

Faculty Group Practice Patient Demographic Form

Patient Information	Name (Last, First, MI)			Email address		
	Street Address			City		State
	Home Phone ()		Preferred <input type="checkbox"/>	Work Phone ()		Preferred <input type="checkbox"/>
	Cell Phone ()		Preferred <input type="checkbox"/>			
	SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Other	
Race	Ethnicity		Preferred Language		Country of Origin	
Financially Responsible Party	Is patient responsible party/guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)					
	Name		Address		City/State/Zip	Relationship to Patient
	Occupation	Employer		Email Address		Date of Birth
	Home Phone ()		Preferred <input type="checkbox"/>	Work Phone ()		Preferred <input type="checkbox"/>
Cell Phone ()		Preferred <input type="checkbox"/>				
Emergency Contact	Name			Relationship to Patient		
	Home Phone ()		Preferred <input type="checkbox"/>	Work Phone ()		Preferred <input type="checkbox"/>
Cell Phone ()		Preferred <input type="checkbox"/>				
Referral Info	Referring Physician's Name			Physician Phone/Fax (if known) ()		
	Physician Address					
PCP Info	Primary Care Physician's Name (Check if same as Referring Physician above <input type="checkbox"/>)			Physician Phone/Fax (if known) ()		
	Physician Address					
Insurance Information	Primary Insurance Company		Policy #		Group #	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber		Work Phone ()
	Secondary Insurance Company		Policy #		Group #	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber		Work Phone ()
By signing below, I acknowledge that the information I provided is correct to the best of my ability.						
Patient Signature: _____				Date: ____ / ____ / ____		
Guarantor Signature (if other than patient): _____				Date: ____ / ____ / ____		



FACULTY GROUP PRACTICE FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

I understand that NYU School of Medicine, my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

- **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYU School of Medicine. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.
- **FINANCIAL LIABILITY:** I have been provided a copy of the NYU School of Medicine financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYU School of Medicine for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:
 - My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at NYU School of Medicine and I have not obtained such a referral or I receive services in excess of the referral, and/or
 - My health plan determines that the services I receive at NYU School of Medicine are not medically necessary and/or not covered by my Insurance plan, and/or
 - My health plan coverage has lapsed or expired at the time I receive services at NYU School of Medicine, and/or
 - I have chosen not to use my health plan coverage, and/or
 - The physician I see does not participate with my health care plan.
- **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient's Medicare Number _____ Patient Signature _____

- **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYU School of Medicine; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor.
- **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

I have been provided the Faculty Group Practice Patient Financial Polices. I understand the information listed above which has been fully explained to me.

Patient Signature

Date

Guarantor Signature

Date



Summary of Faculty Group Practice Financial Policies

Thank you for choosing NYU Langone Medical Center for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible.

Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, and any requirements for specific physicians, labs and/or hospitals to use. You should be knowledgeable of any deductibles, copayments, and/or coinsurance. This applies to all payors regardless of whether or not our physicians participate.

If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees, and coverage limits.

PLEASE KEEP THESE POLICIES FOR FUTURE REFERENCE

Insurance Coverage

Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records.

Please be aware of and provide any required referrals or authorizations in advance of the appointment or service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.

Our doctors belong to many insurance plans but participation differs by doctor. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care. We will help you find out if you have out-of-network benefits and submit a claim to your plan on your behalf. Refer to our out-of-network policy below for more details.

Please let us know at any time if you do not want us to submit a claim to your plan.

Address Change

It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

Co-payments/Co-insurances/Deductibles

You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service.

Other Bills

You may receive services at NYU Langone Medical Center such as anesthesia, radiology testing, pathology, or other services. These doctors provide vital services and are involved in your care even though they may not be present at the time and you may not see them face-to-face. There may be additional charges for these services.

In addition, you may receive in-patient or out-patient hospital care at NYU Langone Medical Center. If so, you will receive a hospital bill for those services. Hospital bills are separate from our doctor services. If you have questions, you may contact the hospital billing office at (800) 237-6977.



Payments

Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card (*American Express, MasterCard, Visa and Discover*). Returned checks are subject to a fee of \$20.00. We do not accept traveler's checks.

Non-Medical Fees

Additional fees may apply to the following:

- Returned Checks
- Copying of medical records
- Completion of disability or other forms

Missed Appointments

Generally, NYU FGP requires a 24 hour (1 business day) cancellation notice for most office visits. Procedures and surgeries may require 48 hours (2 business days) or more. Please note that weekends and holidays are not considered business days. If you miss your appointment, or do not cancel with the required notice, additional fees may apply:

- Office Visit: \$50
- New Patient Visit: \$75
- Second Office Visit \$75
- Procedure/Surgery Per Dept Policy

Out-of Network Providers

If the doctor is not in your insurance plan, the following apply:

- Full payment is due at the time of service for routine visits.
- Payment expected on the date of service may be an estimate of your total charges.
- You will be quoted an estimated fee before services/procedures are performed.
- A deposit is required prior to the date of service for elective surgeries and procedures.
- After your appointment, we will submit a claim to your plan for services performed.
- Even if you have out-of-network benefits, you are ultimately responsible for the full fee charged.
- Depending on your plan, payment may be sent to you. If you receive this payment, you must reimburse NYU Faculty Group Practice immediately.

