Department of Psychiatry

Vagelos College of Physicians and Surgeons
Columbia University Irving Medical Center

COLUMBIA

Columbia Day Program

Thank you for your interest in the Columbia Day Program. We want to give you some information about what to expect in regards to the application and evaluation process. Please read this form carefully and completely to ensure an efficient evaluation process. Please do not hesitate to reach out to us should you have any questions regarding this process.

Important Information about the Columbia Day Program

The Columbia Day Program is a full time intensive group outpatient program. The program is entirely group therapy-based. Individual therapy and medication management are not included in the program. We require patients to continue to meet with their individual providers outside of the day program for weekly therapy and medication management, as needed. The day program coordinators will actively collaborate with those individual providers in the community.

What makes our program unique is that each treatment plan is tailored to the individual's needs. The number of groups that you are engaged in will be specific to you, and will be determined after the evaluation. Most patients are engaged in an average of 6-8 groups per week, which consist of a combination of morning groups from 10:00am-12:00pm and afternoon groups from 2:00pm-4:00pm. The minimum length of stay is 3-6 months and your total number of groups will typically decrease over time.

Insurance and Fees: The Columbia Day Program is only in network with Columbia Employee United Healthcare, Aetna insurance (including Aetna student) and NYU Student Consolidated Health Plans. If you do not have one of these insurances, the Columbia Day Program is considered Self Pay and we will provide receipts for you to submit to your insurance for out of network reimbursement. All charges are incurred at the time of service, using your choice of major credit card or a check for the estimated cost for 1 month's treatment.

The self-pay fees are as follows:

- Evaluation: $525
- Part 2 Evaluation (*if required*): $220
- Multi-Family Orientation (one-time fee): $300
- Daily Group Rate: $300 (half day) & $540 (full day)
- Substance Testing (if appropriate): Determined by tests requested by the provider

What to Expect: Application and Evaluation Process

1. Please complete the attached forms, which we estimate will take approximately 1 hour to complete. ***Each page must be completed in entirety.*** This paperwork is helpful in better understanding your needs and guiding our evaluation and recommendations.
    a. Application: pages 3-28
    b. Release of Information(s): page 29
        i. Please complete a release of information form for **each** provider on your treatment team (therapist, psychiatrist, etc.). If you have more than one provider, we will need a separate form for each.
        ii. Instructions for completion:
            1. Please complete the top section with your personal information (name, date of birth, address)
            2. In box 7, please write the name and contact information for your provider
            3. In box 9a, please initial on the lines next to "Alcohol/Drug Treatment" and "Mental Health Information"
            4. Please sign and date at the bottom of the form
    c. Provider Referral Form
        i. Please send this form to **each** provider on your treatment team to complete.

2. Once all forms are completed, please return to us via email at 51stpsyreferral@cumc.columbia.edu.Our team will review your forms and determine if any further information is needed (e.g., discharge summary or previous providers documentation)

3. Following receipt and review of the completed forms, we will arrange a brief 15-20 minute phone conversation to obtain any remaining history and needed clinical information.

4. Our clinical director will review each completed application to determine if we are an appropriate setting to offer an evaluation. Our intake coordinator will be in touch with you within 48 hours to inform you if we will continue with an evaluation or if we believe another setting is clinically indicated.

5. If an evaluation in the Columbia Day Program is recommended, we will follow up with an email offering days and times to meet with one of our providers.

6. Following the evaluation, our team will determine if the Columbia Day Program is the right fit for you. If accepted, we will develop your individualized treatment plan and schedule the multi-family orientation, in which we ask you to bring a loved one to join. If for any reason the Columbia Day Program is not the appropriate setting for your care, we will provide you with our recommendations following the evaluation.

New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Gender: _____

Home Address: _____ City, ST: _____ Zip: _____

Home Phone: _____ Other Phone: _____ Preferred: Home Other

Patient Email Address: _____ Marital Status: _____

Guarantor/Parent: _____ Date of Birth: ____/____/____

Address: _____ City, ST: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

Guarantor/Parent Email Address:

Emergency Contact (if other than guarantor): _____

Emergency Phone: _____ Relationship to Patient: _____

Insurance Information

Insurance Company Name: _____

Insurance Address: _____ City, ST: _____ ZIP: _____

Certificate/Plan/ID #: _____ Group (Grp): _____

Subscriber (if other than patient or guarantor): _____

Subscriber Address: _____ City, ST: _____ ZIP: _____

Subscriber Date of Birth: ____/____/____ Relationship to Patient: _____

Patient Employment Information

Employer: _____ Occupation: _____

Employer Address: _____ City, ST: _____ Zip: _____

Patient Work Phone: _____

Text Messaging Agreement

□ I consent to receive messages from ColumbiaDoctors for my healthcare services at the phone number(s) above, and my wireless (fill in) _____. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

