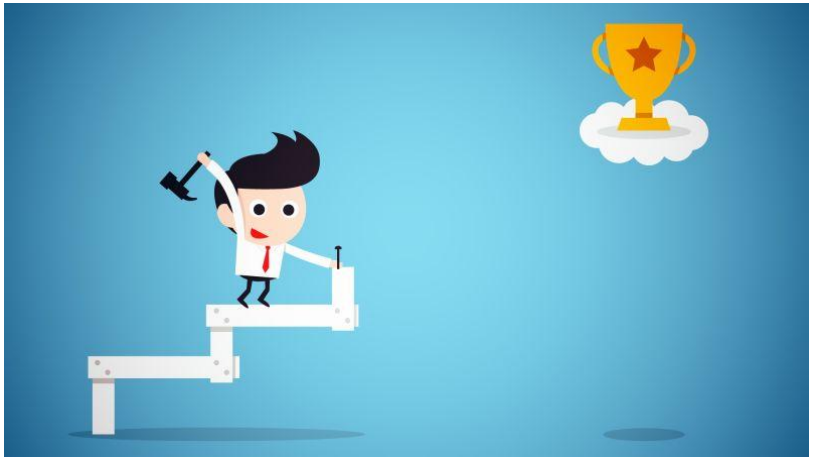
# PDFs and PCC Form Letters

Solving the Mysteries of PDFs

With Jim Smith and Bryan LeMoine


PCC Pediatric EHR Solutions

# Goals



- Modernize your waffle forms.
- Include your letterhead, along with any other images on your forms.
- Make this easier for your office to accomplish.
- And most importantly, do all of this in a timely manner!

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# The Old School

```
What you can pick from in arf:

    prac.name           Practice's name
    prac.addr1          Practice's first address line
    prac.addr2          Practice's second address line
    prac.city           Practice's city
    prac.state          Practice's state
    prac.zip            Practice's zip code
    prac.phone          Practice's phone number
    prac.billphone      Practice's billing phone number
    prac.fax            Practice's fax number
    prac.webaddr        Practice's web address
    prac.taxid          Practice's tax id number
    pracladdr#          Practice's three address lines
    today               Today's date
    p.pcc               Patient's PCC number
    p.born              Patient's birth date
    p.b.month           Patient's birth month
    p.b.day             Patient's birth day
    p.b.year            Patient's birth year as two digits
    p.b.year4           Patient's birth year as four digits
    patname             Patient's name as `Last Suffix, First "Nick" Middle'
    patname2            Patient's name as `First "Nick" Middle Last, Suffix'
    patname3            Patient's name as `patname (F MM/DD/YY)'
    patname-nc          Patient's name as patname, Complete
    patname2-nc         Patient's name as patname2, Complete
    patname3-nc         Patient's name as patname3, Complete
    patname-full        Patient's name as `Last Suffix, First "Nick" Middle'
    patname2-full       Patient's name as `First "Nick" Middle Last, Suffix'
--Less (type q to quit)-- (4%)/PCC/partner/lib/arf.pick
```

```
                                \001setEmph\001PCC Pediatrics\001resetEE\001
\001strtUnd\001\001setEmph\001PATIENT INFO UPDATE FORM FOR:  <patname2;%-32.32

\001strtItl\001This is an update of information already on file for your child
this over and make any necessary changes.  This will be done on a \001setEmph\

\001setEmph\001PATIENT INFORMATION:\001resetEE\001

\001nm12cpi\001      Patient Name:\001nm10cpi\001\001setEmph\001 \001strtUnd\0
\001nm12cpi\001       Patient DOB:\001nm10cpi\001\001setEmph\001 \001strtUnd\0
\001nm12cpi\001    Patient Gender:\001nm10cpi\001\001setEmph\001 \001strtUnd\0
\001nm12cpi\001Preferred Language:\001nm10cpi\001\001setEmph\001 \001strtUnd\0

\001nm12cpi\001Ethnicity:                    Race:
[_] Hispanic or Latino          [_] Am. Indian/AK Native     [_] Native HI/
[_] Not Hispanic or Latino      [_] Asian                    [_] White
[_] Prefers not to answer       [_] Black or African American [_] Prefers no

\001setEmph\001RESPONSIBLE PARTY INFORMATION:\001resetEE\001

Father's Name:_____Occupation_____

Mother's Name:_____Occupation_____

File Name: /dats/bryan/forms/patinfoform                    Mode: insert
 Save Quit | Unix Shell | Help | Print | Restart File | Format Para. | Delete Line | Edit New File
```

