. Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11. Do your friends or relatives know or suspect you abuse drugs?	___	___
12. Has drug abuse ever created problems between you and your spouse?	___	___
13. Has any family member ever sought help for problems related to your drug use?	___	___
14. Have you ever lost friends because of your use of drugs?	___	___
15. Have you ever neglected your family or missed work because of your use of drugs?	___	___
16. Have you ever been in trouble at work because of drug abuse?	___	___
17. Have you ever lost a job because of drug abuse?	___	___
18. Have you gotten into fights when under the influence of drugs?	___	___
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20. Have you ever been arrested for driving while under the influence of drugs?	___	___
21. Have you engaged in illegal activities in order to obtain drug?	___	___
22. Have you ever been arrested for possession of illegal drugs?	___	___
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25. Have you ever gone to anyone for help for a drug problem? ___ ___		
26. Have you ever been in a hospital for medical problems related to your drug use?	___	___
27. Have you ever been involved in a treatment program specifically related to drug use?	___	___
28. Have you been treated as an outpatient for problems related to drug abuse?	___	___

The Patient Health Questionnaire – 2 (PHQ-2)

Over the past two weeks, how often have You been bothered by any of the Following problems?	Not at all	Several Days	More than Half the Days	Nearly Every Day
1. Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Online Communication Agreement

Casa Verde Pediatrics, Inc.

Online communication is a form of communication using 'secure' web sites or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information. Online communication is an additional option for communication and it is not meant to replace other forms of communication with the office.

Please initial each item on the line provided.

_____ The details of online communication have been explained to me in terms I understand.

_____ Alternative methods of communications (i.e. telephone, fax, in-person, mail) are still available to me.

_____ I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include, but are not limited to:

- It is easier for online communication to be forwarded, intercepted or even changed without my knowledge.
- Online communication is easier to falsify than handwritten or signed hard copies. Back-up copies may exist on a computer or in cyberspace even after both of us have deleted our copies.
- I will use a secure network. I will not use standard e-mail or e-mail systems provided by employers. I understand that employers have the right to inspect and keep online communication transmitted through their system.
- Online communications become part of my medical record.

_____ I agree to take precautions to keep online communication confidential, including but not limited to the following:

- I will keep my password confidential
- I will not store messages on an employer-provided computer
- I will not leave messages on my screen for others to read
- I will review my messages before sending them to make sure that they are clear and that all relevant information is included.
- I will update my contact information as soon as it changes.

_____ I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. The doctor is not responsible for breaches of confidentiality caused by an independent third party or me.

_____ I agree to follow the procedures that the doctor implements to allow her to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communications

_____ **I understand that online communication cannot be used for emergencies or time sensitive matters**

_____ I understand that online communication cannot be used to communicate highly sensitive medical information such as treatment for, or information related to HIV/AIDS, sexually transmitted diseases or addiction treatment (alcohol, drugs, etc)

_____ I have informed the doctor of other treatments I do not want transmitted via online communications

_____ I understand that it is my responsibility to determine if an unanswered online communication was received

_____ I acknowledge that I have read and fully understand this consent form, including the risks associated with the online communication

_____ I understand that failure to comply with any of the previous terms may lead to me no longer being able to use the online communication tools.

_____ The doctor or office staff has answered all of my questions

Again, please note that online communication should never be used for emergency communications or urgent requests. These should occur via telephone or by using existing emergency communication tools.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature for online communication between: Casa Verde Pediatrics, Inc. and

_____.

Patient's Name

_____ _____

Patient/Guardian Name Relationship

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Email Address (system allows one per patient) * Contact number

*Parent/Guardian is responsible for any email address changes with Casa Verde Pediatrics, Inc. Please call us and notify us of any changes for your email address.

I certify that I have explained the nature of this agreement to the patient/ legal representative I have answered all questions fully, and I believe that the patient/legal representative fully understands what I have explained

_____ _____

Physician Signature Date

I decline online communication for:

_____.

Patient's Name

_____ _____

Patient/ Legal Guardian Name Relationship

_____ _____

Patient/Legal Guardian Signature Date