Dr. Daniel Cameron and Associates

Name: Date:

Please provide the following:

Is there a history of exposure to ticks? If yes, check the box

- Home? If checked, what state(s)
- Work? If checked, what state(s)
- Recreation? If checked, what state(s)
- Vacation? If checked, what state(s)
- Pets? If checked, what pet(s) e.g. dogs, cats, horses
- Hunting
- Hiking
- Sports
- Other (if checked, list)

Is there a history of a tick bite(s)? If yes, check the box and provide details

- Was it a deer tick?
- Was it another type of tick? If so, what did it look like
- Was the tick engorged?
- How long was the tick attached? Hours _____ Days _____
- Where on your body was it located?

Is there a history of a rash? If yes, check the box and provide details

- Was the rash see by a medical professional?
- Where on your body was it located?
- What was the diameter? Inches _____
- What was the shape? e.g. round or oval
- What did the rash look like? e.g. bull's eye, raised

Is there a history of one the following additional findings described by the CDC? If yes, check the box and provide details

- Bell's palsy
- Heart block
- Meningitis
- Arthritis

Do you have any other symptoms not discussed on Review of Symptoms Scale (ROSS)? If yes, check below:

- o Appetite loss
- o Weight gain
- o Vision loss
- o Light sensitivity
- o Double vision
- o Eye redness
- o Eye swelling
- o Eye discharge
- o Earache
- o Decreased hearing
- o Nasal congestion
- o Hoarseness
- o Difficulty breathing
- o Shortness of breath
- o Cough
- o Heartburn
- o Vomiting
- o Excessive gas
- o Bloating
- o Constipation
- o Inability to control bladder
- o Frequent Urination
- o Burning when urinating
- o Blood in urine
- o Tremors/Seizures
- o Irregular Menstrual Cycle
- o Swelling in hands/feet
- o Changes in skin color/hair/nails
- o Poor Balance
- o Anxiety
- o Difficulty Speaking
- o Thoughts of suicide/violence
- o Muscle weakness
- o Muscle cramp
- o Rash
- o Itching
- o Heat/Cold Intolerance
- o Other
- o Other

5. Initial function: The initial functional limitations include:

- ☐ maintaining personal hygiene and grooming
- ☐ maintaining socially appropriate
- ☐ making simple decisions
- ☐ working
- ☐ working at a consistent pace
- ☐ walking
- ☐ understanding and remembering instructions
- ☐ sitting
- ☐ standing
- ☐ attending school
- ☐ participating in school
- ☐ maintaining grades
- ☐ attending GYM
- ☐ carrying more than 10 pounds
- ☐ stooping
- ☐ crawling
- ☐ repetitive finger movement
- ☐ word finding
- ☐ completing tasks
- ☐ difficulties functioning as a spouse
- ☐ difficulties functioning as parent
- ☐ walking, required a cane
- ☐ walking, required a wheelchair
- ☐ driving

6. Have there been any obstacles in your Lyme disease treatment? If yes, check below:

- ☐ diet of simple sugars
- ☐ evidence of co-infections
- ☐ inactivity
- ☐ pain
- ☐ problems at school
- ☐ problems at work
- ☐ psychiatric problems
- ☐ relationship problems
- ☐ sleep issues
- ☐ substance use
- ☐ steroid use
- ☐ treatment delays

7. Did you have a positive/abnormal tests for Lyme disease or a tick borne illnesses? If yes, check below:

- ☐ Lyme Western blot IgG
- ☐ Lyme Western blot IgM
- ☐ Babesia
- ☐ Ehrlichia
- ☐ Anaplasmosis
- ☐ Bartonella
- ☐ MRI
- ☐ CT
- ☐ EMG
- ☐ NCV
- ☐ Spinal tap
- ☐ SPECT
- ☐ PCR
- ☐ EEG
- ☐ X rays
- ☐ Thyroid
- ☐ Rheumatoid arthritis
- ☐ Sed rate
- ☐ Other