Non-Covered Services

Medicare Patients. Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Non-Medicare Patients. Any service not covered by your plan are your responsibility and must be paid in full at the time of service or upon receiving a bill.

Refunds

A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our billing office at (877) 648-2964.

Failure to Pay

If you do not pay your bill, your account may be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

Policy and Fee Changes

These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

We know medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask any of our Managers for more details or call the billing office at the number listed on your billing statement.



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). In this notice I was advised of how health information about me may be used and disclosed by NYU Langone Medical Center, which includes both NYU Hospitals Center and NYU Faculty Group Practice and their staff. I was also told how I may obtain a copy of this information and correct errors in my health information.

Print Name of Patient

Signature of Patient (or Financially Responsible Party)

Relationship to Patient

Date



NYU Langone Medical Center

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Follows the Privacy Practices in this Notice?

All employees, medical and dental staff, trainees, students, volunteers, and agents of NYU Langone Medical Center must follow these practices. This includes NYU Hospitals Center, the NYU School of Medicine, and our Faculty Group Practices.

Our Commitment to Your Privacy

NYU Langone Medical Center ("NYULMC") is committed to maintaining the privacy of your health information in all formats (electronic, paper or verbally). We keep your health information in a secure (safe) electronic health record. We will only use or disclose (share) your health information as described in this notice.

How We May Use and Share Your Health Information with Others?

We may use and share your health information for treatment, payment, and health care operation purposes.

- We may use and share your health information with other health care providers who are treating you or with a pharmacy that is filling your prescription;
- We may use and share your health information with your health insurance plan to get pre-approval for your treatment or to collect payment for health care services; or
- We may use and share your health information to run our business, to evaluate practitioner or provider performance, or to educate health care professionals.

We may share your health information with business associates who are helping us collect payment for services or other business operations. All of our business associates are required to protect the privacy and security of your health information.

We may use and share your health information to contact you about health-related benefits and services or to fundraise for the benefit of NYULMC. You have the right not to receive fundraising communications and should email developmentoffice@nyumc.org or call 212-404-3640 or 1-800-422-4483 (toll free).

We may also use and disclose your health information for the following reasons:

- For public health activities (for example, to report injuries, diseases, births and deaths to a public health official authorized to receive such information);
- For workers' compensation or similar programs that provide benefits for work-related injuries;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if we reasonably believe that you have been a victim of such abuse, neglect, or domestic violence, we will make every effort to get your permission before sharing this information. However, in some cases we may be required or authorized to act without your permission;
- For oversight by government or private agencies that review health care organization's practices to ensure safety and quality activities;
- For monitoring products which may need repair or are being recalled (for example, to satisfy FDA requirements);
- For research studies where health records are analyzed (when it cannot be done through the normal authorization procedures) and approved by our institutional privacy board. This is done through a special process that makes sure that the research may only be a small risk to your privacy and that researchers keep your information confidential and secure; for preparing for

NYU Langone Medical Center

Notice of Privacy Practices

research, such writing a research proposal or recruiting possible subjects; or, in the unfortunate event of your death, for research solely on information about people who have died;

- To create and disclose de-identified (does not have your name, SS#, etc.) health information or limited data sets that do not have direct identifiers about you;
- For judicial and administrative proceedings (for example, a court order);
- For law enforcement purposes (for example, to identify or find a suspect or missing person, or to report a crime that occurred on or off our property);
- To coroners, medical examiners, or funeral directors as necessary to do their jobs;
- To organizations that handle organ, eye or tissue donation, or transplantation;
- To avoid a serious threat to health or public safety;
- For specialized government functions;
- Incidental uses and disclosures (for example, if a patient or staff member overhears a discussion in our Emergency Department even when reasonable steps were taken to keep your information confidential); and
- As otherwise required or allowed by local, state or federal law.

If you give us permission, we may use or share your health information for:

- Our patient directory;
- Members of our Chaplaincy Services Department, such as a priest or a rabbi;
- To family or friends involved in your care;
- Payment for your care;
- A disaster relief agency for purposes of notifying your family or friends where you are and what your status is in an emergency situation.

Uses and disclosures of your health information that involve psychotherapy notes, marketing, payments from a third party, or any other use or disclosure not described in this notice or required by law will only be made with your written authorization (permission). You have the right to withdraw (take back) your authorization, except when we have already relied on it, by contacting our privacy official provided below.

Additional privacy protections may apply if we are using or sharing sensitive health information, such as HIV-related information, mental health information, alcohol or drug abuse treatment information and genetic information. For example, under New York State Law, confidential HIV-related information can only be shared with persons allowed to have it by law, or persons you have allowed to have it by signing a specific authorization form.

What Rights do you have About Your Health Information?

Although your health record is the property of NYULMC, you have the right to:

- Request restrictions on how we use or share your information for treatment, payment, and health care operations, and how we may share it with your family and friends. We are not required to agree to your request, except when you pay for services out-of-pocket, in full and request us not to share the health information with your health insurance plan.
- Request confidential communications of your health information.
- Review and copy health information in your medical and billing records upon written request. If you request an electronic or paper copy of your health information, one will be provided to you within 3 to 10 days of your request. You may be charged no more than .75¢ per page for paper copies. For electronic copies, we may also charge you a reasonable fee for using electronic media.