□ Opt out

Last Name: _____ First Name: _____ DOB: / /

Please provide information regarding your health care providers in the spaces below:

	Name	Phone	Location	Date of last visit
Primary Care				/ /
Psychiatrist				/ /
Psychotherapist				/ /
Dentist				/ /

Preferred Pharmacy: _____ Pharmacy Phone: _____

Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- □ Decline Response
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Race:

- □ Decline Response
- □ American-Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Pacific Islander
- □ White
- □ Other

Preferred Language: _____ □ Decline Response

Patient Signature: _____ Date: _____

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Important Information About Patient Email

PLEASE READ THIS INFORMATION CAREFULLY

As a patient of ColumbiaDoctors, you may request we communicate with you by electronic mail (email). This Fact Sheet will inform you about the risks of communicating with your health care provider or program via email and how ColumbiaDoctors will use and disclose provider / patient email.

Email communications are a two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely solely on provider / patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider / patient email is not available to you and seek medical attention.

Email messages on your computer, laptop, or other device have inherent privacy risks especially when your email access is provided through your employer or when access to your email messages is not encrypted (protected).

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission can occur. You can also help minimize this risk by using only the email address that you provide to our practice/ program/ provider.

In order to forward or to process and respond to your email, individuals at ColumbiaDoctors other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider.

At your health care provider's discretion, your email message any and all responses may become part of your medical record.

ColumbiaDoctors encourages patients to use the patient portal (FollowMyHealth) to communicate with healthcare providers directly via email.

Alternatively, patients may receive secure (encrypted) email from their health provider. These messages require patients to establish an account to receive messages from providers.

Finally, patients have the right to request to communicate directly with their healthcare provider without encrypting communications

ColumbiaDoctors
The Physicians and Surgeons of Columbia University

Health Information Management (HIM)
603 West 168th Street, Box 123 New York, NY 10032
T (212) 305-8255 F (212) 342-0437
ColumbiaDoctors-HIM@cumc.columbia.edu

Patient Request for Email Communications

Patient Name:_____ Date of Birth: _____

Phone Number:_____ Email Address:_____

I request to communicate with my provider via unencrypted email. Completing this form is needed to document your request and permit a provider/program to communicate with you via unencrypted email. Send completed form to your provider's/programs office.

I understand that communications over the Internet or use of an email system may not be secure. There is no assurance of confidentiality when communicating via email.

Please be advised that:

- **This request applies only to the healthcare provider or program stated indicate below. If you would like to request to communicate via unencrypted email with another health care provider or program, a separate form is required.**
- An email address must be provided
- A test email is recommended before corresponding via email.

I understand and agree to the following:

- The email address provided is accurate and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form.
- I understand and acknowledge that communications over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated via email.
- I understand that email communications may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold ColumbiaDoctors and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

_____ _____

Signature of Patient **Date**

_____

Name of Physician/Program

TRUSTEES OF COLUMBIA UNIVERSITY - DEPARTMENT OF PSYCHIATRY
PATIENT FINANCIAL AGREEMENT

I_____ (Patient Name) acknowledge the payment and insurance information set form below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the programs and physicians and other health care providers affiliated with Trustees of Columbia University, Department of Psychiatry, and Columbia physicians from other medical specialties asked to consult on my care by the psychiatric treatment team.

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I know that I may request and will receive a written fee schedule. Columbia may change its fees in the future. **Insurance coverage may not pay for all my services.** In some instances, payment will be solely my responsibility. I understand that:
   - Payment for regular outpatient service is due at the time of treatment. NOTE: I will be charged for outpatient appointments I do not keep, unless I cancel the appointment at least 24 hours in advance. I understand that I cannot submit bills for cancellations to my insurance company or managed care plan.
   - Payment for a Telephone Session is an out of pocket expense. I understand that Telephone Session is a non-covered service by my insurance company or managed care plan (Calls 16min or longer are billed as a telephone session.)
   - Payment for day treatment must have a credit card on file otherwise; a month in advance check is required based on my treatment plan.
   - Bills for inpatient treatment are sent after discharge. However, if I do not have insurance coverage for inpatient treatment I will have to pay in advance for the expected length of my stay in the hospital. Columbia will refund overpayments within 6-8 weeks.
   - Columbia offers a package of Enhanced Services for inpatient stays. This package is not covered by insurance. The price for these Enhanced Services is **$_____** a day. If I choose to purchase this package, payment will be my responsibility. The Enhanced Services package consists of one or more professional services, per day, and may include: individual and/or family counseling with a clinical psychologist, individual substance abuse therapy and cognitive-behavioral therapy.
   - Columbia offers Ketamine infusions. This service is not covered by insurance. The price is **$_____** an infusion. If I choose to receive this service, payment will be my responsibility.
   - Substance Abuse services may require laboratory testing. These tests can be billed to your insurance plan with variable coverage rates. Payment will be my responsibility.
2. Insurance and Managed Care Plans: Columbia participates in a number of insurance and managed care plans. If Columbia participates in my plan, I agree to pay all applicable charges, deductibles, co-payments, co-insurances. If Columbia does not participate in my insurance plan, Columbia may, at its discretion, accept assignment from my plan. If Columbia accepts such assignment, I agree to pay any charges, deductibles and co-payments required by my plan. If my insurance benefits run out, Columbia will inform me of the ending date, and I will then be responsible for all charges dating from the end of insurance coverage. If my insurance plan denies the visit despite Columbia following necessary procedures, I understand I will be responsible to pay in full for the service.
3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care: I agree to allow my insurance plan or managed care plan to pay Columbia directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Columbia unless I have already paid the charges myself.

