WNY MEDICAL, PC

Competence. Compassion. Collaboration.

Patient Packet
2020

Updated January 2020

WNY MEDICAL, PC

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CONTROLLED FORM

PATIENT'S BASIC INFORMATION SHEET

To be completed at each visit

Name	Date	Date of Birth
SS #	Sex **M** **F**	Race
Marital Status **S** **M** **W** **D**		Language
Address (Street)	City	Zip Code
Home Phone	Work Phone	
Cell Phone	Other Phone	
May we leave a message on your home answering machine? **Y** **N**		
May we talk to someone else about your care? **Y** **N**		
If yes, name of that person:	Relationship	
Pharmacy Name	Employer (self)	
Pharmacy Phone Number	Employer (spouse)	
Pharmacy Address		

INSURANCE INFORMATION

First Insurance	Subscriber	DOB
1st Insurance ID	Group	Plan
Second Insurance	Subscriber	DOB
2nd Insurance ID	Group	Plan

REFERRED BY

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone #

I understand that I am responsible for the full cost of services rendered today if: (1) I have HMO insurance but fail to list a group doctor as my Primary Care Physician (PCP), or (2) I fail to obtain a referral when necessary. I understand that the practice will bill me for any balance for which I am personally responsible. I certify that the above personal and insurance information is correct.

PATIENT'S SIGNATURE _____ DATE _____

Receiving staff member has checked that the information is legible, complete and verified via HealtheNet or other source, and verifies that **Medent has been updated**.

Staff Signature _____ Date _____

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HEALTH AND HISTORY QUESTIONNAIRE

Please complete the following questions to the best of your ability. As your health care provider, we at WNY Medical, PC are always striving toward complete and updated information on our patients.

1. PERSONAL INFORMATION						
Name			Date of Birth			
SS #	Sex **M** **F**		Marital Status **S**	**M**	**W**	**D**
Address (Street)	City			Zip Code		
Home Phone	Work Phone					
Cell Phone	Other Phone					

2. MEDICATIONS: Please list any and all drugs you are currently taking, including over-the-counter vitamins, inhalers, etc.), and state strength and frequency.

3. MEDICATION ALLERGIES: Please list the medication and the reaction that you have to it.

4. SURGERIES (What kind and when):

5. OTHER ALLERGIES: Food and other substances – please list the substance and the reaction to it.

6. FAMILY HISTORY: If relatives are living, list age and any significant health problems. If deceased, list age when deceased and include any significant health problems.
Father:
Mother:
Siblings:
Grandparents:
7. TESTS AND EXAMS: Please state the latest date (if applicable) of the following tests and examinations.
a) PSA:
b) Testicular Self-exam:
c) Breast Self-exam:
d) Physician Breast Exam:
e) Mammogram:
f) Pap/Pelvic Exam:
g) Yearly Physical:
h) Eye Exam:
i) Colonoscopy:
j) EKG:
k) Bone Density Test:
l) Rectal Exam:
m) Cardiac Stress Test:
n) Hearing Evaluation:
8. IMMUNIZATION RECORD: Please state date of latest immunizations.
a) Influenza (Flu):
b) Pneumonia:
c) Tetanus:
9. CHILDHOOD DISEASES: Please state if you had any of the following, and if so, when.
a) Measles:
b) Mumps:
c) Rubella:
d) Chicken Pox:
e) Rheumatic Fever:
f) Polio
10. SOCIAL HISTORY:
a) Marital Status: b) Occupation:
c) Do you smoke? No ☐ Yes ☐ If yes, how many packs per day? How many years?
If you previously smoked, when did you quit?
d) Do you drink alcohol? No ☐ Yes ☐ If yes, how much/how often?
e) Do you exercise? No ☐ Yes ☐ If yes, how often?

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HEALTH CARE PROXY

1) I, _____

hereby appoint _____
(name, home address, telephone number)

As my health care agent to make any and all health care decisions for me, including decisions about artificial nutrition and hydration, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

_____

_____

(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration.)

