ANGELA SHEEHAN NPP-BC, PLLC

516 WASHINGTON AVE., RENSSELAER, NY 12144

63 FRANKLIN ST., SARATOGA SPRINGS, NY 12866

NEW PATIENT INFORMATION

DATE: ______________________

NAME: ____ DOB: ____________________________ M __ F __

ADDRESS: ____

____

CITY STATE ZIP CODE

HOME PH: ______________________ CELL: ______________________ EMAIL: ______________________

EMERGENCY CONTACT INFO: ____

PRIMARY CARE PHYSICIAN NAME & PHONE: ____

PHARMACY NAME, ZIP CODE & PHONE: ____

INSURANCE INFORMATION

PRIMARY INS. CO: ____________________________ ID: ____________________________

GROUP: ________________________ PRIMARY SUBCRIBER: ____________________________

SUBSCRIBER'S DOB: ____________________________ RELATIONSHIP TO PT. ______________________

PRESCRIPTION INSURANCE PROVIDER IF DIFFERENT FROM PRIMARY INSURANCE (i.e. Caremark, Express Scripts,

SilverScripts) NAME: ____________________________ ID NO: ____________________________

SECONDARY INS: __________________________ ID# ________________________ GRP: ______________

I authorize payment of insurance benefits to Angela Sheehan, NPP-BC PLLC. I authorize release of any medical or other information necessary to process claims. I give permission to Angela Sheehan, NPP-BC to contact my primary provider if necessary.

SIGNATURE:______________________________________DATE:________________________________

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ANGELA SHEEHAN, NPP-BC, PLLC.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I understand and have been provided with the Notice of Privacy Policy that is a complete description of how Angela Sheehan, NPP-BC may use and disclose my protected health care information. I further understand that Angela Sheehan NPP-BC reserves the right to change the Privacy Policy. Should this occur an amended copy will be posted in a prominent location in the office or upon my request, the amended copy will be sent to the address I have provided.

I agree that Angela Sheehan, NPP-BC may do the following unless I specifically give direction prohibiting such activity:

- Send routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine or voice mail associated with the telephone numbers I have provided to either confirm appointments or to request that I call Angela Sheehan, NPP-BC on medical or billing matters.

I agree that Angela Sheehan, NPP-BC may share billing information with my spouse and/or the person holding the insurance to secure payment.

PRINT NAME: ______________________________

SIGNATURE: ______________________________________

DATE: ______________________

ANGELA SHEEHAN, NPP-BC PLLC

CONTROLLED MEDICATION AGREEMENT

NAME: ______________________________ DOB: ______________________

The purpose of this agreement is to prevent misunderstanding about controlled medications that you may be taking, as well as to help you and me (your Clinician) to comply with established laws for controlled or scheduled medicines. This agreement is essential to the trust and confidence necessary in a therapeutic Clinician/Patient relationship.

- I understand if I break the Agreement, my prescribing Clinician will stop prescribing the controlled medication. In this case, the medication will be tapered off over several days if clinically necessary to avoid discontinuation syndrome. A drug dependence treatment program may be recommended in some cases.
- I will communicate fully and truthfully with my Prescribing Clinician about the nature of my symptoms and how well the medication is working. I will truthfully and fully communicate how I am taking the medicine.
- I agree I will use my medication at a rate no greater than the prescribed rate unless discussed with my prescriber.
- I will not share, sell or trade my medication with anyone including family members.
- I will not attempt to obtain any controlled medications prescribed by this provider from any other Clinician. If an acute situation pertaining to my medication arises that requires Emergency Room visit, I will notify my Clinician.
- It is my responsibility to safeguard my medication from loss or theft. Lost or stolen medication will not be replaced until the scheduled renewal date.
- I agree that refills of my prescriptions for controlled medications will be made at the time of an office visit or at the discretion of the Prescriber.
- I understand there is a $25 charge for controlled medications prescriptions given outside of scheduled appointment times.
- I authorize the Clinician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or other diversion of controlled medication.
- I am aware that HIPPA privacy regulations do not apply for any DEA (Drug Enforcement Agency) investigation. This includes required participation in the I-STOP program by my prescriber.

______________________________ ______________________________

PATIENT SIGNATURE CLINICIAN SIGNATURE

DATE______________________ DATE______________________

ANGELA SHEEHAN, NPP-BC

SIGNATURE ON FILE FOR HEALTH INSURANCE AND OFFICE POLICIES

I agree to pay in a current manner any charges not covered by payments made directly to Angela Sheehan, NPP-BC by my insurance company(s). These charges may include copayments and/or deductibles.

