Patient Name: _____ DOB: _____ Date: ___/___/_____

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals: _____ + _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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

Form completed by:
☐ Patient
☐ Provider
☐ Other Staff: _____
(Name)

Reviewed by: _____
(Provider Signature)

Revised 4.11.17

COMMUNITY CARE PHYSICIANS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Full Name | **Patient's Date of Birth**

By signing this authorization, I authorize Community Care Physicians to use and/or disclose certain protected health information (PHI) about me to:

1. Please list other medical providers, family, friends, etc. who, with your permission, may receive your medical information. →

Person or Entity to Receive the Information

_____

_____

_____

2. Specific Information to be Released:

☐ Option 1: Entire medical record from (insert date) _____ to (insert date) _____ (If not specified, all dates.)
PLEASE NOTE: ***This includes any and all HIV-related information, drug and alcohol treatment, and mental health information. If you do not wish to have this information disclosed, please indicate below:***

Do NOT Include: ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

☐ Option 2: Include only:
☐ Prescriptions ☐ Office Notes ☐ Lab Results
☐ Billing ☐ Other (Please be specific): _____

Do NOT Include: ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

3. Please Initial:

_____ I understand that this authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV- RELATED INFORMATION** unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

4. The Reason for Release of Information: ☐ At request of individual ☐ Other: _____

5. Expiration Date: This authorization will expire on _____
{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.

I understand that Community Care Physicians will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Community Care Physicians. In fact, I have the right to refuse to sign this authorization. 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 the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

_____ _____

Print Name of Patient or Legal Guardian *Signature of Patient or Legal Guardian*

Date: _____ *Relationship to Patient*: _____

Patient Information Update

Patient Name:_____DOB:_____

Today's Date:_____

Do you have any New Workers Compensation/ No Fault claims? Yes or No
If Yes, please Inform the Front Desk Staff and fill out a Information sheet for billing purposes.

Since your last visit to our office, were you admitted to the hospital? Yes or No

If Yes, please write where and when:_____

Since your last visit to our office, have you had any medical tests? Yes or No

If Yes, please circle all that apply: Mammogram (breast X-ray) PAP Smear (Women) Colonoscopy
DEXA (Bone loss/Osteoporosis) Blood Work X-rays ECG/EKG (heart) Vision MRI
CT ("Cat" Scan) Other:_____

List where and when you had the tests done:_____

Since your last visit to our office, have you started any new prescribed medications? Yes or No

*If Yes, list*_____

Do you currently have any Advanced Care Directives? Yes or No

If Yes, Please Circle and bring in a copy if needed: Health Care Proxy Living Will POA (Power of Attorney)
MOLST (Medical Order for Life Sustaining Treatment (Pink form) DNR ***If No, are you interested in information on any of the above?_____***

Do you or have you seen any of the following Specialist? Yes or No

If yes, Please Write the name of the Provider(s).

Allergist_____ Cardiologist_____

Endocrinologist_____ ENT(Ear, Nose, Throat)_____

Gastroenterologist_____ Nephrologist_____

Neurologist_____ OB/GYN_____

Oncologist_____ Ophthalmologist (EYE)_____

Orthopedist _____ Podiatrist_____

Pulmonologist_____ Rheumatologist_____

Urologist_____ Other_____

COMMUNITY CARE PHYSICIANS, P.C.

Burnt Hills Internal Medicine and Pediatrics
1184 Route 50
Ballston Lake, NY 12019
(518) 384-1281

Date:

Patient DOB:

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		YES / NO
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	Y N
$	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Are you **afraid you might be hurt** in your apartment building or house?	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N