MEDICAL CARE
OF WESTERN NEW YORK AT BUFFALO

Medication Agreement

The purpose of this agreement is to prevent misunderstandings about certain medicines that may be prescribed to assist you. This agreement establishes expectations, helps you and your doctor comply with the law regarding controlled substances and helps to prevent any substance abuse problems.

I understand and agree to the following:

1. **I understand that certain medications can cloud judgments and affect reflexes and motor skills.** I agree to avoid activities that would endanger myself or others while using these medications such as driving a motor vehicle, operating heavy machinery, working, taking care of children and dependents, etc.

2. **I agree to take medications only as prescribed.** I will not increase the dosage on my own or self medicate. I will not abuse alcohol or illegal controlled substances, including speed, cocaine, heroin, etc.

3. **I understand that medication is only one part of my overall treatment plan.** I will cooperate and participate in a range of treatments and referrals.

4. **I understand that controlled medications are prescribed only at medical appointments and only if I am following my individual treatment plan.** I further agree to follow the attendance policies contained in the Practice Policies.

5. **I will protect my medication(s) from loss or theft.** I understand that lost or stolen prescriptions will not be replaced and there are no early refills.

6. **I will inform my doctor of all prescriptions I am currently receiving from all treating physicians.** Since medications can have serious side effects, I understand that taking multiple medications can pose serious health problems. **I will use only ONE prescribing doctor and ONE pharmacy for controlled substances.** I understand that using multiple prescribing doctors and/or pharmacies to fill the same controlled medication will result in my immediate discharge. I will not use the Emergency Room for the sole purpose of obtaining medication. The ER is for severe emergencies only.

7. **I will not alter prescriptions, give or sell prescribed medications, or obtain prescribed medications from other sources.** I understand that if I engage in these unlawful activities, my treatment will end immediately and Medical Care of Western New York is obligated to report the incident to the New York State Department of Health Bureau of Narcotic Enforcement, Local Police Department, Drug Enforcement Agency, other physicians, local medical facilities, pharmacies, and/or other appropriate authorities.

8. **As required by NY law, this office consults I-STOP/PMP (Internet System for Tracking Over-Prescribing-Prescription Monitoring Program) whenever controlled substances are prescribed**. Through I-STOP, patient reports are generated that include all controlled substances that were dispensed in New York State and reported by the pharmacy/dispenser.

9. **Medical Care of WNY utilizes random drug screens. Urine screens, saliva samples,** and/or **pill counts** may be done with or without suspicion and at the discretion of the medical staff. If I decline, I understand that I will no longer receive any controlled substances from this office. Abnormal results may lead to discontinuation of medication and/or discharge. Abnormal results include but are not limited to positive results for illicit substances or negative results for medications I reported taking.

I have read and understand the "Medication Agreement." I understand that failure to comply with the protocols outlined above may result in **discontinuation of medication(s) and/or discharge from the office.**

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

MEDICAL CARE
OF WESTERN NEW YORK AT BUFFALO

Practice Policies

Physician/Patient Relationship

Our staff is committed to serving your medical needs and treating you with dignity and respect. In return, we ask that you treat them with the same dignity and respect. The well-being of our patients and staff members is our utmost concern. Understand that if you are verbally or physically abusive to a staff member or another patient, you will be **discharged.** If you are discharged, you can no longer schedule appointments or consider us your doctor. You will have to find another doctor at a different practice.

Attendance

Regular attendance at doctor's appointments and physical therapy sessions is essential to the success of your treatment. Accordingly, our practice has adopted the following policies –

- ✓ **Please Call to Cancel:** If you cannot make your scheduled appointment, please call 24 hours in advance to reschedule. Our office participates in reminder calls as a courtesy to our patients. However, it is your responsibility to keep track of your appointments. Please listen to the entire message and **confirm** or **cancel** your appointment accordingly.

- ✓ **Follow Up Appointments:** Please schedule any follow up appointments with our office before you leave so that you are able to get an appointment for the day and time that is most convenient for you. It is your responsibility to make the appropriate follow up appointments for your treatment plan.

- ✓ **Late Visits:** If you are late to a scheduled appointment by more than 15 minutes, you will likely be asked to reschedule. However, we will make an effort to see you if the schedule permits.

- ✓ **No-Shows:** A No-Show is when you miss an appointment without calling to cancel or reschedule. If you No-Show an appointment, you will be rescheduled to the next available appointment. Controlled substances will NOT be prescribed until you are seen at the rescheduled appointment. The office procedure regarding No-Shows is as follows:
    - *First Time*: you will receive a verbal warning.
    - *Second Time*: you will receive a written warning.
    - *Third Time*: you will receive a letter stating that you have been **discharged** from the practice.

Compliance

Following your prescribed treatment plan is important for your health and well being. If you do not follow the medical staff's instructions about important health issues, our office will not be able to effectively provide for your medical needs. The office procedure regarding noncompliance is the same as the No-Show procedure.

Contacting Us

Please allow at least *24 to 48 hours* to return your call. However, we will make every effort to return your call as soon as possible. If you are experiencing a medical emergency, please call 911.