8. Were you evaluated by any other physicians during this illness? If yes, check the box below:

- ☐ Allergist – Name:
- ☐ Cardiologist – Name:
- ☐ Chiropractor – Name:
- ☐ Complementary Medicine – Name:
- ☐ Emergency room – Name:
- ☐ Endocrinologist – Name:
- ☐ ENT – Name:
- ☐ Gastroenterologist – Name:
- ☐ Gynecologist – Name:
- ☐ Hospital – Name:
- ☐ Infectious disease physician – Name:
- ☐ Neurologist – Name:
- ☐ Neurosurgeon – Name:
- ☐ Pediatrician
- ☐ Primary care physician – Name:
- ☐ Rheumatologist – Name:
- ☐ Ophthalmologist – Name:
- ☐ Orthopedic surgeon – Name:
- ☐ Otolaryngologist
- ☐ Pain management – Name:
- ☐ Podiatrist – Name:
- ☐ Psychiatrist – Name:
- ☐ Surgeon – Name:
- ☐ Urgent Care Center – Name:
- ☐ Urologist – Name:
- ☐ Vascular surgeon – Name:
- ☐ Physiatrist (Physical Medicine and Rehabilitation) – Name:

9. Antibiotic treatment: The treatment summary includes treatment number, date of treatment, medication, outcome and/or comments:

Treatment 1:

Treatment 2:

Treatment 3:

10. Tick borne illnesses based on: one of the following additional findings described by the CDC? If yes, check below:

☐ Bell's palsy ☐ Meningitis ☐ Heart block ☐ Arthritis

Date of Birth: Gender: ☐Male ☐Female

Race: ☐Caucasian ☐Hispanic ☐African American ☐Asian ☐Indian ☐Pacific Islander ☐Other
Occupation: _____
Number of Children: _____ Ages: _____

The highest level of education I attend is: None: ☐ Elementary: ☐ Partial High School: ☐
High School Graduate:☐ Partial College:☐ College Graduate:☐ Post Graduate:☐ Other: _____

Are you currently smoking? No: ☐ Yes: ☐ How many years: _____ Never: ☐
I smoke _____ packs of cigarettes per day, _____ pipes full per day, _____ of cigars per day

I presently drink alcohol on a regular basis? No: ☐ Yes: ☐
How many per week? _____ Glasses of wine, _____ Bottles of beer, _____ other drinks

Have you ever used alcohol on a regular basis in the past? No: ☐ Yes: ☐
I stopped drinking alcohol on a regular basis on or about:
I drank per week approximately: _____ glasses of wine, _____ bottles of beer, _____ other drinks

Do you consume caffeine daily: No: ☐ Yes: ☐
If yes, I consume __cups of tea, ___cups of coffee, ___chocolate drinks or candy, ___oz. caffeinated soft drinks per day

Do you exercise regularly? No: ☐ Yes: ☐
How many times per week do you exercise: _____ How many minutes per exercise session? _____

MEDICATIONS:

Are you allergic to any medication(s): No: ☐ Yes: ☐

Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____

Are you taking any medicine (Prescription and/or over the counter): No: ☐ Yes: ☐

Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____

Are you taking any controlled drugs? No: ☐ Yes: ☐

Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____

Have you ever had allergies: (Hay Fever, Asthma, Other) No: ☐ Yes: ☐ **If yes:**

Allergy Type: _____ Date started:
Allergy Type: _____ Date started:
Allergy Type: _____ Date started:
Allergy Type: _____ Date started:

Any Illness or Conditions: No: ☐ Yes: ☐

Describe: _____ Date:
Describe: _____ Date:
Describe: _____ Date:
Describe: _____ Date:

Have you had any surgery? No: ☐ Yes: ☐

Type: _____ Date:
Type: _____ Date:
Type: _____ Date:
Type: _____ Date:

Have you been Hospitalized? No: ☐ Yes: ☐

Reason: _____ Date:
Reason: _____ Date:
Reason: _____ Date:
Reason: _____ Date:

Have you had any Injuries? No: ☐ Yes: ☐

Describe: _____ Date:
Describe: _____ Date:
Describe: _____ Date:
Describe: _____ Date:

Did any immediate family members have any disease? No: ☐ Yes: ☐

Relative: _____ Date:
Relative: _____ Date:
Relative: _____ Date:
Relative: _____ Date:

For Women Only:	
Are you post menopausal? No: ☐ Yes: ☐	Date of last breast exam:
Date of last menstrual period:	Date of Mammogram:
Are you pregnant? No: ☐ Yes: ☐	Date of last Pap test:
If yes, expected date of delivery:	
Are you planning a pregnancy? No: ☐ Yes: ☐ If yes, When:	
Form of contraception:	

Review of Systems Scale (ROSS)

Please put an **X** on the line between the brackets that *BEST* describes the severity of each symptom as you experienced it – DURING THE PAST WEEK.

