Brian Bluth, MD

Bluth Family Medicine

1315 N. Washington

Weatherford OK, 73096

(580) 772-2344

To Whom It May Concern,

 We would like to welcome you to our medical practice and explain a little about our office policies and goals. We believe in the theories of Modern Medical Care, which do not support the old premise that a doctor’s office is only a place for the seriously ill. Most illness(s) can be treated effectively with early detection. For that reason, we recommend a system of proper preventative care and regular checkups. If you adhere to this simple philosophy, and watch your diet and exercise, you will minimize the risk of debilitating illness(s).

Our patients can expect from us:

1. A high degree of professional skill and ability.
2. A dedication to your overall health and well being.
3. A minimization of medical expenses through n proper preventative care.
4. The highest effort to make your visits as comfortable as possible.
5. Maintain the privacy of your health information as required by HIPPA regulations.

 In return we expect from our patients:

1. Cooperation in making and keeping appointments. 3 no show appointments within a calendar year will result in dismissal of care. *A "no show" appointment consists of a patient scheduling an appointment and missing that same appointment without prior notification to office staff.*
2. A conscientious effort to follow prescribed treatments.
3. Attention to proper diet and exercise.
4. A definite arrangement for the payment of fees at the time of service.

In order to be mutually satisfying and beneficial we ask that any time you have a question or are unhappy about any treatment (proposed or performed), fee for service, or attitude of our staff, you will discuss it with us promptly and openly.

Thank You,

Brian Bluth, MD

Effective April 14, 2003

**NOTICE OF PRIVACY PRACTICES**

**BRIAN BLUTH, M.D.**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULY.**

The health insurance Portability and accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

**We may use and disclose your medical records only for each of the following purposes:**

\* **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers.

**\* PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

\* **HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be and internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

\* The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, or individuals involved in your care. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

\* The right to reasonable requests to receive confidential communications of protected health information from us by alternative means.

\* The right to inspect and copy your protected health information.

\* The right to amend your protected health information.

\* The right to receive an accounting of disclosures of protected health information.

\* The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective April, 04, 2003 and we are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Office of Civil Rights, RegionVI about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

**Please contact us for more information:** **For more information about HIPAA or to file a complaint:**

Brian Bluth, M.D. Office of Civil Rights, Region VI

211 N. Illinois St U.S. Department of Health and Human Services

Weatherford, OK 73096 1301 Young Street, Suite 1169

 Dallas, TX 75202

**Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I understand that as part of my health and medical care, Bluth Family Medicine, LLC-Brian L. Bluth M.D. originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

+ a basis for planning my care and treatment;

+ a means of communications among the health professionals who contribute to my care;

+ a sources of information for applying my diagnosis and treatment information to my bill;

+ a means for a third-party payer to verify that services were billed as actually provided;

+ and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

**I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release futher information shall remain in force until such time as I shall revoke it in writing.**

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Bluth Family Medicine, LLC-Brian L. Bluth, M.D. reserves the right to change their notice and practices, but that prior to implantation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Bluth Family Medicine, LLC-Brian L. Bluth, M.D. is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify…**that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS)**

In addition to the release outlined above, information may be released to the following individuals/organizations:

|  |  |  |
| --- | --- | --- |
| **Name/Phone Number** | **Relationship** | **Options** |
| **1.** |  | \_\_\_\_ Billing information\_\_\_\_ Appointment Info\_\_\_\_ Medical/Health Info |
| **2.** |  | \_\_\_\_ Billing information\_\_\_\_ Appointment Info\_\_\_\_ Medical/Health Info |
| **3.** |  | \_\_\_\_ Billing information\_\_\_\_ Appointment Info\_\_\_\_ Medical/Health Info |
| **4.** |  | \_\_\_\_ Billing information\_\_\_\_ Appointment Info\_\_\_\_ Medical/Health Info |

I request the following restrictions to the use and/or disclosure of my health information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| \_\_ You May Contact me by telephone | Phone Number: |
| \_\_ You May leave a message/voicemail | Phone Number: |
| \_\_ Please **Do Not** leave a message/voicemail |  |