This notice is effective as of 05/23/2013.

NYU Langone Medical Center

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- Request amendment (changes) to information in your medical and billing records. You must make your request to change, in writing and provide a reason for the request. We are not required to agree to your request, but will let you know in writing, and state a reason, when we do not agree. If we agree, your suggested amendment will be added to your record.
- Receive an accounting of disclosures. An “accounting of disclosures” is a report that identifies certain other people or organizations to which we have disclosed your health information without your authorization. (See the section on “We may also use and disclose your health information for the following reasons” for an explanation of who might be included.) You have a right to receive one accounting of disclosures every 12 months without charge; however, we may charge you for the cost of providing any additional accounting in the same 12-month period.
- Name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information of minors (children under 18 years old) unless the minors are permitted by law to act on their own behalf. There may also be exceptions to this per individual state law.
- Ask for and be given a paper copy of this notice.
- Request additional privacy protections with respect to your electronic medical record.

Requests must be made in writing to the privacy official or appropriate doctor’s office or hospital department. For more information or to get a designated request form, please contact the privacy official provided below.

What are Our Duties about Your Health Information and this Notice?

We are required by federal and state law to keep the privacy and security of health information that may tell your identity. If there is a breach of privacy that compromises your identifiable health information, we will notify you in writing or by email.

We are required to provide you with a copy of this notice and agree to the terms of this notice. We reserve the right to change the terms of this notice; the revised notice will be effective for all health information that we keep. We will post any revised notices on our public website at www.nyumc.org and in admitting or waiting room areas. You may also request a paper copy of the revised notice at the time of your next visit.

If you have any questions about this notice or believe your privacy rights have been violated, please contact us at:

Internal Audit, Compliance & Enterprise Risk Management
One Park Avenue, 3rd Floor, New York, NY 10016, Attention: Privacy Manager
212-263-8488 or 1-877-PHI-LOSS
compliance.help@nyumc.org

You may also contact the Secretary of the United States Department of Health and Human Services. We will not retaliate or take action against you for filing a complaint.

REQUEST FOR ACKNOWLEDGMENT

An acknowledgement form will be printed for you to sign during your registration process. By signing the Notice of Privacy Practices Acknowledgment Form, you are confirming that you have received a copy of this notice.



NYU Langone Medical Center Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I have received a copy of NYU Langone Medical Center's Notice of Privacy Practices.

By providing my email address, I consent (agree) to receiving notifications, including breach notifications, through the Medical Center's secure email messaging system.

Patient Name: _____

Personal Representative Name (if applicable): _____

Personal Representative's Authority (ex: parent, guardian, health care proxy): _____

Email Address: _____

Signature: _____ Date: _____

Effective as of 05/23/2013.

NYU LANGONE MEDICAL CENTER

**NYU Hospitals Center and NYU School of Medicine
Consent for Electronic Health
Information System**

I have received the NYU Langone Medical Center Electronic Health Information System Fact Sheet. It describes (1) the purpose of the NYU Langone Medical Center Electronic Health Information System; (2) how it works; and (3) how the providers participating in the NYU Langone Medical Center Electronic Health Information System will record and access my health information.

I acknowledge receipt of the Electronic Health Information System Fact Sheet. I have read and understand the Fact Sheet.

I also understand that by signing this form, I am agreeing to permit all NYULMC providers directly involved in my care to create, access, use and/or share my health information (including my electronic prescription records) for treatment, payment and healthcare operations and, to permit my health information to be available to my other health care providers, all as described in the attached Electronic Health Information Fact Sheet.

I also understand that there are other uses and disclosures of Protected Health Information that are permitted under applicable law and are outlined in the Notice of Privacy Practices.

I understand that this consent will remain in effect unless revoked in writing. Upon revocation, I understand that, except in an emergency, I can no longer be treated at NYU Langone Medical Center or by NYU providers who use the NYULMC EHR in their office practice.

Signature: _____ **Date:** _____ **Time:** _____ **AM/PM**

(Patient or person authorized to sign)

If the consenting party is other than the patient, print name and relation to patient:

NYU Langone Medical Center
ELECTRONIC HEALTH INFORMATION SYSTEM FACT SHEET

What is the NYU Langone Medical Center Electronic Health Information System?

The Hospitals, the Faculty Group practices and many of the individual physicians, physician practices and other providers that make up the NYU Langone Medical Center community and who are directly involved in your care are able to create, access and share your health and pharmacy records electronically.

What are the advantages to having an electronic health record?

Paper health records may be stored in separate locations and would be otherwise unavailable to us when needed. It is also more difficult to combine into a paper record information about care provided to you by different hospitals, physicians, laboratories, etc.

The electronic health record lets us see your records faster and helps us to keep more complete records of your medical history. This includes information about your allergies, medications, test results, or other past records, including health insurance coverage and billing and payment for services you received.