   I authorize Columbia to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Columbia to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this. If the insurance or managed care plan deny the service
4. I have signed a HIPAA [patient privacy laws and regulations] acknowledgment with the Department.
5. I understand Columbia may release me as a patient if I do not adhere to this agreement. If this happens, Columbia will assist me in making alternative arrangements for my treatment, if necessary.
6. Name of responsible party: _____Rel. to patient: _____

   Signature: _____Telephone: Work_____Home_____

   Address of responsible party: _____

   Date: _____ Witnessed by for Columbia: name: _____signature:_____
7. Credit Card Authorization for co-payments and fees by faculty physicians and providers of Columbia University

   Circle one: *Visa MasterCard Amex Discover* Account No: _____Exp._____

   CVV: _____

Signature: _____Date:_____

ColumbiaDoctors | Psychiatry

TELEHEALTH TERMS AND CONDITIONS

The purpose of this document is to provide information regarding telehealth services within the Faculty Practice Office of Columbia Psychiatry at ColumbiaDoctors. In order to maintain care under certain circumstances, including during periods of medical center closure for any reason, our programs may offer to conduct individual sessions, group sessions, and assessments via telehealth service. Telehealth service is the delivery of healthcare services when the therapist and patient are not in the same physical location/site through the use of various technology. This could include video sessions via telehealth software on a computer or tablet, or phone sessions.

RISKS/BENEFITS

Although the risks and benefits of telehealth are similar to those of in-person sessions, telehealth includes additional risks.

1. Although we will use secure platforms (e.g., Epic or Cisco WebEx) with industry-standard encryption and security, there is no way to guarantee that this software is completely failure-proof. As with any technology, there is a chance of a security breach that would affect the privacy of personal and/or medical information.
2. Since you will be completing sessions in your own home, we cannot guarantee the same level of privacy that you have when you are in our clinic.
3. In the event of group sessions conducted via video, it is possible that your confidentiality could be breached if others in the group are not in a confidential setting, although we will make every effort to minimize this risk.

PRIVACY AND ONLINE ETIQUETTE

1. In order to reduce risks to confidentiality**, we require that all video or telephone sessions occur in a private room with no one else present and that you wear headphones** to limit the possibility of other people overhearing confidential information. We also **require that for designated video sessions you have your camera turned on**, barring technological issues.
2. You are responsible for minimizing distractions and disruptions during your session.
    a. If you leave the session/screen, please announce your departure and return as soon as possible.
    b. Try to designate an appropriate location conducive to mental health treatment (e.g., at a desk or table versus a bed, consider the appropriateness of the visible background particularly for group sessions).
    c. Please try to minimize distractions, for example not looking at cell phones, minimize ambient noise whenever possible, limit distractions from pets or ideally do not have them in the room, silence phones, etc.
    d. Present yourself as you would for in-person sessions, which includes, for example, dressing in appropriate clothing, not engaging in any harmful behaviors during sessions and during groups minimizing exposure to stimuli that could be detrimental to the treatment of others.

Since this may be different than the type of sessions with which you are familiar, it is important that you understand, acknowledge, and agree to the following statements:

- You understand that you have undertaken to engage in a telehealth encounter for yourself that will contain personal identifying information as well as protected health information.
- You understand that the therapist will be at a different location from you.
- You understand that you have the right to withhold or withdraw your consent to the use of telehealth services at any time in the course of your care, without affecting your right to future care or treatment.
- You have been informed of and accept the potential risks associated with telehealth, such as failure of security protocols that may cause a breach of privacy of personal and/or medical information.
- You understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies you will be disclosed to other entities without your consent or as may be allowed by law.
- You have been given the opportunity to ask your provider at the Faculty Practice Office within Columbia Psychiatry questions relative to your Telehealth encounter, security practices, technical specifications, and other related risks.