**This request supersedes any prior request for communication of information I may have made.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative Date Notice Effective**

|  |
| --- |
| **Patient Information** |
| **First Name: Last Name: Date of birth:** |
| **Mailing Address: Apt # City/State/Zip** |
| **Home Phone: Cell Phone: Cell Carrier:** |
| **Marital Status:**  | **Sex:** **\_\_**Male \_\_Female | **Social Security Number:** |
| **Email:** | **Can we leave a voice message regarding your medical care and test results?** \_\_Yes \_\_NO |
| **Race:** \_\_White \_\_American Indian or Alaskan Native **Ethnicity:** \_\_Hispanic or Latino \_\_ Hispanic \_\_ Black or African American \_\_ Not Hispanic or Latino \_\_ Other \_\_ Native Hawaiian or Pacific Islander \_\_ Decline \_\_ Asian \_\_ Decline  **Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Current Home Health Provider:** | **Advanced Directives on File:** \_\_None \_\_Living Will \_\_HC Proxy\_\_Durable Power of Attorney \_\_\_Do Not Resuscitate  |
| **How did you hear about us? \_\_**Facebook \_\_Instagram \_\_Twitter \_\_Google \_\_Radio \_\_Newspaper \_\_Fliers \_\_Friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other (Please Specify) |
| **Pharmacy (Please select only 1)** |
| \_\_Health Express \_\_More-Than-Medicine \_\_Walmart (W’ford) \_\_Walgreens (W’ford) \_\_Eagle Pharmacy\_\_ Clinic (Cordell) \_\_ Hinton Pharmacy \_\_ PharmCare \_\_ Salisbury \_\_ S & D\_\_ K Mart (Clinton) \_\_ Homeland (Elk City) \_\_ Liberty Drug Other\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Responsible Party Information** |
| **First Name: Last Name:** |
| **Date of Birth: Social Security Number:** | **Phone:** |
| **Mailing Address: City/State/Zip** | **Relationship to Patient:** |
| **Primary Medical Insurance** | **Secondary Medical Insurance** |
| Ins. Co. Name | Ins. Co. Name |
| Policy Holder Name: | Policy Holder Name: |
| Policy Holder DOB: SSN: | Policy Holder DOB: SSN: |
| Policy Number: | Policy Number: |
| Group Number: | Group Number: |
| Employer Name: | Employer Name: |
| **Emergency Contact** |
| Name: Phone: Relationship: |
| Name: Phone: Relationship: |
| I hereby authorize the release of medical information concerning my illness and treatments for the purpose of processing my insurance claims and authorize payment to Brian Bluth, M.D. for any benefits paid for services rendered to myself or my dependents. I understand that I am responsible for all fees, regardless of insurance coverage. I also understand that payment is expected at the time of services unless other arrangements are made prior to each visit. I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Bluth is not required to agree to the restrictions requested.  |