Paperwork

We will be glad to complete any forms but cannot interrupt our office hours to do so. Please allow *10 to 14 days* to complete your paperwork.

I, _____, have received a copy of Medical Care of Western New York at Buffalo's Notice of Privacy Practices.

By signing this document, I agree to abide by the above policies.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

MEDICAL CARE
OF WESTERN NEW YORK AT BUFFALO

Parrish Commons
656 Elmwood Avenue
Buffalo, NY 14222
716 · 883 · 0515
Fax 716 · 883 · 8764
www.medicalcareofwny.com

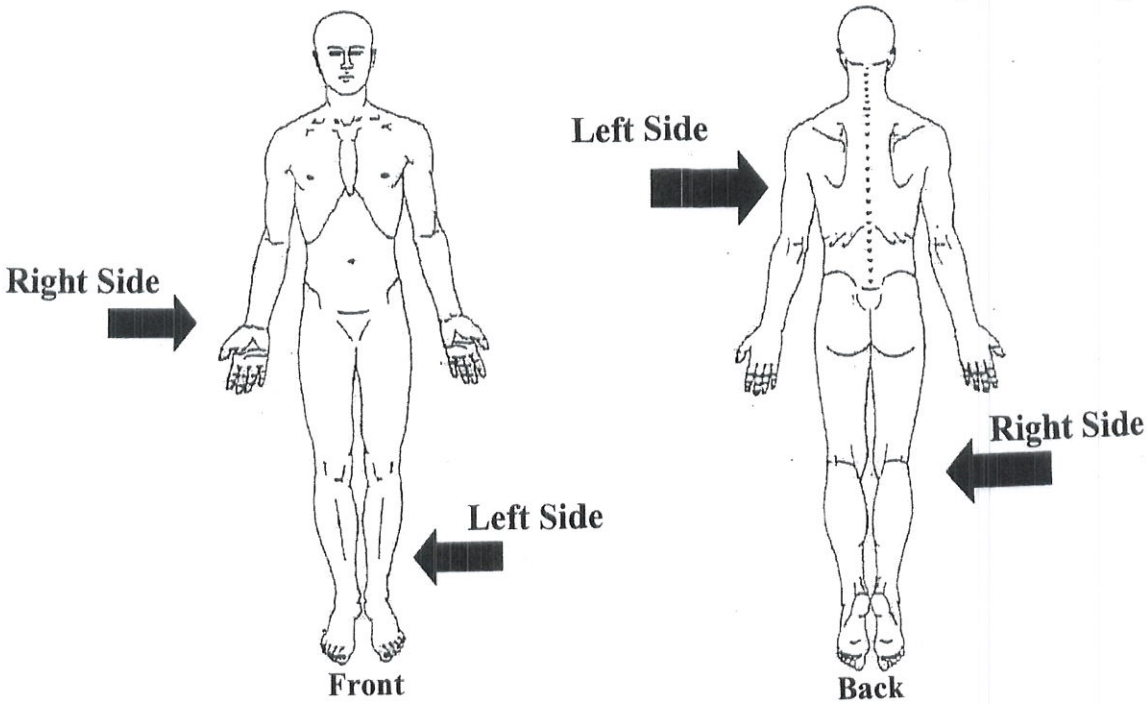
PAIN ASSESSMENT DIAGRAM

Name (Print): _____ Today's Date: _____

Signature: _____ Injury Date: _____

On the diagram below, please indicate the location of your pain or other symptoms. Please use the symbols to represent the type(s) of pain:

A = Aching
B = Burning
C = Cramping
D = Dull
N = Numbness
P = Pins & Needles
S = Stabbing
O = Other (describe)



Using the above scale, please complete the statements below by circling the number representing your level of pain or discomfort.

Rate the level of pain you have right NOW:

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Rate your WORST pain in the past week:

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

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Patient Name: _____ **Date:** ___/___/20___ **Injury Date:** ___/___/____

Activities of Daily Living Summary

Please check all that apply – You may check more than one box per line.

Work Duties		Reason for Limitation		
Lifting	→	□ Increased Pain	□ Restricted movement	□ Weakness
Bending	→	□ Increased Pain	□ Restricted movement	□ Weakness
Walking	→	□ Increased Pain	□ Restricted movement	□ Weakness
Sitting	→	□ Increased Pain	□ Restricted movement	□ Weakness

Household & Domestic Duties		Reason for Limitation		
Vacuuming	→	□ Increased Pain	□ Restricted movement	□ Weakness
Caring for children	→	□ Increased Pain	□ Restricted movement	□ Weakness
Cleaning	→	□ Increased Pain	□ Restricted movement	□ Weakness
Preparing Meals	→	□ Increased Pain	□ Restricted movement	□ Weakness
Yard Work	→	□ Increased Pain	□ Restricted movement	□ Weakness
Transportation	→	□ Increased Pain/Anxiety	□ Restricted movement	□ Fatigue
Shopping	→	□ Increased Pain/Anxiety	□ Restricted movement	□ Fatigue
Taking Out Trash	→	□ Increased Pain/Anxiety	□ Restricted movement	□ Fatigue