Example1: [_____X]
Example 2: [__X_____]
Example 3: [_____X_____]
Example 4: [X_____]

		None	Severe
1.	Fatigue/tiredness ……..	[_____]	
2.	Fevers …….	[_____]	
3.	Chills ……..……..	[_____]	
4.	Facial numbness ……	[_____]	
5.	Disturbed sleep ……..……	[_____]	
6.	Poor concentration …….	[_____]	
7.	Memory loss ……	[_____]	
8.	Irritability ……..	[_____]	
9.	Crying ……..	[_____]	
10.	Sadness/depression …….	[_____]	
11.	Headaches ……..	[_____]	
12.	Blurred vision ……..	[_____]	
13.	Eye pain ……..	[_____]	
14.	Ear ringing/buzzing ……	[_____]	
15.	Jaw pain ……..	[_____]	
16.	Sore throat …….	[_____]	
17.	Swollen glands ……..	[_____]	
18.	Dizziness ……	[_____]	
19.	Lightheadedness …….	[_____]	
20.	Stiff neck ……	[_____]	
21.	Back pain ……..	[_____]	
22.	Chest pain …….	[_____]	
23.	Palpitations ……	[_____]	
24.	Nausea ……	[_____]	
25.	Diarrhea …….	[_____]	
26.	Testicular pain/pelvic pain ….	[_____]	
27.	Tingling/numbness/burning….	[_____]	
28.	Painful joints …….	[_____]	
29.	Stiff joints ……	[_____]	
30.	Sore muscles ..……	[_____]	
31.	Night sweats ……	[_____]	
32.	Other ……	[_____]	
33.	Other ……	[_____]	

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

36-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
Understanding and communicating						
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.3	Analysing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting around						
D2.1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.5	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

In the past 30 days, how much difficulty did you have in:						
Self-care						
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people						
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities						
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.

Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.7	Getting all the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Participation in society						
In the past 30 days:						
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.2	How much of a problem did you have because of barriers or hindrances in the world around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much time did you spend on your health condition, or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ____

This completes the questionnaire. Thank you.

Please provide us with the history of your illness from your first symptoms. Please include any tick bite, rash, symptoms, doctors seen, what they thought, and tests. Also include any antibiotic treatment(s) and if they were helpful. Add extra pages if needed.

Please provide us with the history of your illness from your first symptoms. Please include any tick bite, rash, symptoms, doctors seen, what they thought, and tests. Also include any antibiotic treatment(s) and if they were helpful. Add extra pages if needed.

Please provide us with the history of your illness from your first symptoms. Please include any tick bite, rash, symptoms, doctors seen, what they thought, and tests. Also include any antibiotic treatment(s) and if they were helpful. Add extra pages if needed.

PATIENT INFORMATION						
Patient's Last Name	Patient's First Name					Home Phone No.
Street Address	City		State		Zip Code	Social Security No.
Occupation (Indicate if student)	M	F	Date of Birth	Age	Marital Status	Spouse's Name (If applicable)
Patient's Employer/School Name	Cell Phone No.					Work Phone No.
Employer Address	City			State		Zip Code

OTHER INFORMATION		
Emergency Contact	Relationship	Phone No.
Referred By:	County you live in	How long did it take you to get here?