By signing this form, you certify:

- That you have read or had read and/or had this form explained to you;
- That you fully understand its contents including the risks and benefits of telehealth services; and
- That you have been given ample opportunity to ask questions and that any questions have been answered to your satisfaction.

_____	_____	_____
Signature of Participant	Printed Name of Participant	Date

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Answers to the all questions in this packet are for our records only and are confidential. No outsider, not even your closest relative or family doctor, is permitted to see your case record without your written permission.

SECTION I

1. Do you have any allergies to medications or other substances? **Y / N**
   a. If so, please list allergies and reactions: _____
   _____
2. Do you have any significant medical problems? **Y / N**
   a. If so please list any: _____
3. Are you receiving any medication for these problems? **Y / N**
   a. If so please list these medications: _____

Name(s) of Physician(s): _____
Address: _____Telephone #:_____

SECTION II

1. Please list all medications you have taken for emotional or psychiatric conditions, beginning with those you are currently taking.

Medication Name	Strength/Dose (mg)	Frequency (i.e. daily, three times/day)	Date Started	Date Discontinued	Reason for Discontinuation

2. Has anyone in your family had a history of or received treatment for a mental illness? (Please note what relation, the nature of the problem, and the subsequent treatment. Please also note if any family member has attempted or committed suicide):

Family Member	Describe problem(s)	Treatment for this problem

3. Have you ever been hospitalized for mental/emotional problems and/or chemical dependency? **Y/N**
   a. If YES, how many times? _____

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Describe Problem(s) and Symptoms	Hospital	Date	Treatment(s) (i.e. medication, shock therapy)

SECTION III

1. Have you ever or do you currently have an eating disorder? **Y / N** N
   a. If yes, how did your eating disorder begin? _____
   _____
2. What is the history of your eating disorder up until now? _____
   _____ _____
3. Do you currently restrict your food intake? **Y / N** N
4. Have you ever had an episode of binge eating? **Y / N** N
5. Do you currently binge eat? **Y / N** N
6. During the last three months, how often have you typically had an eating binge? _____
7. At the worst of times, what was the average number of binges per week? _____
   a. When was this? _____
8. Have you ever vomited after eating? **Y / N** N
   a. If yes, at what age did you begin to vomit after eating? _____
9. During the last three months, how often have you typically induced vomiting? _____
10. At the worst of times, what was the average number of vomiting episodes per week? _____
    a. When was this? _____ _____
11. Do you or have you ever used laxatives, diet pills, and/or diuretics? **Y / N** N
    a. In what quantity and how frequently? _____
    b. When was this? _____
12. Do you or have you ever over-exercised? **Y/N** N
    a. If yes, how often and for how long? _____
    b. When was this? _____

SECTION IV

ACADEMIC HISTORY

1. Were you ever diagnosed with a learning disability? **Y / N** N
   a. If yes, when and what type? _____
2. Did you have special accommodations in school or on standardized testing (e.g. extra time)? **Y / N** N
3. Were you ever diagnosed with ADHD? **Y / N** N
4. Were you in special education classes/resource room? **Y / N** N
5. What was the highest grade completed? _ _____
6. Did you skip any grades in school? **Y / N** N
7. Did you ever repeat any grades in school? **Y / N** N

OCCUPATIONAL HISTORY

1. What is your current occupation? _____
2. When was your most recent job? _____
3. What and when was your longest period of continuous employment? _____

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MEDICAL HISTORY

1. Do you have a history of head trauma? **Y / N** N
2. Have you ever lost consciousness? **Y / N** N
   a. If yes, what was the duration of loss of consciousness? _____

SECTION V

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you think you might have felt. Please answer honestly.

	In the course of the last week….	Not at all	A little	Rather	Much	Very strong
1	It was hard for me to concentrate	◉0	○1	○2	○3	○4
2	I felt helpless	○0	◉1	○2	○3	○4
3	I was absent-minded and unable to remember what I was doing	○0	○1	◉2	○3	○4
4	I felt disgust	○0	○1	○2	○3	○4
5	I thought of hurting myself	○0	○1	○2	○3	○4
6	I didn't trust other people	○0	○1	○2	○3	○4
7	I didn't believe in my right to live	○0	○1	◉2	○3	○4
8	I was lonely	○0	○1	○2	○3	○4
9	I experienced stressful inner tension	○0	○1	○2	◉3	○4
10	I had images that I was very much afraid of	○0	○1	○2	◉3	○4
11	I hated myself	○0	○1	○2	○3	○4
12	I wanted to punish myself	○0	○1	○2	○3	○4
13	I suffered from shame	○0	○1	○2	○3	○4
14	My mood rapidly cycled in terms of anxiety, anger, and depression	○0	○1	○2	○3	○4
15	I suffered from voices and noises from inside or outside my head	○0	○1	○2	○3	○4
16	Criticism had a devastating effect on me	○0	○1	○2	○3	○4
17	I felt vulnerable	○0	○1	○2	○3	○4
18	The idea of death had a certain fascination for me	○0	○1	○2	○3	○4
19	Everything seemed senseless to me	○0	○1	○2	○3	○4
20	I was afraid of losing control	○0	○1	○2	○3	○4
21	I felt disgusted by myself	○0	○1	○2	○3	○4
22	I felt as if I was far away from myself	○0	○1	○2	○3	○4
23	I felt worthless	○0	○1	○2	○3	○4

