Inspired Health Group
3671 Southwestern Blvd. Suite 101 & 213
Orchard Park, New York 14127

Office: 716-662-7008
Fax: 716-662-5226

Patient Intake Form

Name: ____ Preferred Name: ______________
First Middle Last

Address: ____
Street City Zip Code

Birth Date: __________________ SS#: __________________ Marital Status (Circle One): S M W D SEP DP

Home Phone #: __________________ Cell Phone #: __________________ Work Phone #: __________________

Preferred Method of Contact (Circle One): Home Work Cell All

Email Address: ____

Do you have a hearing impairment? (Circle One) Yes No Details: ______________________________________

Do you have a vision impairment? (Circle One) Yes No Details: ______________________________________

Race (Circle One): White Black/African American American Indian/Alaska Native Asian Native Hawaii/Pacific Islander

Other: ______________________________

Ethnicity (Circle One): Spanish/Hispanic Origin Not of Spanish/Hispanic Origin Unknown

Sex at birth (Circle One): Male Female Unknown

Sexual Orientation (Circle One): Heterosexual Homosexual Bisexual Queer Pansexual Asexual

Other: ______________________________

Gender Identity (Circle One): Male Female Transgender Male Transgender Female

Other: ____________________________________

Pronoun (Circle One): He She They We Other: ______________________________

Language (s) Spoken: Primary: ___________________________ Secondary: ___________________________

Pharmacy Name: ___________________________________ Phone Number: ___________________________

Pharmacy Address: ____

Patient Employer: ____

Employer Address: ____

Emergency Contact: ____________________ Emergency Contact Address: ______________________________

Emergency Contact Phone Number: Home: ________________ Cell: ________________ Work: ________________

Emergency Contact Relationship: ______________________________

Please continue on back ➔

Spouse Name: ____

Do you have a health care proxy? (Circle One) Yes No If yes, please provide the following information for the proxy.

Name: ___________________________________Address: ____

Phone Number: __________________________________Relationship: _________________________________

INSURANCE INFORMATION

Primary Insurance: ____

ID #: __________________________Group #: ____________________________Employer: ____________________

Subscriber Name: ______________________________________Social Security #: ___________________________

Subscriber Date of Birth: ___________________________Relationship to Subscriber: ______________________

Secondary Insurance: ____

ID #: ____________________Group #: ____________________________Employer: __________________________

Subscriber Name: ______________________________________Social Security #: ___________________________

Authorization for Medicare/Insurance Billing

I request that payment of authorized Medicare and/or other insurance company benefits be made payable to Inspired Health Group. I also authorize Inspired Health Group to release any medical information to the insurance carrier for the sole purpose of processing claims and/or determining benefits. All vaccines will be electronically uploaded into NYSIIS, unless verbally refused.

____

Signature of Patient or Responsible Party Date

PATIENT CONSENT FORM: OFFICE POLICY

Inspired Health Group is committed to providing you with the best possible care and would be happy to discuss our policy with you at any time. Your clear understanding of our Policies is important to our Professional Relationship. Please ask if you are unclear regarding our fees, financial responsibility and policies.

Cancelled, Rescheduled, and No Show Appointments:

Patients are required to notify our office at least **24 hours in advance** of an appointment to cancel or reschedule or it is considered a **NO SHOW**. If the patient is 15 minutes late or more, it is considered a **NO SHOW** and they will be required to reschedule and charged a **NO SHOW** fee. If the patient **NO SHOWS** for an appointment (1st) the patient will be billed a $25 fee. A subsequent (2nd) **NO SHOW** appointment in 12 months will be billed $50. A third **NO SHOW** appointment in 12 months will be billed $75 and the patient will be reviewed for release from our practice for failing to show for scheduled appointments.

Identification:

In the interest of protecting against identity theft, we require each patient to present a valid current insurance card and a valid picture ID. A copy of your ID will be scanned into your medical record for this purpose.

Pediatric Patients:

Children under 18 years of age must be accompanied by a parent or legal guardian, or with a designated family member or friend if consent has been previously signed and in the child's chart.

Payment Due at Time of Service:

Insurance **co-payments are to be made at EACH visit**. Failure to do so will result in an additional **$5** surcharge.