INSURANCE INFORMATION			
Primary Insurance Company	Name of Policy Holder (If not self)		
Primary Insurance ID #	Group #	Policy Holder's DOB	Co-pay Amount
Social Security # of Policy Holder	Relation to Policy Holder	Is your primary insurance through an employer? Yes / No Employer's Name:	

OTHER INSURANCE INFORMATION			
Secondary Insurance Company	Name of Policy Holder (If not self)		
Secondary Insurance ID #	Group #	Policy Holder's DOB	Co – pay amount
Social Security # of Policy Holder	Relation to policy holder	Is your primary insurance through an employer? Yes / No Employer's Name:	

I authorized the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I certify that the information I have reported above is truthful to the best of my knowledge. **I understand that if the insurance information I have provided is incorrect or not in effect for the date of service, that I will be responsible for all charges incurred.** I understand that I am responsible for the terms and conditions of my individual insurance plan. Due to the vast number of different insurance policies, I realize that Dr. Daniel Cameron and Associates/FMA personnel are not responsible for informing me which test and procedures are covered. I herby give consent to medical examination and treatment for the above patient.

_____ _____ _____

Signature Of Patient Responsible Party (***MUST BE OVER 18***) Relation (Example: Self, Spouse, Parent) Date:

FINANCIAL POLICY

Thank you for choosing Dr. Daniel Cameron and Associates (First Medical Associates) as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we would like for you to read and sign.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, NO EXCEPTIONS.

WE ACCEPT CASH, VISA, MASTER CARD, DEBIT CARDS, AND DISCOVER CARDS.

WE WILL CHARGE AN ADDITIONAL 5 PERCENT INTEREST ON ALL DEBT OVER 30 DAYS.

Regarding Insurance:

If we are a participating provider of your insurance plan, we would appreciate that **all co-payment and deductibles be paid at the time of your office visit.** Any unpaid balance will incur monthly finance fees.

If we **do not** participate with your insurance plan, we would appreciate payment in full at the time of your visit. We will give you a receipt to submit to your insurance carrier for reimbursement.

Non-Covered Services:

Please be aware that some of the services provided today maybe non-covered services and not considered reasonable and necessary under your insurance plan. In such a case, these services will become your responsibility. **It is your responsibility to make sure your services are covered.**

Missed Appointments:

In this event that you cannot make you appointment with us, **we require 24 hours advanced notice.** Failure to notify our office, in advanced, at least 24 hours, will result in you being billed for that visit. Insurance will not cover a missed appointment fee. This will become your responsibility to pay before booking your next appointment.

Patient's or Authorized Person's Signature:

I authorized the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorized payment of medical benefits to the undersigned physician or supplier for services rendered. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. By signing below, I understand and agree to this financial policy.

Signature: _____ Date: _____

HIPPA Privacy Act Patient Consent Form

The Health Insurance Portability and Protection Act, H.I.P.P.A requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Name of Patient: _____ **Patient Date of Birth** _____

Signature of Patient or Guardian: _____ **Date** _____

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits, and/or the request results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. This H.I.P.P.A consent is **valid up to one year**. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits, and/or the results of tests and procedures.

1. Individual Name_____ Relation to Patient: _____

2. Individual Name_____ Relation to Patient: _____

Signature of Patient or Guardian: _____ **Date** _____

Leaving Messages with Household Members/Answering Machine

From time to time it is necessary for our office to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to go over insurance benefits, to notify the patient that we would like to discuss lab or procedure results, or to ask a patient to call us regarding an issue or concern. At no time will our office discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

PURPOSE OF CONSENT: By signing this form you will consent to our use and disclosure of protected health information to carry out treatment, payment activities, and health care operations. The office will continue to require additional consent in writing to give out your medical records.

NOTICE C ACY PRACTICES: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides the description of our treatment, payment activities, and health care operations, of the use and disclosures we may make of your protected health information, and of other important matters about protected nformation. A copy of our notice accompanies this consent. We encourage you to read it carefully and complete , signing this consent.

Yes No

Yes No

We reserv ght to change our privacy practices as described in our notice of privacy practices. If we change our privacy pra we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we have maintained.

You may obtain a copy of our notice of privacy practices, including any revisions of our notice, at any time by contacting the following:

CONTACT PERSON: Daniel J. Cameron, M.D., M.P.H.
Address: 657 Main Street, Mount Kisco, NY 10549 **Telephone #:** (914) 666-4665 Fax: (914) 666-6271

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitting to the contact person listed above. Please understand that revocation of this consent will not affect any actual retake and reliance of this consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Please initial if you want us to leave voice mail or send via email regarding your lab result: ☐

I, _____have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this consent is signed by personnel representative on behalf of the patient, complete the following.