An electronic health record also helps us to better coordinate care because NYU Langone Medical Center hospital and healthcare professionals may share information from your health records with one another and with other providers (such as physicians not on staff at NYU Langone Medical Center hospitals, other hospitals, nursing homes, home health agencies, and pharmacies) if: (i) the provider that receives the information is a provider with whom you have a treatment relationship, and/or (ii) the information will be used for treatment, payment, continuity and coordination of care, discharge planning, billing, improving quality and effectiveness and reducing the cost of care, reviewing the qualifications of or training healthcare professionals, or addressing fraud and abuse issues.

Therefore, having a more complete record of your care and the ready access to it helps us to provide better care.

You will be asked to give your consent for your providers to create, access, use and/or share your medical records in the NYU Langone Medical Center Health Information System. You are entitled to a copy of the signed consent form. If you give this consent, but later change your mind, you can *revoke* (take back) your permission by contacting the NYU Langone Medical Center's Privacy Manager or the practice manager in your physician's office.

Which healthcare providers may participate in the Electronic Health information System?

The following providers are currently part of the NYU Langone Medical Center community:

NYU Hospitals Center, including:	Physicians at NYU Faculty Group Practice Offices
<ul style="list-style-type: none">• Tisch Hospital• Rusk Institute• NYU Hospital for Joint Diseases• NYU Clinical Cancer Center• NYU Ambulatory Care Center• Center for Musculoskeletal Care	Physicians in Private Practices with privileges at NYU Hospitals Center
	Physicians at Other NYUHC Outpatient Centers

Other healthcare providers not listed above may join in the future as the NYU Langone Medical Center community grows.

A special message about sensitive information.

Certain state and federal laws have stricter rules about keeping certain types of health information confidential. This includes:

- Information from facilities licensed by the NYS Office of Mental Health.
- Information from federally assisted alcohol and drug abuse programs.
- Information about certain healthcare services to minors, including family planning and abortion services, testing for HIV and sexually transmitted diseases (STD's), and mental health and substance abuse treatment.
- Genetic test results.
- Information about diagnoses, lab results or medications for HIV or AIDS.

The NYU Langone Medical Center Electronic Health Information System will include any of the above types of sensitive information that are a part of your medical record. By giving consent you are agreeing to the creation of, access to, and use and sharing of your medical information, including health information related to your treatment for mental health, developmental disabilities, HIV/AIDS testing and services, genetic testing and counseling services, drug and alcohol abuse, abortion, family planning, or sexually transmitted diseases, even if (a) such information was obtained prior to the date of the visit on which I sign the consent form or (b) I am tested, diagnosed or treated for the conditions to which my restricted information relates for the first time during that visit or a later visit while the consent is in effect ("restricted information"). Such access, use and sharing shall be by and between NYU Langone Medical Center hospitals and healthcare professionals for treatment, continuity and coordination of care, and billing for services provided.

Any NYU Langone Medical Center hospital and healthcare professionals may share your restricted information between and among one another and other providers if: (i) the provider that receives the information is a provider with whom you have a treatment relationship and (ii) the restricted information will be used for treatment, continuity and coordination of care, billing for services provided, or discharge planning.

Your restricted information may also be disclosed for “Health Care Operations” as described within the NYU Langone Medical Center hospitals’ Notice of Privacy Practices (such as reviewing and improving the quality, effectiveness and cost of care, reviewing the qualifications and training of healthcare professionals and addressing fraud and abuse issues.)

If you choose to have your private health insurance, Medicare, Medicaid, or other insurance or payment program pay for your treatment, any NYU Langone Medical Center hospital or healthcare professional may use and release your restricted information to the entity responsible for payment or their agent to obtain payment for the treatment and services provided to you by the NYU Langone Medical Center hospital or healthcare professional.

Is your health information kept private and confidential?

Yes. No one can guarantee that information in medical records will be totally free from access, use and disclosure other than in the ways you agree to in your consent. However, the Medical Center and every healthcare provider or staff member that shares or uses information through the NYU Langone Medical Center Health Information System must obey strict security and privacy rules that permit your health information to be used and shared only as more fully described in this Fact Sheet.

Penalties for Improper Access to or Use of Your Information.

There are penalties for inappropriate access or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call 212-404-4079, your doctor’s office or the NYS Department of Health at 877-690-2211.

Where can I get more information?

For more information or to ask questions, please contact:

NYU Langone Medical Center Privacy Manager One Park Avenue New York, New York 10016 212-404-4079	Call your physician’s office
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Patients' Bill of Rights

As a patient in a hospital in New York State, you have the right, consistent with law, to:

- (1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
- (2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.
- (3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- (4) Receive emergency care if you need it.
- (5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
- (6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
- (7) A no smoking room.
- (8) Receive complete information about your diagnosis, treatment and prognosis.
- (9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- (10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."
- (11) Refuse treatment and be told what effect this may have on your health.
- (12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
- (13) Privacy while in the hospital and confidentiality of all information and records regarding your care.
- (14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
- (15) Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
- (16) Receive an itemized bill and explanation of all charges.
- (17) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.
- (18) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
- (19) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

PRINT Practice Name Here

**HEALTH INFORMATION EXCHANGE,
CARE EVERYWHERE AND HEALTHIX
CONSENT FORM**

*Patient MRN/Patient ID:

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website <http://health-connect.med.nyu.edu/> ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at <http://www.healthix.org> or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

**YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE.
YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.**

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:
Please check Box 1 or 2:

- 1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of my electronic health information through the NYULMC HIE and I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.**
- 2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access my electronic health information through the NYULMC HIE or HEALTHIX for any purpose, even in a medical emergency.**

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

PRINT Name of Patient

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative
to Patient (if applicable)

Please Fax signed consents to: **917-829-2096**

NYULMC HIE, Care Everywhere and Healthix Fact Sheet

Details about patient information in the NYULMC HIE, Care Everywhere and Healthix and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used by the HIE Participants and Care Everywhere Providers only to:
- Provide you with medical treatment and related services.
 - Check whether you have health insurance and what it covers.
 - Evaluate and improve the quality of medical care provided to all patients.

Unless otherwise permitted by State and Federal law and if permitted by Healthix, your electronic health information shall be disclosed, accessed and used by NYULMC healthcare insurance plans only to:

- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care provided to you and all NYULMC patients and members.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included.** If you give consent, the HIE Participants and Care Everywhere Providers may access ALL of your electronic health information available through the NYULMC HIE and all employees, agents and members of the medical staff of NYU Hospitals Center may access ALL of your electronic health information available through Healthix. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

• Alcohol or drug use problems	• Mental health conditions
• Birth control and abortion (family planning)	• HIV/AIDS
• Genetic (inherited) diseases or tests	• Sexually transmitted diseases

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance (“Information Sources”). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current HIE Information Sources is available from NYU Hospitals Center or your HIE Participant health care provider, as applicable. You can obtain an updated list of Information Sources at any time by checking the NYULMC HIE website <http://health-connect.med.nyu.edu/>. **You can contact the NYULMC HIE Privacy Officer by writing to: NYU Langone Medical Center, Privacy Officer, One Park Ave, 10th Floor, New York, NY 10016 or calling: 212-263-8488. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at <http://www.healthix.org> or by calling Healthix at 877-695-4749.**

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the medical staff of an approved HIE Participant or Care Everywhere Provider who are involved in your medical care; health care providers who are covering or on call for an approved HIE Participant or Care Everywhere Provider’s doctors; designated staff involved in quality improvement or care management activities; and staff members of an approved HIE Participant or Care Everywhere Provider who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call one of the HIE Participants or Care Everywhere Providers you have approved to access your records; visit the NYULMC HIE website: <http://health-connect.med.nyu.edu/> or call the NYS Department of Health at 877-690-2211. If at any time you suspect that someone should not have seen or gotten access to information about you has done so through Healthix, call Healthix at: 877-695-4749; or visit Healthix’s website: <http://www.healthix.org>; or call the NYS Department of Health at 877-690-2211.

- 6. Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by an HIE Participant or Care Everywhere Provider to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through the NYULMC HIE and Healthix. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) predisposition genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The NYULMC HIE, Healthix and persons, including Care Everywhere Providers, who access this information through these health information exchanges must comply with these requirements.
- 7. Effective Period.** This Consent Form will remain in effect until the day you withdraw your consent or until such time the NYULMC HIE ceases operation, or until 50 years after your death, whichever is later.
- 8. Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to NYU Hospitals Center or one of the other HIE Participants, as applicable. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on the NYULMC HIE website <http://health-connect.med.nyu.edu/>. Once completed please fax to 917-829-2085 or submit to your provider.

Note: Organizations, including Care Everywhere Providers, that access your health information through the NYULMC HIE and/or Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.
- 9. Refusing to Check a Box (make a choice).** Unless you check the "I DENY CONSENT" box, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. If you do not make a choice, the records will not be shared except in an emergency as allowed by New York State Law.
- 10. Copy of Form.** You are entitled to get a copy of this Consent Form after you sign it.
- 11. Risks of Denying Consent.** If you deny consent for HIE Participants and Care Everywhere Providers to access your information through the NYULMC HIE and Healthix, your healthcare providers may not be able to access critical health information about you, obtained during a prior encounter, in a timely manner.



FACULTY GROUP PRACTICE LABORATORY BILLING INFORMATION

Thank you for choosing NYU Langone Medical Center Faculty Group Practice for your medical care. Any laboratory services or specimens provided by NYU are sent to the NYU Langone Medical Center outpatient laboratory for processing. The outpatient laboratory is a hospital service that is billed separately from your physician visit. The NYU Langone Medical Center laboratory participates with most insurance plans; however some plans have a specific laboratory facility preference. You should review your laboratory plan to understand your benefits as services provided may be subjected to hospital coinsurances and deductibles. It is your responsibility to understand your insurance plan benefits and to notify our staff or physicians of your preferred laboratory at each visit. Based on your request we will send your specimen to the laboratory your choice.

Should you have questions our practice staff will either answer your question or direct you to your insurance carrier.



Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.

****Note:** Controlled medications are not eligible for e-prescribing.

Please complete the information below if you are interested in e-prescribing.