# The New School


PCC Pediatrics

**Patient Demographics** Today's Date: <today:%8.8s>

First Name: <p.first> Last Name: <p.last>

Date of Birth: <p.born:%8.8s> Sex: ☐ Male ☐ Female

Patient's PCP (check one): ☐ Dr. Gast ☐ Dr. Kerns ☐ Dr. Miller ☐ Dr. Weintraub

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to Answer

Race: ☐ American Indian/AK Native ☐ Asian ☐ Black or African American

☐ Native HI / Pacific IS ☐ White ☐ Prefer not to Answer

The language I prefer to communicate in about my child's care is:

☐ English ☐ Spanish ☐ Other _____

**Patient Information**

| Patient lives with: | Send bills to: |
|---|---|
| Name: <c.first> <c.last> | Name: <a.first> <a.last> |
| Address: <c.addr1> | Address: <a.addr1> |
| City: <c.city> State: <c.st> Zip: <c.zip> | City: <a.city> State: <a.st> Zip: <a.zip> |
| Email: <c.email> | Email: <a.email> |

Please list all phone numbers that apply:

Patient phone: <c.hphone>

Mom's Cell Phone: <c.wphone>

Dad's Cell Phone: <c.fphone>

Our office was recommended by _____

**Primary Insurance Information**

Cardholder Name: <i1.first> <i1.last> ID#: <i1.certs>

Group #: <i1.grp> Effective Dates: <i1.start:%8.8s><i1.end:%8.8s>

DOB of Cardholder: <i1.born:%10.10s> Employer: <i1.employer>

Insurance Company Name: <i1.name>

I certify that I, or my dependents above, have insurance coverage as indicated above and assign directly to Marblehead Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims.

**Signature** _____ **Date** <today:%8.8s>

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# What is your role in this process?

- Keep a copy of the form on your computer for future edits
  - This will be both necessary and helpful for updating your forms

# How can you achieve this?

- Store all of your PCC forms and documents in the same place
  - Example 1 - Create a folder on your Desktop and organize your forms there
  - Example 2 - Create a subfolder in your Documents and organize your forms there

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# What can you provide PCC?

1. The final version of the document in PDF form
2. A finalized copy of file
    a. Examples: .doc or .odt
3. Directions as to what you would like to autofill

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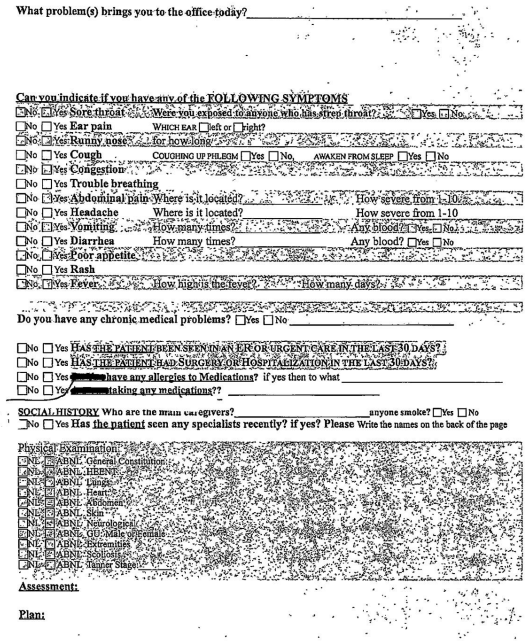
# What can PCC not use?