3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent:

_____
(name, home address, and telephone number)

4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the data or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

_____

5) Signature: _____

Address: _____

Date: _____

6) Statement by Witnesses (must be 18 or older):

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1: _____

Address: _____

Witness 2: _____

Address: _____

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service, or procedure to diagnose or treat your physical or mental condition.

2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.

3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.

4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

*If I become terminally ill, I **do/don't** want to receive the following treatments…*

*If I am in a coma or unconscious, with no hope of recovery, then I **do/don't** want…*

*If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I **do/don't** want…*

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is **not** a complete list of the treatments about which you may leave instructions.

- Artificial respiration
- Electric shock therapy
- Psychosurgery
- Transplantation
- Abortion
- Antipsychotic medication
- Antibiotics
- Dialysis
- Blood transfusions
- Sterilization
- Cardiopulmonary resuscitation (CPR)
- Artificial nutrition and hydration (nourishment and water provided by feeding tube)

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. **You do not need a lawyer to fill out this form.**

You can choose any adult (over 18), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home, or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. You agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing.

Filling out the Proxy form

Item 1): Write your name and the name, home address, and telephone number of the person you are selecting as your agent.

Item 2): If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment. You may also state your wishes about organ tissue donation.

Item 3): You may write the name, home address, and telephone number of an alternate agent.

Item 4): This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

Item 5): You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

From material provided by the New York State Department of Health.

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Financial Policies Summary Sheet and Signoff Form

Thank you for choosing our practice as you health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our financial policies is important to our professional relationship. Please understand that payment for services is an important part of that relationship because it ensures that we will always be here when you need us. Ask if you have any questions about our fees, our policies, or your responsibilities. Our billing department (716-923-4380 x3119/3127/3135) can usually set up a payment plan for any budget. It is your responsibility to notify our office and/or billing department of any patient information changes such as address, name, insurance coverage, etc. Failure to do so may result in higher balances due.

Co-Pays and Past-Due Balances (Policy #0015)

All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit cards. Post-dated checks will only be accepted on the approval of the BILLING DEPARTMENT.

Missed Appointments (Policy #0017)

We require 24-hour notice of appointment cancellation. Appointments missed without cancellation will be charged a "no-show" fee of $40.00, unless the appointment is rescheduled within 48 hours. If the second scheduled appointment is missed, YOU WILL BE CHARGED FOR BOTH ($80.00).

If the appointment was at our psychiatric facility the "no-show" fee is $50 unless the appointment is rescheduled iwthin 48 hours. If the second scheduled appointment is missed YOU WILL BE CHARGED FOR BOTH ($100.00).

Returned Checks (Policy #0014)

The charge for a returned check is $30.00. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check.

Outstanding Balance Policy (Policy #0014).

It is our office policy that all past-due accounts be sent three statements. If payment is not made on this account, a 10 day collection notice will be mailed. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

Insurance Claims (Policy #0080)

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If you have claims forms we can help you with them, but we may need to charge an additional fee for working on them if you do not bring them with you at the time of your office visit (Policy #0019). Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for services performed at our office or you do not have insurance coverage, you will be responsible for the complete balance of the non-payable services ("self-pay", Policy #0030). If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. We will take all necessary action to recoup payments for our services in this case.

Signoff Form

Workers' Compensation and Automobile Accidents (Policy #0157)

In the case of a workers' compensation injury or automobile accident, you must provide WNY Medical, PC the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for you visit at the time of service. You will be required to provide all injury and or accidental information. Please note that Workers' Compensation and No Fault Visits cannot and will not be combined with a SICK WELL, or ANNUAL PHYSICAL visit.

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Minors (Policy #0158)

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs as well as a $50.00 collection fee.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

I have read the above summary of financial policies and understand my financial responsibility to my healthcare provider.

Patient Signature_____

Annual Wellness Visit

For Established Patients

I will notify in written at-once to my PCP if I take my Annual Wellness Visit other than WNY Medical PC, in-case I fail to do so, I will be responsible to pay the cost of that wellness visit.