Our practice accepts cash, personal check, Discover, MasterCard, American Express and Visa. There is a service charge of **$15** for returned checks.

The office does offer patients with no insurance a flat fee of **$50** for an office visit **plus any additional charges** that may be incurred during the visit. These fees are due at the time of visit.

If you have a high deductible insurance policy, you are required to pay **$50** at the time of service for each appointment and we will bill you for the remaining balance. NO EXCEPTIONS.

Late payments:

Patients with an outstanding balance of 120 days or more may be discharged from the practice unless payment arrangements are made and honored. These accounts will be referred to a collection agency unless prior agreements are made with our billing department.

Patient Forms:

The patient will be required to pay a **$10 fee for any forms** that are required to be completed (i.e., disability, FMLA, etc.).

Worker's Compensation:

As of **July 1, 2017**, our office **NO LONGER** accepts worker's compensation cases. If you are seen for an illness or injury that is worker's compensation related, you will be responsible for payment of services, as these charges cannot be billed to your insurance.

Insurance Participation and Financial Responsibility:

It is the patient's responsibility to be aware of their insurance coverage, policy provisions, authorization requirements as well as network providers, if applicable. Insurance information must be given to us at time of service or within 15 days of the date of service, as we only have a certain time frame to submit a claim to your insurance on your behalf. We will bill insurance companies as a courtesy to you. If we have not received payment from an insurance company within 60 days of the date of service, you will be expected to pay the balance. We provide you with all necessary information to submit your claim to your insurance company. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payment, secondary or tertiary insurances, co-insurance, covered charges etc. other than to supply them with necessary actual information.

Custodial Parent Responsibilities:

The custodial parent is responsible for payments at time of service whether the child has insurance or not. The office will not get involved with % breakdowns such as one parent being responsible for 20% and the other parent 80%. It is the parent's responsibility to work out an agreement for payment in full at the time of service.

After Hours:

We provide our own after-hours coverage. The providers are available on call after hours and on weekends and holidays for emergencies and urgent medical matters. By calling our office number, our answering service will contact the provider on call. Be sure to disable your call blocking. Please call the office during normal business hours for non-emergency matters.

Emergency Closing:

We notify our answering service when extreme bad weather or other emergency situations force closure of our office. If possible, we will also notify the local media (Channels 2, 4, 7 and will post on our website at www.IHGWNY.com) if there is a weather emergency that prohibits us from having normal business hours.

Assignment of Benefits and Consent for Treatment:

I hereby assign all medical benefits to include Major Medical benefits to which I am entitled, including Medicare, private insurance, and any other plan to Inspired Health Group. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize my physician to perform any medical treatment as deemed necessary.

Sharing Your Health Information:

We participate in CIPA Western New York IPA, Inc. dba Catholic Medical Partners (CMP) which is an Independent Practice Association. These are NYS regulated organizations created to coordinate your care and to reduce unnecessary or duplicate medical procedures or tests. By signing this form, you allow us to share your health information with and receive information from this organization and share with and receive such information from other health care providers who are participating in this organization, in order to coordinate your care. A list of those participating providers and further information can be found at www.catholicmedicalpartners.org. Note that the health information you are allowing us to share may include alcohol and drug treatment information, HIV/AIDS information, mental health conditions, and/or information about sexually transmitted diseases.

I have read the above Policies and Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that, unless I maintain the agreed upon payment agreement, my account may be turned over to a collection agency. If my balance should go to collections, I am aware that I will incur an added fee of up to $50.00 to cover the collection company's fee.

I have read and understand Inspired Health Group Office and Financial Policies.

Signature:____ Date: ___________________

Patient Authorization for Use and Disclosure of Protected Health Information to Inspired Health Group from Another Practice

Memo To:

____

Phone: ____________________

(Name of Doctor, Practice, Hospital, Clinic or other Health Care Provider) Fax: ______________________

____

(Address City, State, Zip)

Memo From:

____

(Name of Patient Information is being Requested For/ Date of Birth)

____

(Address City, State, Zip)

My doctor has provided this HIPAA compliant request/authorization form in order to assist me in requesting you to forward copies of my record:

By signing this authorization, I request and authorize you to release certain protected health information (PHI) about me to:

Inspired Health Group **Phone: 716-662-7008** **Fax: 716-662-5226**
3671 Southwestern Blvd., Suite 101
Orchard Park, New York 14127

This authorization permits you to use and /or disclose the following individually identifiable health information about me (specifically describe the information to be released, such as date (s) of services, type of services, level of detail to be released, origin of information, etc.):

All recent progress notes, diagnostics and immunization records.