PERSONNEL REPRESENTATIVE'S NAME: _____ **_____**

RELATIONSHIP TO PATIENT: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Informed Consent for Treatment of Persistent Lyme Disease

There is considerable uncertainty regarding the diagnosis and treatment of Lyme disease. No single diagnostic and treatment program for Lyme disease is universally successful or accepted. Medical opinion is divided, and two schools of thought regarding diagnosis and treatment exist. Each of the two schools of thought is described in peer-reviewed, evidence-based treatment guidelines. Until we know more, patients must weigh the risks and benefits of treatment in consultation with their doctor.

My Diagnosis. The diagnosis of Lyme disease is primarily a clinical determination made by my doctor based on my exposure to ticks, my report of symptoms, and my doctor's observation of signs of the disease, with diagnostic tests playing a supportive role.

Doctors differ in how they diagnose Lyme disease.

- Some physicians rely on the narrow surveillance case criteria of the CDC for clinical diagnosis even though the CDC itself cautions against this approach. That approach diagnoses the existence of Lyme disease based exclusively upon positive serological (blood) tests which confirm the presence or absence of the antibodies created by the immune system to fight the Lyme bacteria. These physicians may fail to diagnose some patients who actually have Lyme disease because the two-tiered testing methodology known as ELISA/Western Blot, have been proven to be inaccurate. For these patients, treatment will either not occur or will be delayed.

- Other physicians use broader clinical criteria for diagnosing Lyme disease. These physicians believe it is better to err on the side of treatment because of the serious consequences of failing to treat active Lyme disease. Physicians such as Dr. Cameron use history, symptomatology, travel patterns and exposure to Lyme endemic areas as well as physical symptomatology to diagnose Lyme disease. Since no treatment is risk-free, use of broader clinical criteria to diagnose disease could in some cases expose patients to increased treatment complications. This approach may result in a tendency to over diagnose and over treat Lyme disease. Consequently, the careful monitoring of the patient's response to the particular antibiotic regiment prescribed by Dr. Cameron is an integral part of the treatment

My Treatment Choices. The medical community is divided regarding the best approach for treating persistent Lyme disease. Many physicians follow the treatment guidelines of the Infectious Diseases Society of America (IDSA) that recommend short term treatment only and view the long-term effects of Lyme disease as an autoimmune process or permanent damage that is unaffected by antibiotics.[1] Other physicians believe that the infection persists, is often associated with other tick-borne co-infections, is difficult to

eradicate, and therefore requires long-term treatment with intravenous, intramuscular, or oral antibiotics, frequently in high and/or combination or pulsed dosing. These physicians follow the guidelines promulgated by the International Lyme and Associated Diseases Society (ILADS), which recognize that commercial diagnostic tests may be insensitive and that diagnosis and treatment must be based on the physician's clinical judgment and that the risk/benefit of any treatment must be individualized. [2]
Potential Benefits of Treatment. Some clinical studies support longer term treatment approaches, while others do not. The experience in this office is that although most patients improve with continued treatment, some do not.

Risks of treatment. There are potential risks involved in using any treatment, just as there are in foregoing treatment entirely. Some of the problems with the use of long term or short term antibiotics may include (a) allergic reactions, which may manifest as rashes, swelling, and difficulty with breathing, (b) stomach or bowel upset, or (c) yeast infections. Severe allergic reactions may require emergency treatments, while other problems may require suspension of treatment, or adjustment of medication. Other problems such as adverse effects on liver, kidneys gallbladder, or other organs may occur.

