The Memory Clinic

Paul R. Solomon, PhD
Clinical Director
Neuropsychologist

Cynthia Murphy, PsyD, MBA
Executive Director
Geriatric Neuropsychologist

Lisa Catapano-Friedman, MD
Medical Director
Psychiatrist

Andrew E. Budson, MD
Neurologist

Diana E. Michalczuk, PsyD
Geriatric Neuropsychologist
Clinical Research Coordinator

Paula D. Levin, CCRC
Clinical Research Manager

Megan Casey, RN
Clinical Research Coordinator

Stephanie J. Merrill
Clinic Manager

Rita L. Burgher
Laboratory Coordinator

Mary Pat Mazzola, MA
Clinical Psychologist-Masters

Madeline M. Robinson, BA
Psychometrician

Donna F. Fontaine
Regulatory Specialist
Business Manager

Alzheimer's Disease Cooperative Study Site (ADCS)

Sponsored by the National Institute on Aging

Your Appointment:

_____

_____

_____

Enclosed are directions to our office, a couple forms to complete and a few medical release forms to sign.

The New Patient Evaluation is a two-appointment process. Your first appointment will last about 3 hours and the second appointment will last 1 ½ - 2 hours.

- ❑ **Please bring this completed packet,**
- ❑ **your insurance cards,**
- ❑ **and a list of medications, supplements and vitamins you currently take with you to the clinic. If you would like help with your medication list, please bring the bottles of all the medications, vitamins and supplements with you.**

- ❑ **You must bring someone who knows you well (like a spouse, friend, sibling, or child) with you to this appointment.**

If you have any questions please don't hesitate to call me.

Welcome to The Memory Clinic! We look forward to seeing you.

Sincerely,

Stephanie J. Merrill
Patient Care Coordination

The Memory Clinic
357 Shields Drive
Bennington, VT 05201
Local: (802) 447-1409 / Toll Free: (866) 646-3362

Name: _____

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Gender: ❑ **Male** ❑ **Female**

Ethnicity: ❑ Caucasian ❑ African American ❑ Hispanic/Latino
❑ Asian/Pacific Islander ❑ Other: _____

Eye Color: ❑ Blue ❑ Brown ❑ Other: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed (since _____)

Handedness: ❑ Right ❑ Left ❑ Ambidextrous

Is English your first language? ❑ Yes ❑ No

Do you live… (please check *all* that apply)

- ❑ Alone
- ❑ With your spouse
- ❑ With other family members: _____
- ❑ At home
- ❑ In an assisted living community
- ❑ In senior housing
- ❑ In a full-time care facility (since _____)

Are you retired? ❑ Yes (since _____) ❑ No ❑ Never worked for pay
Current or most recent occupation: _____

How many years of school did you finish?

1 2 3 4 5 6 7 8	Elementary School
9 10 11 12	High School
13 14 15 16	Associate's or Bachelor's Degree
17 18 19 20+	Graduate Degree

PLEASE LIST AN EMERGENCY CONTACT WHO DOES NOT LIVE WITH YOU

Name: _____ Relationship: _____

Address: _____

Phone Number: _____

Medical History Questionnaire

Name:_____Date:_____

During the course of your life, have you been affected by any of the following? Please check Yes or No. **If your answer is yes, please give approximate date of onset.**

	Yes	No		Yes	No
Exposure to toxins			Sleep Disorder		
Glaucoma			Stomach or colon disorders		
Macular degeneration			Bleeding disorders		
Diabetes			Immune Disorder		
Thyroid disorder (Hyper/Hypo)			Anemia		
High Cholesterol			Cigarette smoking		
Hypertension (High Blood Pressure)			Drug reactions (e.g., rash)		
Heart disease			Alcohol or drug abuse		
Heart Attack			Psychiatric disorders		
Coronary Artery Disease			Major Depression		
Heart Valve abnormalities			Bipolar Disorder		
Congestive Heart Failure (CHF)			Hysterectomy		
Bodily injuries			Oophorectomy		
Meningitis			*Have you had **recent** experience of:*		
Head injury			Weakness		
Syphilis			Numbness		
Encephalitis			Fever, chills or night sweats		
Stroke/TIA			Nausea, vomiting or diarrhea		
Epilepsy/seizures			Chest pain		
Learning disability			Shortness of breath		
Skin Cancer			Rashes		
Other Cancer			Joint pain		
Hearing loss			Incontinence		
Liver disease			Mood difficulties		
Kidney disease			Sleeping difficulties such as over-sleeping or insomnia?		
Lung or breathing disorders					
Have you ever been hospitalized for psychiatric treatment?					