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Now we would like to know in addition the quality of your overall personal state in the course of the last week. 0% means very bad, 100% means excellent. Please check the percentage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Very Bad ←---------- ----------→ **Excellent** 100%										

	During the last month…	Not at all	Once	2-3 times	4-6 times	Daily or more often
1	I hurt myself by cutting, burning, strangling, head banging etc.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
2	I told other people that I was going to kill myself	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
3	I tried to commit suicide	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
4	I had episodes of binge eating	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
5	I induced vomiting	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
6	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balancing on bridges, etc.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
7	I got drunk	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
8	I took drugs	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
9	I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
10	I had outbreaks of uncontrolled anger or physically attacked others	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
11	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

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SECTION VI

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness 3
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism 3
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me
3 I feel my future is hopeless and will only get worse.

3. Past Failure 3
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure 3
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings 3
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings 3
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel like I am being punished.

7. Self Dislike 3
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness 3
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes 3
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying 0
0 I don't cry any more than I used to.
1 I cry more than I used to.
2 I cry over everything little thing.
3 I feel like crying, but I can't.

11. Agitation 0
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest 3

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness 3

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness 3

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy 3

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Patterns 3

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1-2 hours early, can't get back to sleep.

17. Irritability 3

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite 3

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat more than usual.
2a My appetite is much less than usual.
2b My appetite is much more than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty 3

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness of Fatigue 3

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex 3

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

ColumbiaDoctors

SECTION VII

Please circle the name of any substance from the list below that you used in the last 3 months. In the case of medications, only circle it if you have taken a substance other than prescribed:

Caffeine ◯ Tobacco ◯

Marijuana/Hashish ◯ Cocaine/Crack ◯

Tranquilizers (i.e. Xanax, Valium) ◯ Barbiturates ◯

Inhalants (i.e. poppers, whit its, nitrous oxide) ◯ Methamphetamines (Crystal Meth, amphetamines) ◯

Hallucinogens (i.e. ecstasy, PCP, LSD, angel dust) ◯ Opiates (i.e. Oxycontin, heroin, methadone, morphine) ◯

If you circled any of the above, please indicate how much and how often you have used each substance in the last 3 months:

Caffeine: _____
Tobacco: _____
Tranquilizers: _____
Marijuana/Hashish: _____
Barbiturates: _____
Cocaine/crack: _____
Hallucinogens: _____
Opiates: _____
Methamphetamines: _____
Inhalants: _____

1. Have you ever been treated for alcohol or drug abuse? **Y / N**
   a. When and Where? _____
   _____
2. Explain the feeling you get from drinking and or using drugs: _____
   _____
3. Describe your behavior when you use: _____
   _____
4. Do you intermix drugs and alcohol? **Y / N**
5. What situations make you want to use? _____
6. When was your last drink? _____
7. When did you last use drugs and which drug was it? _____
8. How many times have you tried to stop using drugs or alcohol? _____
   _____
9. What was the longest time you were able to stop? _____
   _____
10. Explain what you would like to do about your use of drugs or alcohol, if anything: _____
    _____

Dimensional Obsessive-Compulsive Scale

This questionnaire asks you about 4 different types of concerns that you might or might not experience. For each type there is a description of the kinds of thoughts (sometimes called *obsessions*) and behaviors (sometimes called *rituals* or *compulsions*) that are typical of that particular concern, followed by 5 questions about your experiences with these thoughts and behaviors. Please read each description carefully and answer the questions for each category based on your experiences in the last month.

Category 1: Concerns about Germs and Contamination

Examples…

-Thoughts or feelings that you are contaminated because you came into contact with (or were nearby) a certain object or person.
-The feeling of being contaminated because you were in a certain place (such as a bathroom).
-Thoughts about germs, sickness, or the possibility of spreading contamination.
-Washing your hands, using hand sanitizer gels, showering, changing your clothes, or cleaning objects because of concerns about contamination.
-Following a certain routine (e.g., in the bathroom, getting dressed) because of contamination
-Avoiding certain people, objects, or places because of contamination.

