Inspired Health Group
3671 Southwestern Blvd. Suite 101, 110 & 213
Orchard Park, New York 14127
Office: 716-662-7008 Fax: 716-662-5226

Name: _____
First Middle Last

Address: _____
Street City Zip

Birth Date: _____ SS#: _____ Marital Status: 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? Yes No Details: _____ Do you have a vision impairment? Yes No Details: _____

Race: White Black/African American American Indian/Alaska Native Asian Native Hawaii/Pacific Islander Other

Ethnicity: Spanish/Hispanic Origin Not of Spanish/Hispanic Origin Unknown

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: _____

Spouse Name: _____

Do you have a health care proxy? 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 for 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

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

Total ESS: 0

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.

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

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 _____

_____

NEW YORK STATE | Department of Health

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 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: _____