What problem(s) brings you to the office today?_____

Can you indicate if you have any of the FOLLOWING SYMPTOMS

☐No ☐Yes Sore throat Were you exposed to anyone who has strep throat? ☐Yes ☐No
☐No ☐Yes Ear pain WHICH EAR ☐left or ☐right?
☐No ☐Yes Runny nose for how long?
☐No ☐Yes Cough COUGHING UP PHLEGM ☐Yes ☐No AWAKEN FROM SLEEP ☐Yes ☐No
☐No ☐Yes Congestion
☐No ☐Yes Trouble breathing
☐No ☐Yes Abdominal pain Where is it located? How severe from 1-10
☐No ☐Yes Headache Where is it located? How severe from 1-10
☐No ☐Yes Vomiting How many times? Any blood? ☐Yes ☐No
☐No ☐Yes Diarrhea How many times? Any blood? ☐Yes ☐No
☐No ☐Yes Poor appetite
☐No ☐Yes Rash
☐No ☐Yes Fever How high is the fever? How many days?

Do you have any chronic medical problems? ☐Yes ☐No _____

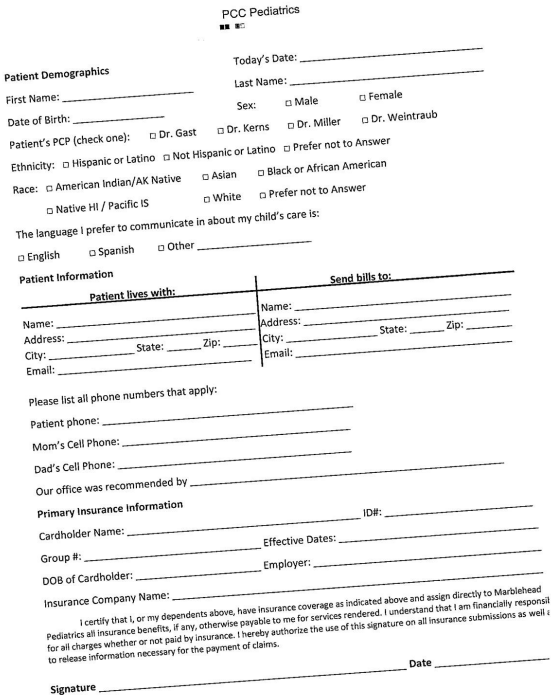
☐No ☐Yes HAS THE PATIENT BEEN SEEN IN AN ER OR URGENT CARE IN THE LAST 30 DAYS?
☐No ☐Yes HAS THE PATIENT HAD SURGERY OR HOSPITALIZATION IN THE LAST 30 DAYS?
☐No ☐Yes [redacted] have any allergies to Medications? if yes then to what _____
☐No ☐Yes [redacted] taking any medications?? _____

SOCIAL HISTORY Who are the main caregivers?_____anyone smoke? ☐Yes ☐No
☐No ☐Yes Has the patient seen any specialists recently? if yes? Please Write the names on the back of the page

Physical Examination:
☐NL ☐ABNL General Constitution
☐NL ☐ABNL HEENT
☐NL ☐ABNL Lungs
☐NL ☐ABNL Heart
☐NL ☐ABNL Abdomen
☐NL ☐ABNL Skin
☐NL ☐ABNL Neurological
☐NL ☐ABNL GU Male / Female
☐NL ☐ABNL Extremities
☐NL ☐ABNL Scoliosis
☐NL ☐ABNL Tanner Stage

Assessment:

Plan:



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Patient Demographics

First Name: _____ Today's Date: _____
Last Name: _____
Date of Birth: _____ Sex: ☐ Male ☐ Female
Patient's PCP (check one): ☐ Dr. Gast ☐ Dr. Kerns ☐ Dr. Miller ☐ Dr. Weintraub
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to Answer
Race: ☐ American Indian/AK Native ☐ Asian ☐ Black or African American
☐ Native HI / Pacific IS ☐ White ☐ Prefer not to Answer

The language I prefer to communicate in about my child's care is:
☐ English ☐ Spanish ☐ Other _____

Patient Information

Patient lives with:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____

Send bills to:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____

Please list all phone numbers that apply:
Patient phone: _____
Mom's Cell Phone: _____
Dad's Cell Phone: _____
Our office was recommended by _____

Primary Insurance Information
Cardholder Name: _____ ID#: _____
Group #: _____ Effective Dates: _____
DOB of Cardholder: _____ Employer: _____
Insurance Company Name: _____

I certify that I, or my dependents above, have insurance coverage as indicated above and assign directly to Marblehead Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsil for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well a to release information necessary for the payment of claims.