The next questions ask about your experiences with thoughts and behaviors related to contamination over the last month. Keep in mind that your experiences might be different than the examples listed above. Please circle the number next to your answer:

1. About how much time have you spent each day thinking about contamination and engaging in washing or cleaning behaviors because of contamination?

   ○ 0 None at all
   ○ 1 Less than 1 hour each day
   ○ 2 Between 1 and 3 hours each day
   ○ 3 Between 3 and 8 hours each day
   ○ 4 8 hours or more each day

2. To what extent have you avoided situations in order to prevent concerns with contamination or having to spend time washing, cleaning, or showering?

   ○ 0 None at all
   ○ 1 A little avoidance
   ○ 2 A moderate amount of avoidance
   ○ 3 A great deal of avoidance
   ○ 4 Extreme avoidance of nearly all things

3. If you had thoughts about contamination but could not wash, clean, or shower (or otherwise remove the contamination), how distressed or anxious did you become?

   ○ 0 Not at all distressed/anxious
   ○ 1 Mildly distressed/anxious
   ○ 2 Moderately distressed/anxious
   ○ 3 Severely distressed/anxious
   ○ 4 Extremely distressed/anxious

4. To what extent has your daily routine (work, school, self-care, social life) been disrupted by contamination concerns and excessive washing, showering, cleaning, or avoidance behaviors?

   ○ 0 No disruption at all.
   ○ 1 A little disruption, but I mostly function well.
   ○ 2 Many things are disrupted, but I can still manage.
   ○ 3 My life is disrupted in many ways and I have trouble managing.
   ○ 4 My life is completely disrupted and I cannot function at all.

5. How difficult is it for you to disregard thoughts about contamination and refrain from behaviors such as washing, showering, cleaning, and other decontamination routines when you try to do so?

   ○ 0 Not at all difficult
   ○ 1 A little difficult
   ○ 2 Moderately difficult
   ○ 3 Very difficult
   ○ 4 Extremely difficult

continued →

Category 2: Concerns about being Responsible for Harm, Injury, or Bad Luck

Examples…

-A doubt that you might have made a mistake that could cause something awful or harmful to happen.
-The thought that a terrible accident, disaster, injury, or other bad luck might have occurred and you weren't careful enough to prevent it.
-The thought that you could prevent harm or bad luck by doing things in a certain way, counting to certain numbers, or by avoiding certain "bad" numbers or words.
-Thought of losing something important that you are unlikely to lose (e.g., wallet, identify theft, papers).
-Checking things such as locks, switches, your wallet, etc. more often than is necessary.
-Repeatedly asking or checking for reassurance that something bad did not (or will not) happen.
-Mentally reviewing past events to make sure you didn't do anything wrong.
-The need to follow a special routine because it will prevent harm or disasters from occurring.
-The need to count to certain numbers, or avoid certain bad numbers, due to the fear of harm.

The next questions ask about your experiences with thoughts and behaviors related to harm and disasters over the last month. Keep in mind that your experiences might be slightly different than the examples listed above. Please circle the number next to your answer:

1. About how much time have you spent each day thinking about the possibility of harm or disasters and engaging in checking or efforts to get reassurance that such things do not (or did not) occur?

   0 None at all
   1 Less than 1 hour each day
   2 Between 1 and 3 hours each day
   3 Between 3 and 8 hours each day
   4 8 hours or more each day

2. To what extent have you avoided situations so that you did not have to check for danger or worry about possible harm or disasters?

   0 None at all
   1 A little avoidance
   2 A moderate amount of avoidance
   3 A great deal of avoidance
   4 Extreme avoidance of nearly all things

3. When you think about the possibility of harm or disasters, or if you cannot check or get reassurance about these things, how distressed or anxious did you become?

   0 Not at all distressed/anxious
   1 Mildly distressed/anxious
   2 Moderately distressed/anxious
   3 Severely distressed/anxious
   4 Extremely distressed/anxious

4. To what extent has your daily routine (work, school, self-care, social life) been disrupted by thoughts about harm or disasters and excessive checking or asking for reassurance?

   0 No disruption at all.
   1 A little disruption, but I mostly function well.
   2 Many things are disrupted, but I can still manage.
   3 My life is disrupted in many ways and I have trouble managing.
   4 My life is completely disrupted and I cannot function at all.

5. How difficult is it for you to disregard thoughts about possible harm or disasters and refrain from checking or reassurance-seeking behaviors when you try to do so?