Patient Name: _____

Preferred Pharmacy	
Name of Pharmacy:	_____
Address:	_____
City:	_____
State:	_____
Zip Code:	_____
Phone Number:	_____
Fax Number:	_____

Alternate Pharmacy	
Name of Pharmacy:	_____
Address:	_____
City:	_____
State:	_____
Zip Code:	_____
Phone Number:	_____
Fax Number:	_____

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to NYU laboratory.**

LabCorp	<input type="checkbox"/>
Quest Labs	<input type="checkbox"/>
NYU Lab	<input type="checkbox"/>
Other External Location	<input type="checkbox"/>

Please provide name of external location: _____



Dear patient,

In accordance with HIPPA regulations, we are taking your privacy very seriously. To help us better protect your confidential information, please list the name and relationship of all persons that you would allow us to release medical information to.

PATIENT NAME	
---------------------	--

Name of the person that you would allow us to release medical information to	Relationship	Telephone No.

Patient signature

Date

Patient phone # _____



NYU Parkinson's and Movement Disorders Center

New Patient Intake Questionnaire

Name: _____ Appointment Date: _____

Address: _____ Date of birth: _____ Age: _____

_____ Handedness: Right Left Ambidextrous

E-mail address: _____ Accompanied by: _____

Phone numbers: Home: () _____ Work / daytime: () _____

Fax: () _____ Mobile phone: () _____

Relative or other contact person:

Name: _____

Phone number: () _____

Another contact person:

Name: _____

Phone number: () _____

What is your preferred pharmacy?

Name/branch #: _____

Phone number: () _____

Address: _____

Who referred you to our center?

Name: _____

Phone number: () _____

Fax number: () _____

Address: _____

Type of Doctor (if relevant): _____

Who is your internist, general doctor, or primary care provider?

Name: _____

Phone number: () _____

Fax number: () _____

Address: _____

Type of Doctor (if relevant): _____

Current Medications, Vitamins, and Supplements:

Please list the medication **name, dose, and timing.**

Examples: Carbidopa-Levodopa 25/100 mg, 2 tablets 5 times daily at 8-12-2-4-8
Melatonin 3 mg tablets, 1 tablet every evening

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Past Medical and Surgical History:

What medical problems do you have (or have you had in the past)?
Please include hospitalizations.

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Please list all surgeries or accidents that you have had, and the dates.

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Allergies:

Are you allergic to any medications, foods, or contrast dye? Y N

What are you allergic to? What is your reaction? _____

Please fill in the table below for your **parents**:

Name	Current Age (or age at death)	Medical problems (and/or cause of death)	Alive (Y/N)?
Mother:			
Father:			

Please fill in the table below for your **brothers & sisters**:

Name	Sex	Current age (or age at death)	Medical problems (and/or cause of death)	Alive (Y/N)?
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			

Please fill in the table below for each of your **children**:

Name	Sex	Current age (or age at death)	Medical problems, learning disabilities, or developmental delay?	Alive (Y/N)?
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			

NYU Parkinson's and Movement Disorders Center

Activities of Daily Living Questionnaire

Choose the statement that best describes how you have been feeling, since your last visit, **because of your neurological problems.**

Please circle only **ONE ANSWER.**

1. **Do you ever have forgetfulness or loss of memory (e.g., difficulty remembering names, telephone numbers)?**

- 0 No. I do not have forgetfulness or loss of memory.
- 1 Yes. I have mild and consistent forgetfulness.
- 2 Yes. I have moderate memory loss. Sometimes I am disoriented and have difficulty handling complex problems.
- 3 Yes. I have severe memory loss. At times, I am not sure where I am or what day or time it is.
- 4 Yes. I have severe memory loss. I usually don't know where I am or what day or time it is. I can't be left alone.

2. **Do you have hallucinations? (A hallucination is when you see or hear something that is not really there).**

- 0 No. I do not have hallucinations.
- 1 No. I do not have hallucinations, but at night I frequently have vivid nightmares.
- 2 Yes. I have hallucinations, but when I have them, I realize that what is happening is not real and is only imaginary.
- 3 Yes. I have frequent hallucinations that interfere with my ability to function on a day-to-day basis.
- 4 Yes. I have so many hallucinations that I am unable to take care of myself.

3. Do you experience depression (e.g., feelings of sadness and hopelessness, tearfulness, poor appetite)?

- 0 No. I do not experience depression.
- 1 Yes. I have periods of sadness that are greater than normal, but I am never depressed for more than one week.
- 2 Yes. I have periods of sadness that are greater than normal; I am sometimes depressed for more than one week.
- 3 Yes. I have periods of depression where I have difficulty sleeping, loss of appetite or loss of interest in things. These periods last longer than one week.
- 4 Yes. I have constant depression with difficulty sleeping, loss of appetite or loss of interest. Sometimes I even have suicidal thoughts.

4. Do you have loss of motivation or interest?

- 0 No. I do not have loss of motivation or interest. I am not more passive than I used to be.
- 1 Yes. I am more passive than I used to be.
- 2 Yes. I have loss of interest in activities like going out or socializing with friends.
- 3 Yes. I have lost interest in even day-to-day activities like getting bathed, getting dressed and going to work.
- 4 Yes. I am withdrawn and have complete loss of interest in anything.

