Four Seasons Pediatrics

Well Visit Form for 3 Year Well Visit

Child's Name: _____ Birth Date: _____ Age: _____
Today's Date: _____

Feeding History:

- How many ounces of milk does your child drink each day? _____
- Does he/she eat most table foods? _____
- Does he/she use a spoon and cup okay? _____
- Any problems with eating? _____

Behavior:

- Any problems with his/her sleeping? _____
- Does your child have any difficult behavior you would like to change?

  _____
- Does your child have to be spanked frequently? _____
- Is your family having any serious problems? _____

Illnesses:

- If your child is on medicines, name them: _____
- Has your child had any serious illnesses since the last check up? _____

Development:

Please check the boxes to indicate if your 3 year old does the following:

[ ] Copies a circle
[ ] Alternates feet up stairs
[ ] Rides a tricycle
[ ] Knows full name, gender
[ ] Dresses with supervision
[ ] Unbuttons, slips on shoes
[ ] Plays tag and other games

Social:

- Are both parents living at home? _____
- Does your child brush his/her teeth every day? _____
- Is your child taking fluoride? _____
- Do you have any concerns about meeting your daily needs, paying for medications, household income, food or housing, crime or other social and economic issues? _____
- Does anyone in the family have any vision, hearing or cognitive problems that would hinder communication with the medical provider? _____

Screening – Please check the box if any of the following are true:

[ ] My child has had exposure to tuberculosis or a person with a positive skin test
[ ] My child spends a significant amount of time in a home built before 1960
[ ] There is a family history of high cholesterol of > 240 in either parent or grandparents
[ ] There is a family history of heart disease before 55 in either parent or grandparents
[ ] There are concerns with family mental health, substance abuse or firearms in the home

Vaccine Information Statements (Check One)

[ ] I will review the in-room copy
[ ] I will review the on-line copy at your website
[ ] I would like a paper copy

Vision Photoscreening (CPT-99174)

In January 2016, the American Academy of Pediatrics recommended that instrument based vision screening (known as Photoscreening) "should be first attempted between 12 months and 3 years of age and at annual well child visits until acuity can be tested with a wall chart"

Four Seasons Pediatrics has evaluated this technology and we have started screening as recommended by the American Academy of Pediatrics. You may see this recommendation at the following link:

http://pediatrics.aappublications.org/content/early/2015/12/07/peds.2015-3596

Some insurance plans have been identified that do not consider this service preventative or do not cover outright the cost of this screening tool. We do not alter our evidence based recommendations due to insurance coverage and therefore still recommend that this be done. This instrument uses a computer based program to detect conditions that may lead to permanent vision loss known as amblyopia**.** You have the option to have the screening and if it is not covered as a preventive service, we will appeal your denial and ask that the insurance company update their policy to reflect current recommendations. If unsuccessful, we want to make you aware that you may be responsible for payment for anywhere from $5 to $38.17* (*the billed amount of this service) depending on your policy. Another option is to use a non computer based photoscreening, which is provided as a free service if you travel to the Northeast Association for the Blind in Albany. You may set up an appointment by calling 518-463-1211

Notice to Tricare subscribers and insured patients: I am hereby requesting that the following services be provided to me by Four Seasons Pediatrics. In making this request, I acknowledge that these services are not a benefit of my health coverage under TRICARE and that I will not receive the benefit of the TRICARE Hold Harmless Policy (defined below), which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by TRICARE policy, I may be responsible for that professional service. I also understand that if authorization for this care has been denied by TRICARE, or if reimbursement is denied upon submittal of a claim form, I may appeal the written notification of the denial issued by Health Net Federal Services, Inc./MHN Services. Unless the decision to deny is overturned as the result of an appeal or dispute, I agree that I will be personally responsible for the payment IN FULL of the billed charges for these services. **TRICARE Hold Harmless Policy:** A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has been properly informed that the services are excluded or excludable and has agreed in advance in writing to pay for the services.

□ I understand the above and would like my child screened
□ I decline the screening and will consider screening at NABA. I understand that if not screened, it may result in later detection of vision problems leading to amblyopia

_____ _____/_____/_____
Patient Name DOB

_____ _____
Print Name Relationship to patient

_____ _____
Parent/Guardian/Subscriber Signature Date

□ I would like a copy of this statement provided to me