   0 Not at all difficult
   1 A little difficult
   2 Moderately difficult
   3 Very difficult
   4 Extremely difficult

Continued →

Category 3: Unacceptable Thoughts

Examples…

-Unpleasant thoughts about sex, immorality, or violence that come to mind against your will.
-Thoughts about doing awful, improper, or embarrassing things that you don't really want to do.
-Repeating an action or following a special routine because of a bad thought.
-Mentally performing an action or saying prayers to get rid of an unwanted or unpleasant thought.
-Avoidance of certain people, places, situations or other triggers of unwanted or unpleasant thoughts

The next questions ask about your experiences with unwanted thoughts that come to mind against your will and behaviors designed to deal with these kinds of thoughts over the last month. Keep in mind that your experiences might be slightly different than the examples listed above. Please circle the number next to your answer:

1. About how much time have you spent each day with unwanted unpleasant thoughts and with behavioral or mental actions to deal with them?

   0 None at all
   1 Less than 1 hour each day
   2 Between 1 and 3 hours each day
   3 Between 3 and 8 hours each day
   4 8 hours or more each day

2. To what extent have you been avoiding situations, places, objects and other reminders (e.g., numbers, people) that trigger unwanted or unpleasant thoughts?

   0 None at all
   1 A little avoidance
   2 A moderate amount of avoidance
   3 A great deal of avoidance
   4 Extreme avoidance of nearly all things

3. When unwanted or unpleasant thoughts come to mind against your will how distressed or anxious did you become?

   0 Not at all distressed/anxious
   1 Mildly distressed/anxious
   2 Moderately distressed/anxious
   3 Severely distressed/anxious
   4 Extremely distressed/anxious

4. To what extent has your daily routine (work, school, self-care, social life) been disrupted by unwanted and unpleasant thoughts and efforts to avoid or deal with such thoughts?

   0 No disruption at all.
   1 A little disruption, but I mostly function well.
   2 Many things are disrupted, but I can still manage.
   3 My life is disrupted in many ways and I have trouble managing.
   4 My life is completely disrupted and I cannot function at all.

5. How difficult is it for you to disregard unwanted or unpleasant thoughts and refrain from using behavioral or mental acts to deal with them when you try to do so?

   0 Not at all difficult
   1 A little difficult
   2 Moderately difficult
   3 Very difficult
   4 Extremely difficult

Continued →

Category 4: Concerns about Symmetry, Completeness, and the Need for Things to be "Just Right"

Examples…

-The need for symmetry, evenness, balance, or exactness.
-Feelings that something isn't "just right."
-Repeating a routine action until it feels "just right" or "balanced."
-Counting senseless things (e.g., ceiling tiles, words in a sentence).
-Unnecessarily arranging things in "order."
-Having to say something over and over in the same way until it feels "just right."

The next questions ask about your experiences with feelings that something is not "just right" and behaviors designed to achieve order, symmetry, or balance over the last month. Keep in mind that your experiences might be slightly different than the examples listed above. Please circle the number next to your answer:

1. About how much time have you spent each day with unwanted thoughts about symmetry, order, or balance and with behaviors intended to achieve symmetry, order or balance?

   0 None at all
   1 Less than 1 hour each day
   2 Between 1 and 3 hours each day
   3 Between 3 and 8 hours each day
   4 8 hours or more each day

2. To what extent have you been avoiding situations, places or objects associated with feelings that something is not symmetrical or "just right?"

   0 None at all
   1 A little avoidance
   2 A moderate amount of avoidance
   3 A great deal of avoidance
   4 Extreme avoidance of nearly all things

3. When you have the feeling of something being "not just right," how distressed or anxious did you become?

   0 Not at all distressed/anxious
   1 Mildly distressed/anxious
   2 Moderately distressed/anxious
   3 Severely distressed/anxious
   4 Extremely distressed/anxious

4. To what extent has your daily routine (work, school, self-care, social life) been disrupted by the feeling of things being "not just right," and efforts to put things in order or make them feel right?

   0 No disruption at all.
   1 A little disruption, but I mostly function well.
   2 Many things are disrupted, but I can still manage.
   3 My life is disrupted in many ways and I have trouble managing.
   4 My life is completely disrupted and I cannot function at all.

5. How difficult is it for you to disregard thoughts about the lack of symmetry and order, and refrain from urges to arrange things in order or repeat certain behaviors when you try to do so?

   0 Not at all difficult
   1 A little difficult
   2 Moderately difficult
   3 Very difficult
   4 Extremely difficult

Box 10

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

SIP SCALE

Patient Name: _____ Date: _____

Instructions: Here are a number of events that people sometimes experience. Read each one carefully and indicate how often each one has happened to you DURING THE PAST MONTH by checking the box next to the appropriate response (never, once, a few times, etc.).