Patient Signature:

_____

For New Patients

For new patients: I've taken my Annual Visit from previous practice for this year: Yes / No

Patient Signature_____

Witness_____

Effective Date: 9/21/18 Document 0084, Rev 3: Financial Policies Summary Sheet and Page 2 of 2

Sign off Form

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PATIENT PRIVACY POLICY STATEMENT & SIGNOFF

WNY Medical, PC is committed to maintaining the privacy of your Protected Health Information (PHI), which includes information about your health condition and the care and treatment you receive from this practice. The formation of a record detailing the care and services you obtain helps this office to provide you with exceptional quality health care. This notice details how your PHI may be used and disclosed to third parties. This document also details your rights concerning your PHI.

WNY Medical, PC may use and/or disclose your PHI for the following purposes:

a) **Treatment:** WNY Medical, PC may provide your PHI to those health care officials directly involved in your care so that they may understand your health condition and needs.

b) **Payment:** In order to obtain payment for services provided to you, WNY Medical, PC will provide your PHI directly or through a billing service to appropriate third parties, pursuant to their billing and payments requirements.

c) **Health Care Operations:** It may be necessary for the practice to compile, use, and/or disclose your PHI in order for WNY Medical, PC to operate in accordance with applicable law and insurance requirements and in order for the practice to continue to provide quality and efficient care.

WNY Medical, PC may also use and/or disclose your PHI without your specific authorization in the following adiditonal instances:

a) **De-identified information:** Information that does not identify you.

b) **Business Associate:** An entity that assists WNY Medical, PC in undertaking some essential function.

c) **Personal Representative:** A person who represents you in making health care decisions.

d) **Emergency Situations.**

e) **Law and Government Authorities:** All government and legal authorities to whom we are obliged by law to provide your information.

f) **Coroner or Medical Examiner.**

g) **Organ, eye, tissue donation:** Applies to those who are organ, eye, or tissue donors.

h) **Averting a threat to health or safety.**

i) **Specialized Governmental Functions:** This refers to disclosure of PHI that relates primarily to military activity.

j) **Workers Compensation.**

Above are the major categories. To see a detailed and complete list, please see the Department of Health and Human Services website (http://www.hhs.gov).

Family/Friends

WNY Medical, PC may disclose to your family members, other relatives, a close personal friend, or any other person identified by you, your PHI directly relevant to such persons' involvement with your care. All such disclosures are subject to our professional judgment.

Authorization

Uses and/or disclosures other than those described above will be made only with your written authorization.

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Your Rights

You have the right to:

a) Revoke any authorization in writing, at any time.

b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, WNY Medical, PC is not obligated to agree to any requested restrictions.

c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the practice's privacy officer. The practice will accommodate all reasonable requests.

d) Inspect and copy your PHI as provided by law.

e) Request an amendment to your PHI as provided by law.

f) Receive any paper copy of this privacy notice from WNY Medical upon reuest to the practice's privacy officer.

g) Complain to WNY Medical or to the secretary of HHS (http://www.hhs.gov/ocr/hipaa/) if you believe your privacy rights have been violated.

To obtain more information or have your questions about your rights answered, you may contact the practice's privacy officer.

Responsibilities

WNY Medical, PC acknowledges and affirms that it:

a) Is required by Federal law to maintain the privacy of your PHI and to provide you with a privacy notice detailing WNY Medial, PC's legal duties and privacy practices with respect to your PHI.

b) Is required by New York State law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is set forth by Federal law.

c) Is required to abide by the terms of this privacy notice.

d) Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for your entire PHI that it maintains.

e) Will make readily available to you any revised privacy notice prior to implementation.

f) Will not retaliate against you for filing a complaint.

For a full list and description of your rights, please go to http://www.hhs.gov/ocr/hipaa/ or call (866) 627-7748.

By signing below, I certify that I have received and reviewed the WNY Medical, PC Patient Privacy Policy and all of my questions have been answered to my satisfaction in language that I can understand.