1. How did you get to the office today (drove, driven, bus, taxi, etc)? _____
2. How often do you have to change your position while sitting or standing? _____
3. How many times do you wake up throughout the night? _____
4. Who does the housekeeping and cooking? _____
5. Who helps you with personal hygiene? _____
6. Do you feel anxious or depressed? _____
7. Are you currently working? _____ Last day worked? _____

MEDICAL CARE
OF WESTERN NEW YORK AT BUFFALO

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Medical Care of Western New York at Buffalo to use and/or disclose certain protected health information (PHI) about me to:

_____

Name of entity to receive this information / Name, Phone number, Relationship

This authorization permits Medical Care of Western New York at Buffalo to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as *"at the request of the individual."* The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. **This authorization will remain in effect until revoked by the patient or other approved legal representative in writing.**

I do not have to sign this authorization in order to receive treatment from Medical Care of Western New York at Buffalo. In fact: I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 656 Elmwood Avenue Buffalo, NY 14222.

Signed by:_____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____

Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

656 Elmwood Avenue ◆ Buffalo, New York 14222
Phone: 716-883-0515 ◆ Fax: 716-883-8764
www.medicalcareofwny.com

MEDICAL CARE
OF WESTERN NEW YORK AT BUFFALO

Michael D. Calabrese, Physician P.C.

To: Attorney (s) _____

Patient's Name: _____

DOCTOR'S LIEN

I hereby authorize the above doctor to furnish you, my attorney, with a full report of the case history, examination, diagnosis, treatment and prognosis of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney(s), or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of pending payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Patient's signature _____ Dated _____

Patient's address _____

City _____ State _____ Zip _____

Telephone Number _____

Attorney(s): **Please sign, date, and return this document to the above named doctor's office.**

The undersigned, being attorney(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above lien and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the said doctor named above.

Attorney(s) signature _____ Dated _____

656 Elmwood Avenue ♦ Buffalo, New York 14222
Phone: 716-883-0515 ♦ Fax: 716-883-8764
www.medicalcareofwny.com

HEALTHeLINK **Authorization for Access to Patient Information Through HEALTHeLINK**

Patient First Name

Patient Last Name

Date of Birth M M / D D / Y Y Y Y

Patient Address

Street _____ Apartment _____

City _____, State _____ Postal Code _____

Gender

☐ Male

☐ Female

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at www.wnyhealthelink.com.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

SELECT ONLY ONE

My Consent Choice. Only ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.

☐ **1. YES**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
☐ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **3. YES, ONLY SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **4. NO, EXCEPT IN AN EMERGENCY**	**I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.
☐ **5. NO, EVEN IN AN EMERGENCY**	**I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, ***even*** in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Signature of Patient or Patient's Legal Representative

X_____

Date of Signature M M / D D / Y Y Y Y

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ Parent ☐ Healthcare agent/proxy

☐ Guardian ☐ Other_____

This Box To Be Filled Out Only By The Provider

_____
Entity Consent Received By

Witness*

*Required if NOT completing this form in a Participant's office.

_____ Print Name of Witness

_____ Signature of Witness

_____
Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information May Be Used.** With limited exceptions, if you give consent, the Participant(s) you approve may use your electronic health information **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of 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.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information About You Are Included.** If you give consent, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. 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
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, traurna history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

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 Information Sources is available from HEALTHeLINK at www.wnyhealthelink.com or by calling 716- 206-0993 ext. 311.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Participant(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may only be accessed where there is a treating provider relationship. A complete list of Participants is available from HEALTHeLINK at www.wnyhealthelink.com/PhysiciansandStaff/CurrentParticipants/ParticipatingHEALTHeLINKProviders or by calling 716-206-0993 ext. 311 if you want a hard copy which will be provided at no charge within 5 business days of the request.

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 Participants you have approved to access our records; or visit HEALTHeLINK's website at www.wnyhealthelink.com; or call HEALTHeLINK at 716- 206-0993 ext. 311; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

6. **Re-disclosure of Information.** Any Participant(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

7. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HEALTHeLINK ceases operation ***(or until 50 years after your death whichever occurs first)***. If HEALTHeLINK merges with another Qualified Entity our consent choices will remain effective with the newly merged entity.

8. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Participant(s) that access your health information through HEALTHeLINK while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFTIS FORM

(FOR ACCIDENTS ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to,
(Print Patient's Name)

Michael D. Calabrese, Physician P.C. ("Assignee")
(Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided to said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conducts of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR ANYCOMERCIALORPERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERTO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRESWITH ANOTHER TO MAKE A FALSE REPORT OF THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR ANY INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____
(Print Name of Patient)

_____
(Signature of Patient)

_____
(Date of Signature)

_____
(Address of Patient)

Michael D. Calabrese, Physician P.C.
(Print Name of Provider)

_____
(Signature of Provider)

dba Medical Care of WNY at Buffalo

_____
(Date of Signature)

656 Elmwood Avenue

Buffalo, New York 14222
(Address)

NYS FORM NF-AOB (Rev 1/2004)