Signature _____ Date _____

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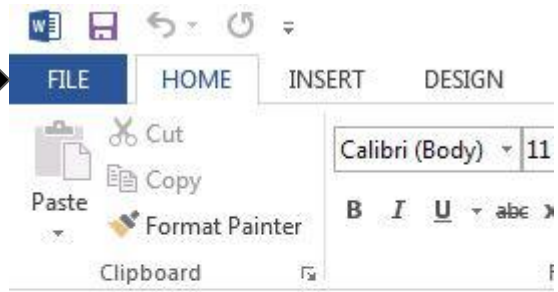
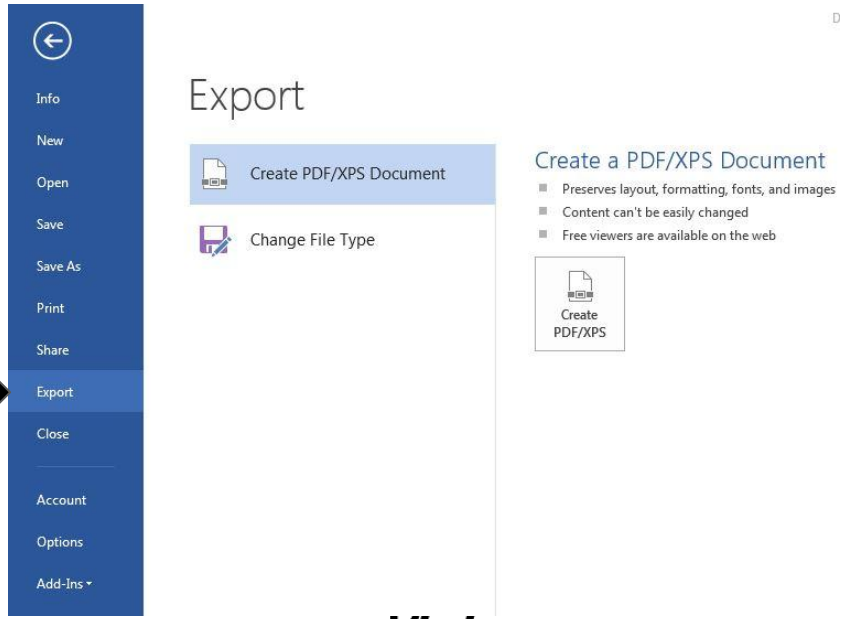
# Exporting to PDF on a Windows Computer