Patient's Signature

Patient's Name (Printed)

Date

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POLICY

Number: 0030	Title: Self-Pay Policy	Approved: Riffat Sadiq, M.D.
Applies to: All Patients Without Insurance, and All Employees		Prepared By: Debra Wills
Revision History: Rev 1, 09/01/2015: Original release (based on memo of 7/1/2010).		
Next Required Review Date: 12/01/2015		

1. **PURPOSE:** In reflection of our core values of Competence, Courtesy, and Compassion, this policy has been established to provide a standardized and fair way to assist patients who are without insurance coverage.

2. **DETAILED POLICY STATEMENT:** Since July 2010 it has been the policy of Western New York Medical, PC to assist patients who are without insurance coverage by offering a 30% discount if payment is made at the time of the visit. Payment is accepted by means of cash, check, or credit card.
    - If payment cannot be made on the same day, we cannot offer the discount but I will contact the Billing Dept. to establish a payment schedule and contract before I am seen by the doctor.
    - I am aware that I will be responsible for any additional charges for procedures done at the time of the visit. There is no courtesy offered for additional procedures. A statement will be sent in the mail for these additional charges. I will be responsible for PROMPT PAYMENT per financial policy.

3. **APPLICABILITY:** This policy applies to all patients who are without insurance coverage, and to all employees who assist them with application of this policy. If a patient is not able to pay in full at the time of the visit, the discount does NOT apply. In that case, the patient must contact our billing department to establish a financial contract to be signed and payment plan schedule to be in place before they come to the office.

4. **DEFINITIONS:** Self-Pay: Those individuals without commercial, HMO, or government health insurance (including Medicare/Medicaid).

5. **AUTHORITY:** This policy has been authorized by the President and Founder of WNY Medical, PC, Riffat Sadiq, M.D.

PATIENT SELF-PAY POLICY

I, _____, have read and reviewed the Self-Pay policy supplied to me by WNY Medical, PC staff, and agree to the terms. I understand that payment for listed services is due on the day of my appointment and will make payment prior to leaving the office.

I am aware if **payment is not** made on the day of service I will be held responsible for the full charge and that WNY Medical, PC will take all necessary action to recoup payment of any and all balances.

_____ _____

Patient Signature Date

_____ _____

Staff Name/Signature Date

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RECORDS RELEASE FORM

To: (Physician/Practice Name & Address)

_____

_____

_____

Re: _____ DOB: _____
(Patient's Name)

Please release _____ records for the above patient to:
(type of records)

WNY Medical, PC
Main Office
4979 Harlem Road, Suite 1
Amherst, NY 14226
Phone: (716) 923-4380
FAX: (716) 923-4384
http://www.wnymedical.com

_____
Patient's preferred provider at WNY Medical, PC

This disclosure is being made at the request of the patient, their authorized health care proxy, or their legal representative.

I understand that if the person or entity that receives this information is not a healthcare provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA regulations.

This authorization expires one (1) year after the date of the signature below.

I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal request, I must contact WNY Medical, PC. I am aware that my withdrawal will not be effective on any actions the requesting entity took before they received written notification of my withdrawal.

A photocopy of this authorization is to be considered as valid as the original.

_____ _____
Patient's Signature Date

_____ _____
Witness Date

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: **Date:**
Start Time:

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Choose an answer of Not at all, Several days, More than half the days, Nearly every day w/ pts.)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite--being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

(Healthcare professional : For interpretation of TOTAL, Please refer to accompanying scoring card.) **TOTAL:**

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10. If you choose any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

Depression Screening Result:
☐ Positive
☐ Negative

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Using PHQ-9 Diagnosis and Score for Initial Treatment Selection

A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (*little pleasure, feeling depressed*) indicating the symptom has been present more than half the time in the past two weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least "somewhat difficult".

When a depression diagnosis has been made, patient preferences should be considered, especially when choosing between treatment recommendations of antidepressant treatment and psychotherapy.

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation
5-9	Minimal Symptoms*	Support, educate to call if worse, return in 1 month
10-14	Minor depression + +	Support, watchful waiting
	Dysthymia*	Antidepressant or psychotherapy
	Major depression, *mild*	Antidepressant or psychotherapy
15-19	Major depression, *moderately severe*	Antidepressant or psychotherapy
≥ 20	Major depression, *severe*	Antidepressant and psychotherapy (especially if not improved on monotherapy)

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask, "*In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?*").