I authorize the release of any clinical information necessary to process insurance claims, including and periodic treatment reviews required by the insurer or managed care company.

I authorize the release of this information to my PCP if required by my insurance company or managed care company.

I agree to be responsible for obtaining authorization from my insurance company if required. I agree to pay in full in a timely manner for visits not paid by my insurance company.

I understand that if I do not present my insurance coverage on the date of service, I will be responsible for any charges incurred during my visit on that date of service. I understand that Angela Sheehan, NPP-BC does not call to confirm insurance coverage and that any charges not covered by my insurance are my responsibility. These and all charges are expected to be paid in a timely manner or they will be sent to collection.

I agree to pay $75.00 if I do not cancel a scheduled appointment by 2:00pm on the day prior to that scheduled appointment. Canceled Monday appointments must be made by 2:00pm on the Friday prior to scheduled appointment. We agree to waive the charge if appointment is missed because of an emergency, illness or adverse weather.

I understand there is a fee of $25.00 charged for calling in refill requests of controlled substances outside of appointment times. This fee is expected to be paid in a timely manner and is subject to go to collections if not done so.

I understand that Angela Sheehan, NPP-BC reserves the right to terminate the patient-provider relationship if there are an excessive number of appointment cancellations and three (3) no show appointments. Ms. Sheehan will deem what amount is excessive.

PRINT NAME: ______________________________

SIGNATURE: ___________________________ DATE: _________________________

ANGELA SHEEHAN, NPP-BC

PERMISSION GRANTED FOR ELECTRONIC PRESCRIPTIONS

- I understand that prescriptions are required by New York State to be done electronically.
- I understand that, because of the law in New York State, that all New York State based prescriptions must be prescribed electronically for me to receive medication from pharmacies located in New York State.
- I understand that Angela Sheehan, NPP-BC may be able to see prescriptions written by prescribers from other practices.
- I give permission to Angela Sheehan, NPP-BC to prescribe electronically for me if and when a prescription is written for me.

PRINT NAME ______________________________________

SIGNATURE________________________________DATE_______________

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

	Never	Rarely	Sometimes	Often	Very Often
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:____________

Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	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 or 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 are 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 figety 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	0	1	2	3
	add columns		+	+

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

10. 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	______

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Mood Disorder Questionnaire

Patient Name ______________________ Date of Visit ____________

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

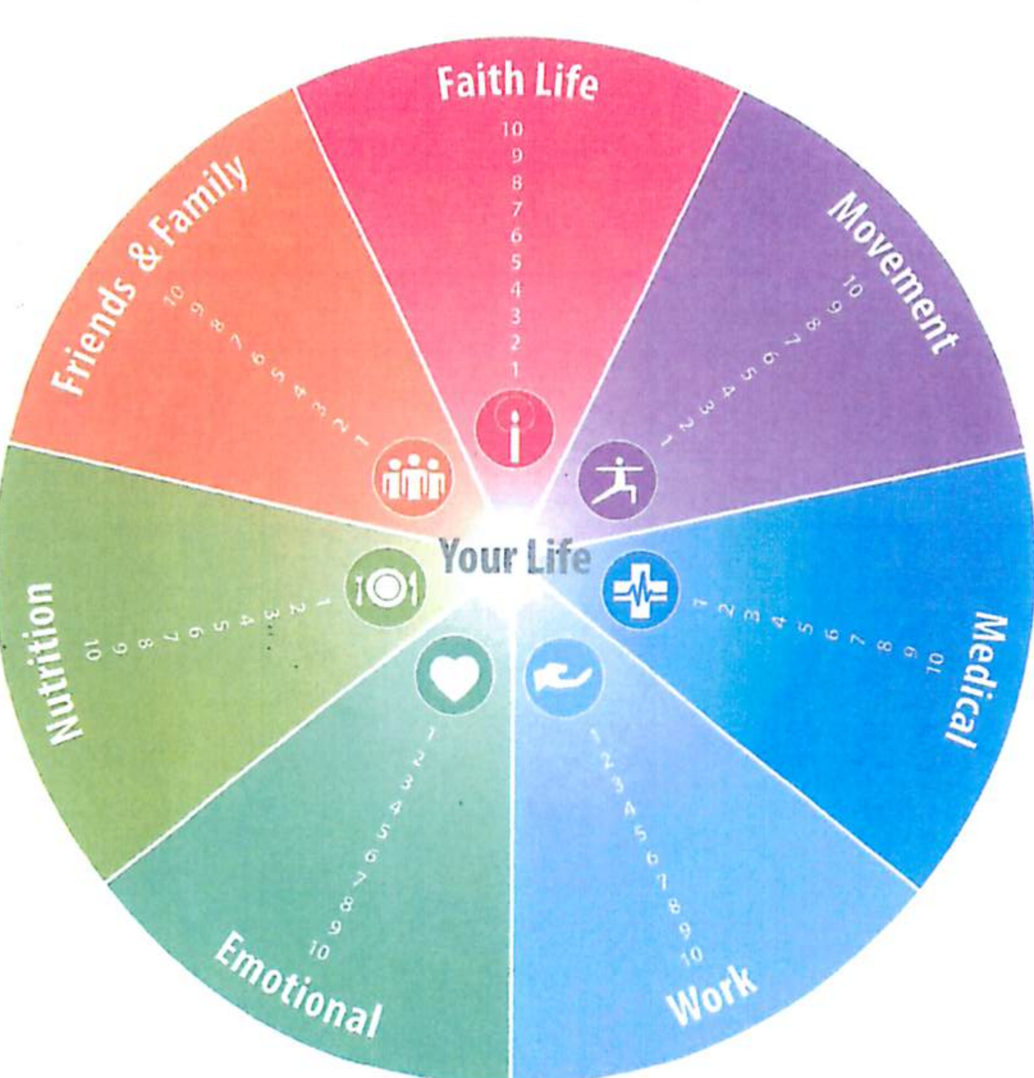
☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