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Health History Questionnaire** |
| **All questions contained in this questionnaire are strictly confidential and will become part of your medical record.** |
| **Patient Name:** |
| Previous/Referring Doctor: | Date of last physical exam: |
| Childhood Illness: | \_\_Measles \_\_Mumps \_\_Rubella \_\_Polio \_\_Chickenpox \_\_Rheumatic Fever |
| **Immunizations and Dates (if known)** |
|  Tetanus\_\_\_\_\_\_\_\_ Pneumonia\_\_\_\_\_\_\_\_ Hepatitis\_\_\_\_\_\_\_\_ Chickenpox\_\_\_\_\_\_\_\_ Influenza\_\_\_\_\_\_\_\_ MMR\_\_\_\_\_\_\_\_ Have you had a blood transfusion? \_\_NO \_\_YES When? \_\_\_\_\_\_\_\_ Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Previous Medical Diagnosis** |
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|  |  |
| **Surgeries/Other Hospitalization** |
| **Date** | **Surgery/Reason** | **Hospital/Doctor** |
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| **Medications-List all medications you take, prescription and non-prescription** |
| \_\_\_\_\_ I do not take any medications |
| **Mediation Name** | **Dosage** | **Frequency** |
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| **Medications and Food Allergies- List all known allergies (drug, food, animals, etc.)** |
| \_\_\_\_\_ No Known Allergies |
| **Name of drug/Allergy** | **Reaction** | **Name of drug/Allergy** | **Reaction** |
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| **Social History** |
| **Tobacco Use** | **\_\_**Never | \_\_Daily | Cigarette #/Day:\_\_\_ | **Alcohol Use** | **\_\_**Never | \_\_Daily | **\_\_** Beer |
| **\_\_**Weekly | **\_\_**Former | Cigars #/Day: \_\_\_ | **\_\_**Weekly | **\_\_**Former | **\_\_** Liquor |
| Number of years:\_\_\_\_ | Chewing #/Day: \_\_\_ | Number of years:\_\_\_\_ | \_\_ Wine |
| Year Quit:\_\_\_\_\_ | Other #/Day: \_\_\_ | Year Quit:\_\_\_\_\_ | \_\_ Other |
| **Secondhand smoke** | Do you have any children that are exposed to second hand smoke regularly? \_\_\_Yes \_\_\_ No |
| **Drug Use** | Do you currently uses recreational/street drugs?\_\_\_Y\_\_\_N Have you ever used drugs with a needle? \_\_Y \_\_N |
| **Medical Marijuana** | Do you have a Medical Marijuanna Card? \_\_\_Y \_\_\_N If so, in what state?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Caffeine** | \_\_ None \_\_Coffee \_\_Tea \_\_Soda \_\_Chocolate \_\_Other How often: \_\_\_\_\_\_\_\_\_\_\_ |
| **Diet** | Are you dieting? \_\_Yes \_\_No If yes, are you on a physician prescribed diet? \_\_Yes \_\_No |
| Salt Intake: \_\_High \_\_Medium \_\_Low Fat Intake: \_\_High \_\_Medium \_\_Low Average Daily Meals?\_\_\_\_\_\_\_ |
| **Exercise** | \_\_Sedentary \_\_Moderate \_\_Vigorous Days/week:\_\_\_\_\_\_\_\_\_\_  |
| **Sex** | Sexually Active? \_\_Yes \_\_No Are you trying to get pregnant? Contraceptive Used?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have children? \_\_Yes \_\_No How many children \_\_\_ |
| **Personal Safety/Mental Health** |
| Do you live alone? | Yes | No | Do you have problems with eating? | Yes | No |
| Do you have frequent falls? | Yes | No | Do you have trouble sleeping? | Yes | No |
| Do you have vision/hearing loss? | Yes | No | Do you panic when stressed? | Yes | NO |
| Is stress a major problem for you? | Yes | NO | Have you ever been to a counsler? | Yes | NO |
| Do you cry frequently?  | Yes | No | Have you ever attempted suicide? | Yes | No |
| Do you feel depressed? | Yes | No | Have you had serious thoughts of hurting yourself? | Yes | No |
| **Family Health History** |
| \_\_Adopted/No History Available | Mother | Father | Brother | Sister | Other (Please Specify) |
| Alzheimer’s Disease |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Blood Disease |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |
| Cancer-Type |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Hypertension |  |  |  |  |  |
| IBS |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |
| Obesity |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other |  |  |  |  |  |
|  |
| **Signature:** | **Date:** |

**ADULT BEHAVIORAL HEALTH SCREEN**

**Physical and emotional health go together. You can help us provide you with the best health care possible by answering these questions. Please circle the box that best describes you. If you do not wish to answer a question, you may leave it blank.**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PHQ-2+1**Please circle the answer that best describes you during the past 2 weeks.** | **Not at All** | **Several Days** | **More than Half the Days** | **Nearly Every Day** |
| 1. Little interest or pleasure in doing things
 | **0** | **1** | **2** | **3** |
| 1. Feeling down, depressed or hopeless
 | **0** | **1** | **2** | **3** |
| 1. Thinking that you would be better off dead or that you want to hurt yourself in some way
 | **0** | **1** | **2** | **3** |
| AUDIT, NM-ASSIST**Please circle the answer that best describes your use of alcohol or drugs. Drugs include all kinds of street drugs, marijuana, meth, cocaine, or prescription drugs such as tranquilizers or painkillers that are not taken as directed by your doctor.** |
| 1. How often do you drink alcohol?
 | **Never****0** | **Monthly or less****1** | **2-4 times a month****2** | **2-3 times a week****3** | **4 or more times a week****4** |
| 1. How many drinks of alcohol do you have on a typical day? Leave blank if none.
 | **1 or 2 drinks a day** | **3 or 4 drinks a day****1** | **5 or 6 drinks a day****2** | **7 to 9 drinks a day****3** | **10 or more drinks a day****3** |
| 1. In the **past year**, did you have 6 or more drinks\* of alcohol in one day if you are a male; 5 or more if you are a female
 | **Never****0** | **Less than Monthly****1** | **Monthly****2** | **Weekly****3** | **Daily or almost daily****4** |
| 1. In the **past 3 months**, how often have you used marijuana, other drugs or nonmedical use of prescription drugs?
 | **Never****0** | **Less than monthly****1** | **Monthly****2** | **Weekly****3** | **Daily or almost daily****4** |
| 1. In the **past 3 months**, how often have you a had a strong desire or urge to use alcohol or drugs?
 | **Never****0** | **Less than monthly****1** | **Monthly****2** | **Weekly****3** | **Daily or almost daily****4** |
| 1. In the **past 3 months**, has your use of alcohol or drugs led to health, social, legal or financial problems?
 | **Never****0** | **Less than monthly****1** | **Monthly****2** | **Weekly****3** | **Daily or almost daily****4** |
| 1. In the **past 3 months**, how often have you failed to do what was normally expected of you because of your uses of alcohol or drugs?
 | **Never****0** | **Less than monthly****1** | **Monthly****2** | **Weekly****3** | **Daily or almost daily****4** |