1




2

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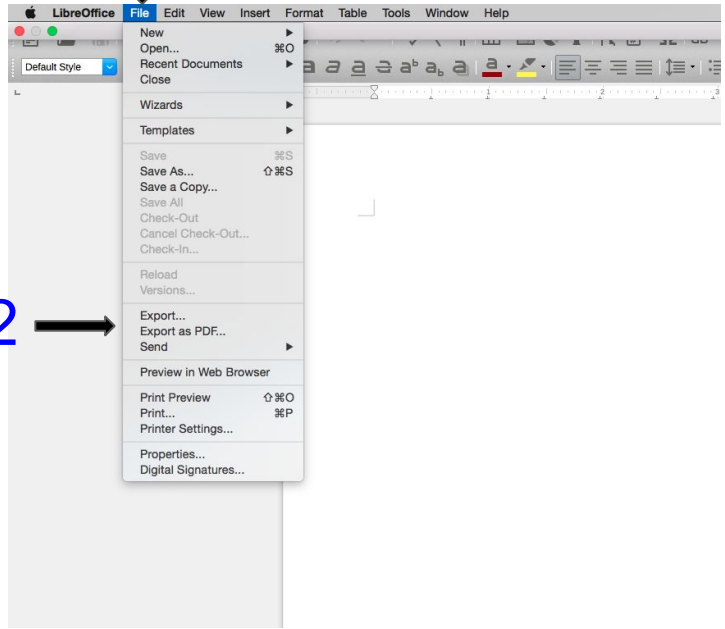
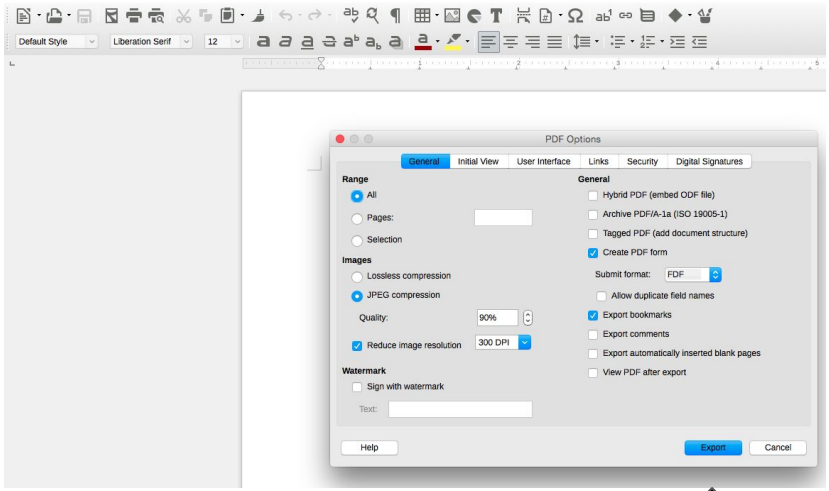
# Exporting to PDF on a Mac (Apple)

1




2




3

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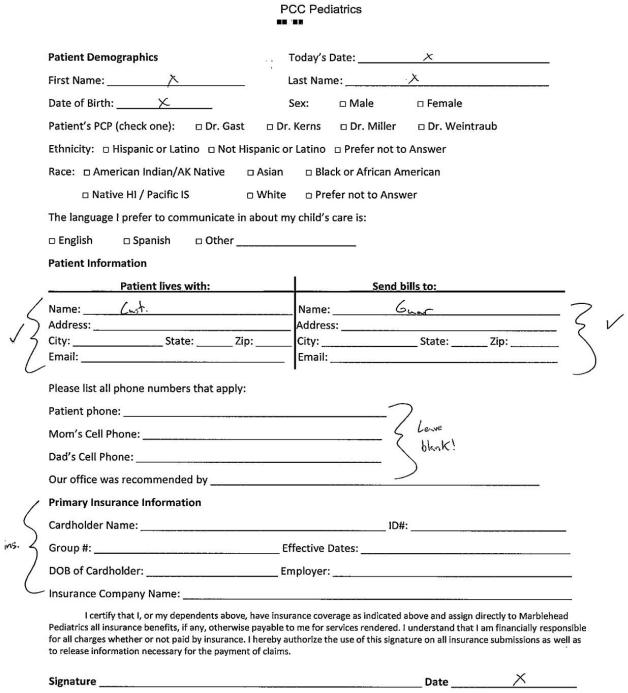
# How can we demonstrate what we want autofilled?

## Easy! Here are a few ideas:



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**Patient Demographics** Today's Date: X

First Name: X Last Name: X

Date of Birth: X Sex: ☐ Male ☐ Female

Patient's PCP (check one): ☐ Dr. Gast ☐ Dr. Kerns ☐ Dr. Miller ☐ Dr. Weintraub

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to Answer

Race: ☐ American Indian/AK Native ☐ Asian ☐ Black or African American

☐ Native HI / Pacific IS ☐ White ☐ Prefer not to Answer

The language I prefer to communicate in about my child's care is:

☐ English ☐ Spanish ☐ Other _____

**Patient Information**

| Patient lives with: | Send bills to: |
|---|---|
| Name: Last. | Name: Same |
| Address: | Address: |
| City: State: Zip: | City: State: Zip: |
| Email: | Email: |

Please list all phone numbers that apply:

Patient phone: Leave blank!