SIP 1 I have been unhappy because of my drinking or drug use. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 2 Because of my drinking or drug use, I have lost weight or not eaten properly. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 3 I have failed to do what is expected of me because of my drinking or drug use. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 4 When drinking or using drugs my personality has changed for the worse. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 5 I have taken foolish risks when I have been drinking or using drugs. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP SCALE

SIP 6 When drinking or using drugs, I have said harsh or cruel things to someone. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 7 When drinking or using drugs, I have done impulsive things that I regretted later. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 8 I have had money problems because of my drinking or drug use. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 9 My physical appearance has been harmed by my drinking or drug use. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 10 My family has been hurt by my drinking or drug use. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP SCALE

SIP 11 A friendship or close relationship has been damaged by my drinking or drug use. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 12 I have lost interest in activities and hobbies because of my drinking and drug use. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 13 My drinking and drug use has gotten in the way of my growth as a person. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 14 My drinking or drug use has damaged my social life, popularity or reputation. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

SIP 15 I have spent too much or lost a lot of money because of my drinking or drug use. 8

0 = Never
1 = Once or a few times
2 = Once or twice a week
3 = Daily or almost daily
7 = Don't know
8 = Refuse to answer

Difficulties in Emotion Regulation Scale – Short Form (DERS-SF)

Kaufman, Xia, Fosco, Yaptangco, Skidmore, & Crowell (2015)

Please indicate how often the following apply to you.

	Almost Never (0–10%)	Some-times (11–35%)	About Half Of the Time (36–65%)	Most of the Time (66–90%)	Almost Always (91–100%)
1. I pay attention to how I feel	1	2	3	4	5
2. I have no idea how I am feeling	1	2	3	4	5
3. I have difficulty making sense out of my feelings	1	2	3	4	5
4. I care about what I am feeling	1	2	3	4	5
5. I am confused about how I feel	1	2	3	4	5
6. When I'm upset, I acknowledge my emotions	1	2	3	4	5
7. When I'm upset, I become embarrassed for feeling that way	1	2	3	4	5
8. When I'm upset, I have difficulty getting work done	1	2	3	4	5
9. When I'm upset, I become out of control	1	2	3	4	5
10. When I'm upset, I believe that I will end up feeling very depressed	1	2	3	4	5
11. When I'm upset, I have difficulty focusing on other things	1	2	3	4	5
12. When I'm upset, I feel guilty for feeling that way	1	2	3	4	5
13. When I'm upset, I have difficulty concentrating	1	2	3	4	5
14. When I'm upset, I have difficulty controlling my behaviors	1	2	3	4	5
15. When I'm upset, I believe there is nothing I can do to make myself feel better	1	2	3	4	5
16. When I'm upset, I become irritated with myself for feeling that way	1	2	3	4	5
17. When I'm upset, I lose control over my behavior	1	2	3	4	5
18. When I'm upset, it takes me a long time to feel better	1	2	3	4	5

Generalized Anxiety Disorder 7-item (GAD-7) scale

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
1. Feeling nervous, anxious, or on edge	◯ 0	◯ 1	◯ 2	◯ 3
2. Not being able to stop or control worrying	◯ 0	◯ 1	◯ 2	◯ 3
3. Worrying too much about different things	◯ 0	◯ 1	◯ 2	◯ 3
4. Trouble relaxing	◯ 0	◯ 1	◯ 2	◯ 3
5. Being so restless that it's hard to sit still	◯ 0	◯ 1	◯ 2	◯ 3
6. Becoming easily annoyed or irritable	◯ 0	◯ 1	◯ 2	◯ 3
7. Feeling afraid as if something awful might happen	◯ 0	◯ 1	◯ 2	◯ 3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

WSAS

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems, look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity. This assessment is not intended to be a diagnosis. If you are concerned about results in any way, please speak with a professional.

1) Because of the way I feel, my ability to work is impaired
0 indicates no impairment at all and 8 indicates severe impairment

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8

2. Because of the way I feel, my home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired
0 indicates no impairment at all and 8 indicates severe impairment

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8

3. Because of the way I feel, my social leisure activities involving other people (such as parties, outings, visits, dating, home entertainment, cinema) are impaired
0 indicates no impairment at all and 8 indicates severe impairment

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8

4. Because of the way I feel, my private leisure activities done alone (such as reading, watching TV, gardening, craft work, walking, sewing) are impaired
0 indicates no impairment at all and 8 indicates severe impairment

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8

5. Because of the way I feel, my ability to form and maintain close relationships with others, including those I live with is impaired
0 indicates no impairment at all and 8 indicates severe impairment

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

□ Medical Record form (insert date) _____to (insert date)_____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other:_____ _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

_____ **Genetic Testing**

Authorization to Discuss Health Information

(b). □ By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm or Governmental Agency Name)

10. Reason for release of information: □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**