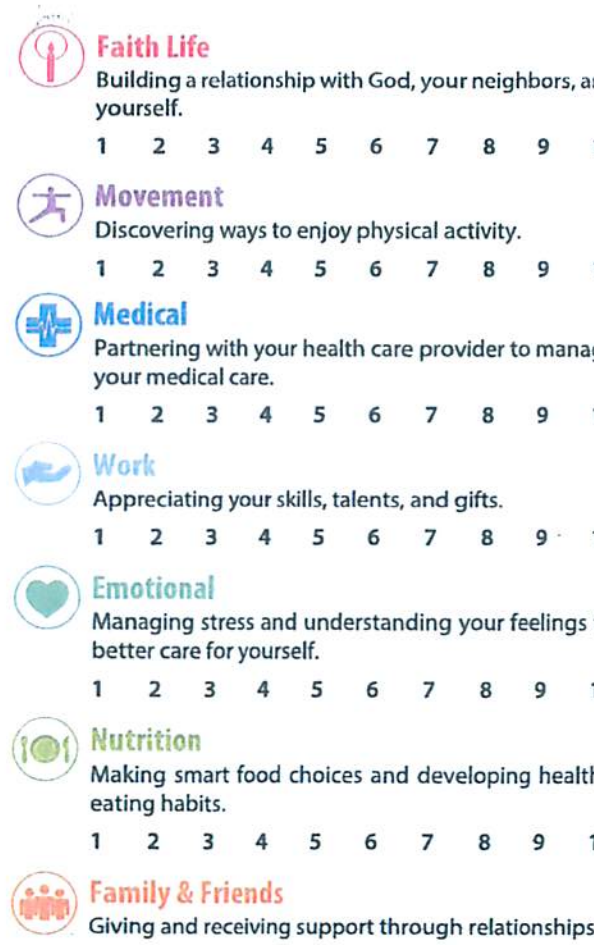
This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

Model for Healthy Living

Assessment Wheel

Circle the number on the wheel that best describes your satisfaction in each of these areas in your life or the life of your church (1- unsatisfied, 10- completely satisfied). Connect the circles. What areas would you like to improve?





Faith Life
Building a relationship with God, your neighbors, and yourself.
1 2 3 4 5 6 7 8 9 10

Movement
Discovering ways to enjoy physical activity.
1 2 3 4 5 6 7 8 9 10

Medical
Partnering with your health care provider to manage your medical care.
1 2 3 4 5 6 7 8 9 10

Work
Appreciating your skills, talents, and gifts.
1 2 3 4 5 6 7 8 9 10

Emotional
Managing stress and understanding your feelings to better care for yourself.
1 2 3 4 5 6 7 8 9 10

Nutrition
Making smart food choices and developing healthy eating habits.
1 2 3 4 5 6 7 8 9 10

Family & Friends
Giving and receiving support through relationships.
1 2 3 4 5 6 7 8 9 10