Please list Surgeries/Hospitalizations:	Approximate year done:

Medication List

Name (brand or generic)	Dose	Route	Indication (reason for taking)	Start Date	Stop Date (if not taking)

Medical Release Forms

1.) The first 2 forms are for your primary care doctors' information.
- Please complete *both* these forms with your doctor's information, then sign and date below on the signature line. *If you do not have their address or telephone number, just leave those areas blank.*

2.) This form allows you to give us permission to speak to people among your family and friends.
- Please provide their first and last name and their relationship to you then sign and date on the signature line.
-

3.) The next form is the HIPAA form, which outlines how your information is protected.
- Please sign and date the top copy and keep the other copy for your record.

If you have any questions regarding these forms please bring them with you to your appointment and we will be glad to assist you.

Anyone may witness your signatures.

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Donna F. Fontaine
Regulatory Specialist
Business Manager

Release Authorization

I, _____, hereby authorize

The Memory Clinic
357 Shields Drive
Bennington, VT 05201

to communicate (via telephone, facsimile, or letter) and/or to release all needed records and/or information pertaining to my treatment to:

_____
Name of Person, Agency, and/or Office

_____
Street Address

_____
City, State, ZIP

_____
Telephone #

in order to facilitate my treatment and/or evaluate my continued care and/or referral. I understand that I have the right to inspect and copy the information to be disclosed and that I may withdraw this authorization at any time, except to the extent that action has been taken based on this authorization. I understand that there will be **NO EXPIRATION** for this authorization unless revoked by me.

_____
Signature of Patient

_____
Signature of Individual Authorized to Sign in Lieu of Patient

_____
Signature of Witness

_____
Date of Signature

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357 Shields Drive
Bennington, VT 05201

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Signature of Patient

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Signature of Individual Authorized to Sign in Lieu of Patient

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Signature of Witness

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Date of Signature

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Release Authorization

I, _____, hereby authorize the staff at

The Memory Clinic
357 Shields Drive
Bennington, VT 05201

to communicate (via telephone, facsimile, or letter) and/or to release all needed records and/or information pertaining to my treatment to:

_____	_____
Name of Person	Relationship
_____	_____
Name of Person	Relationship
_____	_____
Name of Person	Relationship
_____	_____
Name of Person	Relationship
_____	_____
Name of Person	Relationship

I understand that I may withdraw this authorization at any time, except to the extent that action has been taken based on this authorization. I understand that there will be **NO EXPIRATION** for this authorization unless revoked by me.

_____
Signature of Patient

_____
Signature of Individual Authorized to Sign in Lieu of Patient

_____
Signature of Witness

_____
Date of Signature

The Memory Clinic
Clinical Neuroscience Research Associates
357 Shields Drive
Bennington, VT 05201

VERMONT HIPAA NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)* for *treatment, payment*, and *health care operations* purposes with your consent. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.

- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychiatrist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- *"Use"* applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is

written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and heath care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been abused or neglected, I am required by law to report such information within 24 hours to the Commissioner of Social and Rehabilitation Services or its designee.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an elderly or disabled adult has been abused, neglected or exploited, I am required by law to report this information to the Commissioner of Aging and Disabilities.

- **Health Oversight:** If I receive a subpoena for records from the Vermont Board of Psychological Examiners in relation to a disciplinary action, I must submit such records to the Board.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If I know that you pose a serious risk of danger to an identifiable victim, I am required by law to exercise reasonable care to protect such victim. This may include disclosing your relevant confidential information to those people necessary to address the problem. Also, I may disclose your confidential information if I judge disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflected by you on yourself or another person.

IV. Patient's Rights and Psychiatrist's Duties

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.

- *Right* to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychiatrist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will present you with a copy if you are in active treatment with me.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Dr. Paul Solomon, Clinical Director, or Cynthia A. Murphy, Executive Director, Clinical Neuroscience Research Associates/The Memory Clinic, 357 Shields Drive, Bennington, VT. 05201, phone number 802-447-1409.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice is in effect on 4/14/03.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by our next meeting.

I, _____, acknowledge receipt of
patient name

this VERMONT HIPAA NOTICE FORM provided me by Clinical Neuroscience

Research Associates/The Memory Clinic staff.

Signature: _____

Name of Person Authorized to sign for Patient: _____

Relationship between authorized person and patient: _____

Date: _____

PATIENT COPY

The Memory Clinic
Clinical Neuroscience Research Associates
357 Shields Drive
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