Mom's Cell Phone:

Dad's Cell Phone:

Our office was recommended by

**Primary Insurance Information**

Cardholder Name: ID#:

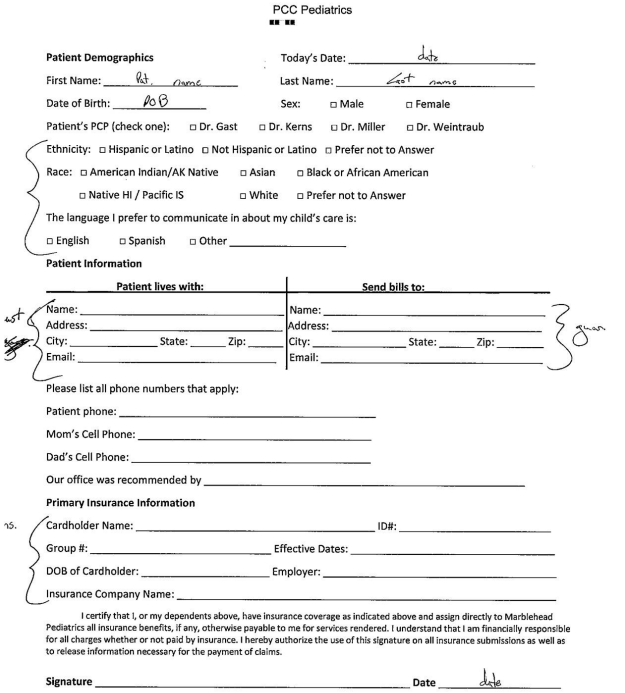
Group #: Effective Dates:

DOB of Cardholder: Employer:

Insurance Company Name:

I certify that I, or my dependents above, have insurance coverage as indicated above and assign directly to Marblehead Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims.

**Signature** _____ **Date** X



PCC Pediatrics

**Patient Demographics** Today's Date: date

First Name: Pt. name Last Name: Last name

Date of Birth: DOB Sex: ☐ Male ☐ Female

Patient's PCP (check one): ☐ Dr. Gast ☐ Dr. Kerns ☐ Dr. Miller ☐ Dr. Weintraub

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to Answer

Race: ☐ American Indian/AK Native ☐ Asian ☐ Black or African American

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The language I prefer to communicate in about my child's care is:

☐ English ☐ Spanish ☐ Other _____

**Patient Information**

| Patient lives with: | Send bills to: |
|---|---|
| Name: | Name: |
| Address: | Address: |
| City: State: Zip: | City: State: Zip: |
| Email: | Email: |

Please list all phone numbers that apply:

Patient phone:

Mom's Cell Phone:

Dad's Cell Phone:

Our office was recommended by

**Primary Insurance Information**

Cardholder Name: ID#:

Group #: Effective Dates:

DOB of Cardholder: Employer:

Insurance Company Name:

I certify that I, or my dependents above, have insurance coverage as indicated above and assign directly to Marblehead Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims.

**Signature** _____ **Date** date

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# How can we demonstrate what we want autofilled? Continued...

Ex.

Dear PCC support,

I've attached my demographics form. Would you mind setting it up so that the Patient Demographics and the Primary Insurance sections autofill with account information? Let me know if you need further clarification!

Thanks!

PCC Pediatric EHR Solutions

# What Can PCC Provide for you?

- Faster turnaround time
- Our own repository for your forms
  - However, you should still keep a copy of the form for future edits
- Consistency in the final product
- A professional form to be proud of when you present it to your families
- Technical support to ensure you have the proper printer
  - Call your friendly TST tech to verify this

PCC Pediatric EHR Solutions


# Brief Overview

1. Provide a finalized PDF
2. Provide a finalized .doc
3. Provide instructions for placement of variables

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# Questions?

Thanks so much for coming and please take the time to fill out the survey!

PCC Pediatric EHR Solutions