+ + If symptoms present ≥ one month or severe functional impairment, consider active treatment.

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ADVANCE DIRECTIVE DECLARATION

I, , being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of dying if I should be in terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment:

I DO	I DO NOT	
☐	☐	want cardiac resuscitation.
☐	☐	want mechanical respiration.
☐	☐	want feeding tube.
☐	☐	want other artificial or invasive form of nutrition (food).
☐	☐	want other artificial or invasive form of hydration (water).
☐	☐	want blood or blood products.
☐	☐	want any form of surgery.
☐	☐	want any invasive diagnostic tests.
☐	☐	want kidney dialysis.
☐	☐	want antibiotics.
☐	☐	want other:

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

Other Instructions:

I DO	I DO NOT	
☐	☐	want to donate my organs upon death.
☐	☐	want to designate a surrogate to make medical treatment decisions for me if I should be incompetent in a terminal condition or in a state of permanent unconsciousness. Surrogate (name and address): Substitute Surrogate (name and address):

I made this declaration on :

Your Signature:
Address:

The above named individual or a person on behalf of and at the direction of the individual knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's Signature:
Address:

Witness's Signature:
Address:

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CAGE Alcohol Questionnaire

A Screening Test for Alcohol Dependence

Patient Name: D.O.B.:
Date:

C. Have you ever felt you should **cut down** on your drinking?
- ☐ Yes
- ☐ No

A. Have people **annoyed** you by criticizing your drinking?
- ☐ Yes
- ☐ No

G. Have you ever felt bad or **guilty** about your drinking?
- ☐ Yes
- ☐ No

E. Have you ever had a drink first thing in the morning [an **eye opener** or **early morning drink**] to steady your nerves or get rid of a hangover?
- ☐ Yes
- ☐ No

Self-assessment tests and screening tools can be the key to identifying, understanding and getting support for alcohol abuse problems. They are not designed to provide a diagnosis. If you think you or someone you know may have an alcohol problem, please consult a physician for a full evaluation.

Goal of screening, therefore, is to determine whether a person should receive a more thorough evaluation.

The scoring is confidential and only for your eyes. The answers to the questions are scored 0 for "no" and 1 for "yes", with a total score of 2 or greater considered indicative of an alcohol or drug problem.

Total Score:

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Generalized Anxiety Disorder GAD-7

Patient Name: DOB:

Date of screening:

GAD-7 Screening Questions

During the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

Add Columns: ++ +

Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

WNY MEDICAL, PC

Competence. Compassion. Collaboration.

Scoring and Interpretation of Scores:

GAD-7 Anxiety Severity: This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21.

Scores of 5, 10, and 15 represent cut points for mild, moderate, and severe anxiety, respectively. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders - panic disorder, social anxiety disorder, and post-traumatic stress disorder. When screening for individual or any anxiety disorder, a recommended cut point for further evaluation is a score of 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for generalized anxiety disorder. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%), and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Interpreting Scores

5-9	mild anxiety
10-14	moderate anxiety [(1)]
15-21	severe anxiety

[(1)] When screening for individual or any anxiety disorder, a recommended cut point for further evaluation is a score of 10 or greater.

Source: Robert L. Spitzer, MD; Kurt Kroenke, MD; Janet B.W. Williams, DSW; Bernd Lowe, MD, PhD *A brief measure for assessing generalized anxiety disorder. The GAD-7,* Arch Intern Med. 2006; 166:1092-1097.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name: Date of Birth: Social Security Number:
Patient Address:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action had already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**
7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) to (insert date)

☐ Entire Medical record, including patient's histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, and records sent to you by other health care providers.

☐ Other:

Include: *(Indicate by Initialing)*
Alcohol/Drug Treatment
Mental Health Information
HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here I authorize to discuss my health information with my attorney, or governmental agency, listed here:

10. Reason for release of information:
☐ At request of individual
☐ Other:

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date:

Signature of patient or representative authorized by law

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filling out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.