The following information will not be released unless specifically requested by initialing the item:

______Chemical Dependency records (records relating to alcohol or substance abuse)

______Mental health records (including any care for anxiety or depression)

______HIV related information (signed NYS form 2557 required)

- The information will be used or disclosed for the following purpose: Further medical care.
- This authorization will expire in 90 days. This disclosure can be revoked at your request.
- When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer at the address listed above.

Signed by: ______________________________ ______________________________

Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________________

Patient's Name Date

______________________________ ______________________________

Print Name of Patient or Legal Guardian Date of Birth

Health Care Proxy

(1) I, ______________________________

hereby appoint ______________________________
(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint ______________________________
(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

____

____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

____

____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name ____

Your Signature ____________________________ Date ______________

Your Address ____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

- ☐ Any needed organs and/or tissues
- ☐ The following organs and/or tissues ____________________________

____

- ☐ Limitations ____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature ____________________________ Date ______________

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

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

Date ______________________

Name *(print)* ____

Signature ____

Address ____

____

Witness 2

Date ______________________

Name *(print)* ____

Signature ____

Address ____

____

Department of Health

Patient Health Questionnaire (PHQ-9)

Patient Name: ______________________________ **Date:** ______________

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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 ☐

Weisfogel Sleep Disorder Assessment

Your physician requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a sleep test. The sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date: ___________Name: ______________________________________ Date of Birth__________

Phone Number __________________Physician Name: ____________________________________

1. Have you ever been given a CPAP device?..Yes ___ No___
2. If you have been given any form of CPAP, do you use it nightly?.........Yes ___ No___
3. Are you comfortable with your CPAP and satisfied with its use?.......... Yes___ No___

If the answer is "Yes" to all three questions, YOU ARE DONE!

If your answer is **"No"** to any of the above questions, please continue to ***Part 1***.

Part 1 Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale:
0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more. ……... 0 1 2 3
2. Sitting and talking to someone…………………………………… 0 1 2 3
3. Sitting and reading……………………………………………….. 0 1 2 3
4. Watching TV……………………………………………………... 0 1 2 3
5. Sitting inactive in a public place…………………………………. 0 1 2 3
6. Lying down to rest in the afternoon…………………………….... 0 1 2 3
7. Sitting quietly after lunch without alcohol……………………….. 0 1 2 3
8. In a car, while stopped for a few minutes in traffic………………. 0 1 2 3

Total ESS: _____

Part 2

1. Have you been told that you snore? .... Yes___ No___
2. Does your family have a history of premature death in sleep? .... Yes___ No___
3. Do you have diabetes?..Yes___ No___
4. Have you ever been told you have coronary artery disease? .... Yes___ No___
5. Do you have high blood pressure? .... Yes___ No___
6. Have you ever experienced irregular heart rhythms?...................... Yes___ No___

Part 3

1. Have you ever been diagnosed with sleep apnea? .... Yes___ No___
2. Do you awaken from sleep with chest pain or shortness of breath? Yes___ No___
3. Has anyone said that you seem to stop breathing while sleeping? .. Yes___ No___
4. Is your neck size larger than 15" (female) or 16.5'' (male)…...........Yes___ No___
5. Have you ever had a stroke? ....Yes___ No___
6. Have you ever been told you have congestive heart failure? .... Yes___ No___
7. Do you have or did you ever have atrial fibrillation?........................Yes___ No___

Actual Neck Size:

NAME ____DATE _______________

CAGE Questionnaire

If you do not drink or use drugs answer no to all questions.

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?

☐ **Yes** ☐ **No**

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?

☐ **Yes** ☐ **No**

3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?

☐ **Yes** ☐ **No**

4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

☐ **Yes** ☐ **No**

General Anxiety Disorder (GAD-7)

NAME DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, 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?	☐ 0	☐ 1	☐ 2	☐ 3

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.