5. Have you noticed that your speech has changed or do you have problems speaking?

- 0 No. My speech has not changed.
- 1 Yes. My speech is mildly affected but I have no difficulty being understood.
- 2 Yes. My speech is mildly affected and I am sometimes asked to repeat myself.
- 3 Yes. My speech is severely affected and I am sometimes asked to repeat myself.
- 4 Yes. My speech is so severely affected that it is hard for others to understand me.

6. Have you noticed that you have too much saliva?

- 0 No. I do not have too much saliva and I never drool.
- 1 Yes. I have a slight excess of saliva. Sometimes I drool into my pillow at night.
- 2 Yes. I have moderately excessive saliva and I occasionally drool during the daytime.
- 3 Yes. I have markedly excessive saliva and I often drool during the daytime.
- 4 Yes. I have been drooling so much that I often carry a tissue or handkerchief.

7. Do you have problems swallowing or do you choke on your food?

- 0 No. I do not have problems swallowing and I do not choke.
- 1 Yes. I have problems with swallowing but I rarely choke.
- 2 Yes. I have problems with swallowing and I occasionally choke.
- 3 Yes. I have problems with swallowing and I have to eat soft food.
- 4 Yes. I am unable to swallow and must use an NG or gastrostomy tube to eat

8. Have you noticed a change in your handwriting?

- 0 No. I do not notice a change in my handwriting.
- 1 Yes. My handwriting is slightly slow or small.
- 2 Yes. My handwriting is moderately slow or small but all of the words are readable.
- 3 Yes. My handwriting is severely affected. Not all of the words are readable.
- 4 Yes. My handwriting is severely affected. Most of the words are readable.

9. Do you have slowness or difficulties using utensils or cutting your food?

- 0 No. I do not have slowness or difficulty cutting my food.
- 1 Yes. I am a little slow or clumsy, but I am able to feed myself without help.
- 2 Yes. I am slow or clumsy. I need help cutting some types of food.
- 3 Yes. Someone must cut my food, but I am still able to feed myself.
- 4 Yes. I am unable to feed myself. Someone else feeds me.

10. Do you have difficulties with dressing?

- 0 No. I do not have slowness or difficulty with dressing.
- 1 Yes. I am a little slow or clumsy, but I don't need any help.
- 2 Yes. I am slow and sometimes need help buttoning buttons, tying shoelaces or getting my arm into a sleeve.
- 3 Yes. I need a lot of help getting dressed but I can still do some things on my own.
- 4 Yes. I am unable to get dressed without assistance.

11. Have you slowed down or are you experiencing problems with bathing, brushing your teeth, combing your hair, or going to the bathroom?

- 0 No. I am not slow with these activities.
- 1 Yes. I am a little slow with these activities but I do not need help.
- 2 Yes. I am slow with these activities and I need help to shower/bathe.
- 3 Yes. I need help with washing, brushing my teeth, combing my hair and going to the bathroom.
- 4 Yes. I need help with all these activities and I have a Foley Catheter.

12. Do you have difficulty turning in bed or adjusting the sheets?

- 0 No. I do not have difficulties turning in bed or adjusting my sheets.
- 1 Yes. I am a little clumsy or slow with turning in bed and adjusting the sheets but I do not need any help.
- 2 Yes. I am only able to turn or adjust the sheets with great difficulty.
- 3 Yes. I am able to start turning but am unable to do it without help.
- 4 Yes. I am not able to turn in bed or adjust the sheets without help.

13. Do you have problems with falling?

- 0 No. I do not fall.
- 1 Yes. I rarely fall.
- 2 Yes. I occasionally fall but less than once per day.
- 3 Yes. I fall an average of once per day.
- 4 Yes. I fall an average of more than once per day.

14. Do you have freezing while you are walking? (Freezing is when you are unable to walk for a few seconds because your feet 'stutter' or seem stuck to the ground)

- 0 No. I do not have freezing.
- 1 Yes. I have been freezing when I walk but this rarely happens OR Yes. Sometimes when I first start to walk I have been freezing.
- 2 Yes. I occasionally have freezing when I walk.
- 3 Yes. I frequently have freezing when I walk. I occasionally fall because of the freezing.
- 4 Yes. I frequently have freezing when I walk. I frequently fall because of the freezing.

15. Has your walking changed? Is it difficult to walk?

- 0 No. My walking and my arm swing have not changed.
- 1 Yes. I do not swing my arms and I tend to drag my legs.
- 2 Yes. I have a moderate amount of difficulty with walking but usually don't need assistance.
- 3 Yes. I have severe problems with walking and usually need assistance.
- 4 Yes. I can't walk at all, even when someone tries to help me.

16. Do you have visible tremor anywhere in your body?

- 0 No. I do not have a visible tremor.
- 1 Yes. I have a slight visible tremor, which is infrequently present.
- 2 Yes. I have a moderate amount of tremor. The tremor bothers me.
- 3 Yes. I have a severe amount of tremor and it interferes with many activities.
- 4 Yes. I have a severe tremor and it interferes with most activities.

17. Do you have numbness, tingling, discomfort or aching that you would attribute to your Parkinson's disease (or other movement disorder)?