**Are you currently receiving services from a psychologist, a substance abuse program or counselor, and/or mental health program or counselor? (Circle your answer)**

|  |  |
| --- | --- |
| **Yes** | **No** |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pediatric Behavioral Health Screen (Ages 5-16)**

**Person Completing Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle the number that best describes your child. If you do not wish to answer a question, you can leave it blank.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PSC** | **Never** | **Some-times** | **Often** | Office UseI A E |
| 1.Figery, unable to sit still | **0** | **1** | **2** |  |  |  |
| 2. Feels sad, unhappy | **0** | **1** | **2** |  |  |  |
| 3. Daydreams too much | **0** | **1** | **2** |  |  |  |
| 4. Refuses to share | **0** | **1** | **2** |  |  |  |
| 5. Does not understand other people’s feelings | **0** | **1** | **2** |  |  |  |
| 6. Feels hopeless | **0** | **1** | **2** |  |  |  |
| 7. Has trouble paying attention | **0** | **1** | **2** |  |  |  |
| 8. Fights with other children | **0** | **1** | **2** |  |  |  |
| 9. Is down on himself/herself | **0** | **1** | **2** |  |  |  |
| 10. Blames others for his/her actions | **0** | **1** | **2** |  |  |  |
| 11. Seems to be having less fun | **0** | **1** | **2** |  |  |  |
| 12. Doesn’t listen to the rules | **0** | **1** | **2** |  |  |  |
| 13. Acts as if driven by a motor | **0** | **1** | **2** |  |  |  |
| 14. Teases others | **0** | **1** | **2** |  |  |  |
| 15. Worries a lot | **0** | **1** | **2** |  |  |  |
| 16. Takes things that don’t belong to him/her | **0** | **1** | **2** |  |  |  |
| 17. Distracted easily | **0** | **1** | **2** |  |  |  |

**How much do the problems or difficulties you circled above interfere with your child’s everyday life?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Only a little** | **A lot** | **A great deal** |
| 18. Do the difficulties you checked above upset or distress your child? | **0** | **1** | **2** | **3** |
| 19. Do the difficulties you checked above place a burden on you and your family? | **0** | **1** | **2** | **3** |
| 20. Do the difficulties you checked above interfere with your child’s homelife? | **0** | **1** | **2** | **3** |
| 21. Do the difficulties you checked above interfere with your child’s friendships? | **0** | **1** | **2** | **3** |
| 22. Do the difficulties you checked above interfere with your child’s activities? | **0** | **1** | **2** | **3** |
| 23. Do the difficulties you checked above interfere with school or learning? | **0** | **1** | **2** | **3** |
| 24. Do you think your child might have a problem with alcohol or drugs? |  |  | **Yes** | **No** |
| 25. Is your child in counseling or seeing a mental health professional? |  |  | **Yes** | **No** |
| 26. Does your child have an IEP (Individual Educational Plan) at school? |  |  | **Yes** | **No** |
| 27. Are there problems or concerns about your child, yourself or your family that you would like to talk about privately with your doctor? |  |  | **Yes** | **No** |