Factors to consider in my decision. No one knows the optimal treatment of symptoms that persist after a patient is diagnosed with Lyme disease and treated with a simple short course of antibiotic therapy. The appropriate treatment may be supportive therapy without the administration of any additional antibiotics. Or, the appropriate treatment might be additional antibiotic therapy. If additional antibiotic therapy is warranted, no one knows for certain exactly how long to give the additional therapy. By taking antibiotics for longer periods of time, I place myself at greater risk of developing side effects. By stopping antibiotic treatment, I place myself at greater risk that a potentially serious infection will progress. Antibiotics are the only form of treatment shown to be effective for Lyme disease, but not all patients respond to antibiotic therapy. There is no currently available diagnostic test that can demonstrate the eradication of the Lyme bacteria from my body. Other forms of treatment designed to strengthen my immune system also may be important. Some forms of treatment are only intended to make me more comfortable by relieving my symptoms and do not address any underlying infection.

My decision about continued treatment may depend on a number of factors and the importance of these factors to me. Some of these factors include (a) the severity of my illness and degree to which it impairs my quality of life, (b) whether I have co-infections, which can complicate treatment, (c) my ability to tolerate antibiotic treatment and the risk of major and minor side effects associated with the treatment, (d) whether I have been responsive to antibiotics in the past, (e) whether I relapse or my illness progresses when I stop taking antibiotics, and (f) my willingness to accept the risk that, left untreated, a bacterial infection potentially may get worse

For example, if my illness is severe, significantly affects the quality of my life, and I have been responsive to antibiotic treatment in the past, I may wish to continue my treatment. However, if I am not responsive to antibiotics, I may wish to terminate treatment. I will ask my doctor if I need any more information to make this decision and am aware that I have the right to obtain a second opinion at any time if I think this would be helpful.

I realize that the choice of treatment approach to use in treating my condition is mine to make in consultation with my physician. After weighting the risks and benefits of the two treatment approaches, I have decided: (CHECK ONE)

☐ To treat my Lyme disease through a treatment approach that relies heavily on clinical judgment and may use antibiotics until my clinical symptoms resolve. I recognize that this treatment approach does not conform to IDSA guidelines and that insurance companies may not cover the cost of some or all of my treatment.

☐Only to treat my Lyme disease with antibiotics for thirty days, even if I still have symptoms.

☐Not to pursue antibiotic therapy

The IDSA guidelines are available free at: http://www.idsociety.org/uploadedFiles/IDSA/Guidelines-Patient_Care/PDF_Library/Lyme%20Disease.pdf

The ILADS guidelines are available free at: http://www.tandfonline.com/doi/full/10.1586/14787210.2014.940900

_____

I understand the benefits and risks of the proposed course of treatment, and of the alternatives to it, including the risks and benefits of foregoing treatment altogether. My questions have all been answered in terms I understand. All blanks on this document have been filled in as of the time of my signature.

Physician Signature: _____
Date: _____

Signature: _____
Date: _____

Print Name: _____
Witness:_____

For more information on the treatment approaches used in diagnosing and treating Lyme disease, see:

1. Wormser GP, RJ Dattwyler, ED Shapiro, AJ Halperin, AC Steere, MS Klempner, PJ Krause, JS Bakken, F Strle, G Stanek, L Bockenstedt, D Fish, JS Dumler, and RB Nadelman. The clinical assessment, treatment, and prevention of Lyme disease, Human Granulocytic Anaplasmosis, and Babesiosis: Clinical practice guidelines by the Infectious Diseases Society of America. Clin Infect Dis. 2006; 41(1 November): 1089. Available at http://cid.oxfordjournals.org/content/43/9/1089.full

2. Cameron DJ, Johnson LB, Maloney EL. Evidence assessments and guideline recommendations in Lyme disease: the clinical management of known tick bites, erythema migrans rashes and persistent disease. Expert Review Anti-Infective Therapy. 2014 Sep;12(9):1103-35.

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Name _____ Date _____

Our office needs your medical records to enable communication with those physicians or facilities, as necessary. We are requesting that you summarize the names and addresses of these physicians or facilities and grant consent to request these records.

Specialty or facility	**Name**	**Address**	**Telephone Number**	**Fax Number**	**Consent for medical records Yes No***
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐

A request for records will be provided. If you choose not to grant consent for medical records from one or more physicians or facilities, write the reasons below.
Reasons:
_____
_____

Patient's signature: _____ Date: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released 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 from (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**

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 Name 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.**