- 0 No. I do not have numbness, tingling, discomfort or aching that I attribute to my Parkinson's disease (or other movement disorder).
- 1 Yes. I do have occasional numbness, tingling, discomfort or aching that I attribute to my Parkinson's disease (or other movement disorder).
- 2 Yes. I frequently have numbness, tingling or aching that I attribute to my Parkinson's disease (or other movement disorder).
- 3 Yes. I frequently have painful sensations that I attribute to my Parkinson's disease (or other movement disorder).
- 4 Yes. I have excruciating pain that I attribute to my Parkinson's disease (or other movement disorder).

In the following table, please circle the number that fits you best.

How well do you perform chores and other daily activities such as preparing food, eating, dressing, washing, and using the toilet?

- 100%** = Completely independent. Able to do all chores without slowness, difficulty, or impairment. Essentially normal. Unaware of any difficulty.
- 90%** = Completely independent. Able to do all chores with some degree of slowness, difficulty, and impairment. Might take twice as long. Beginning to be aware of difficulty.
- 80%** = Completely independent in most chores. Takes twice as long. Conscious of difficulty and slowness.
- 70%** = Not completely independent. More difficulty with some chores. May take three to four times as long. Must spend a large part of the day with chores.
- 60%** = Some dependency. Can do most chores, but exceedingly slowly and with much effort. Errors are made, and some chores are impossible.
- 50%** = More dependent. Help needed with half of chores. Slower. Difficulty with everything.
- 40%** = Very dependent. Able to assist with chores, but can do few alone.
- 30%** = With effort, can occasionally do a few chores alone, or at least begin them alone. Much help is needed.
- 20%** = Can't do any chores alone. Can be a slight help with some chores. Severe invalid.
- 10%** = Totally dependent, helpless. Complete invalid.
- 0%** = Bedridden, with loss of control of swallowing, bowels, and/or bladder function.

PD NMS QUESTIONNAIRE

Name:

Date:

Age:

Centre ID:

Male

Female

NON-MOVEMENT PROBLEMS IN PARKINSON'S

The movement symptoms of Parkinson's are well known. However, other problems can sometimes occur as part of the condition or its treatment. It is important that the doctor knows about these, particularly if they are troublesome for you.

A range of problems is listed below. Please tick the box 'Yes' if you have experienced it **during the past month**. The doctor or nurse may ask you some questions to help decide. If you have **not** experienced the problem in the past month tick the 'No' box. You should answer 'No' even if you have had the problem in the past but not in the past month.

Have you experienced any of the following in the last month?

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Dribbling of saliva during the daytime | <input type="checkbox"/> | <input type="checkbox"/> | 16. Feeling sad, 'low' or 'blue' | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Loss or change in your ability to taste or smell | <input type="checkbox"/> | <input type="checkbox"/> | 17. Feeling anxious, frightened or panicky | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Difficulty swallowing food or drink or problems with choking | <input type="checkbox"/> | <input type="checkbox"/> | 18. Feeling less interested in sex or more interested in sex | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Vomiting or feelings of sickness (nausea) | <input type="checkbox"/> | <input type="checkbox"/> | 19. Finding it difficult to have sex when you try | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Constipation (less than 3 bowel movements a week) or having to strain to pass a stool (faeces) | <input type="checkbox"/> | <input type="checkbox"/> | 20. Feeling light headed, dizzy or weak standing from sitting or lying | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Bowel (fecal) incontinence | <input type="checkbox"/> | <input type="checkbox"/> | 21. Falling | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Feeling that your bowel emptying is incomplete after having been to the toilet | <input type="checkbox"/> | <input type="checkbox"/> | 22. Finding it difficult to stay awake during activities such as working, driving or eating | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. A sense of urgency to pass urine makes you rush to the toilet | <input type="checkbox"/> | <input type="checkbox"/> | 23. Difficulty getting to sleep at night or staying asleep at night | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Getting up regularly at night to pass urine | <input type="checkbox"/> | <input type="checkbox"/> | 24. Intense, vivid dreams or frightening dreams | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Unexplained pains (not due to known conditions such as arthritis) | <input type="checkbox"/> | <input type="checkbox"/> | 25. Talking or moving about in your sleep as if you are 'acting' out a dream | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Unexplained change in weight (not due to change in diet) | <input type="checkbox"/> | <input type="checkbox"/> | 26. Unpleasant sensations in your legs at night or while resting, and a feeling that you need to move | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Problems remembering things that have happened recently or forgetting to do things | <input type="checkbox"/> | <input type="checkbox"/> | 27. Swelling of your legs | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Loss of interest in what is happening around you or doing things | <input type="checkbox"/> | <input type="checkbox"/> | 28. Excessive sweating | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Seeing or hearing things that you know or are told are not there | <input type="checkbox"/> | <input type="checkbox"/> | 29. Double vision | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Difficulty concentrating or staying focussed | <input type="checkbox"/> | <input type="checkbox"/> | 30. Believing things are happening to you that other people say are not true | <input type="checkbox"/> | <input type="checkbox"/> |

All the information you supply through this form will be treated with confidence and will only be used for the purpose for which it has been collected. Information supplied will be used for monitoring purposes. Your personal data will be processed and held in accordance with the Data Protection Act 1998.

Developed and validated by the International PD Non Motor Group
For information contact: susanne.tluk@uhl.nhs.uk or alison.forbes@uhl.nhs.uk