HIGHGATE
medical group

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Williamsville, NY 14221
Phone: (716) 636-7979
Fax: (716) 929-0192

Suite 104 & 207

3950 E. Robinson Rd
W. Amherst, NY 14228
Phone: (716) 564-1111
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Suite 106 & 207

Physicians
Michael Dlugosz, M.D.
Stacey Gugino, M.D.
Justin Green, M.D.
Nicholas Pantano, M.D.
Lori Luzi, M.D.
David Pawlowski, M.D.
Michael Freitas, M.D.
Kristina Semidey, M.D.

Nurse Practitioners
Kathleen Barone, F.N.P.
Kimberly MacDonald, F.N.P.
Sharon Tasner, F.N.P.
Elliott Yadon, F.N.P.
Rachel Yadon, F.N.P.

Physician Assistants
Derek Aube-Marchant, PA-C
Jessica Schoenhals, PA-C
Brie Anne Slaughter, PA-C
Stephanie Guize, PA-C
Jillian LaMarca, PA-C
Christine Divita-McKenna, PA-C
Chelsey Milleville, PA-C
Alicia Reimondo, PA-C
Renee Sawka, PA-C
Megan Schifferli, PA-C
Chelsea Percy, PA-C
Emily Kowalski, PA-C
Meaghan Piegay, PA-C

Long-Term Nursing Care/Short-Term Rehab
Ellen Brody, F.N.P.
Danielle Casillo, A.G.N.P.
Leah Gorsline, PA-C
Kimberly Gruber, F.N.P.
Sandy Michel, A.N.P.
Erin Morgan, PA-C
Christina Parkot, F.N.P.
Elizabeth Leiser, F.N.P.
Mallory Furniss, F.N.P.
Mary Nolan, PA
Sara Baker, F.N.P.
Larika Evans, F.N.P.
Veronica Miles, F.N.P.
Chris Laduca, PA
Tiffany Phalen, PA
Timothy Giglio, ANP

Welcome, and thank you for considering Highgate Medical Group, P.C. for your health care needs. We are dedicated to providing you and your family the best in modern medical services in a caring environment. Our goal is to provide you with the highest quality of care and positive patient experience.

In order to expedite your patient registration, please bring the following to your appointment:

- Health Insurance Card
- Photo Identification
- Health Records – including immunizations
- Completed enclosed forms

We offer the following service to make your experience both easy and convenient:

Our phones are turned off and on service during the lunch hour 11:50-1PM daily

- Monday 7-6 PM
- Tuesday 7-6 PM
- Wednesday 7-6 PM
- Thursday 7-6 PM
- Friday 7-5 PM (Office Phones turn off at 4PM)
- Saturday 8AM – 1PM (At our Williamsville location for all patients)
  - Same day sick visits only

We offer the following service to make your experience both easy and convenient:

- Same Day appointment availability
- Our affiliation with McGuire Group gives us access to continue care with short-term rehabilitation and long-term nursing home care coverage
- An online patient portal, for easy communication and appointment scheduling. We anticipate all patients to use the patient portal to effortlessly retrieve test results and communicate directly with your care team.

Your primary care physician plays an important role in the coordination of your care. We have a provider on call 24 hours a day, 7 days a week to help with emergency situations. We can help you identify the most appropriate level of care and refer you to providers that share our philosophy of patient-centered medical care.

We look forward to meeting you!

Highgate Medical Group, P.C.

www.highgatemedical.com
You can also make payments on our website!

APPOINTMENT DATE: _____ **TIME:** _____

PROVIDER: _____

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TRANSITIONING FROM A PEDIATRIC PATIENT TO AN ADULT PATIENT

Highgate Medical Group, P.C., is a family medicine practice treating all patients age 6 and older.

It is our goal to provide a smooth transition from childhood to adolescence and beyond. We want our patients to know that their privacy is secure and that our staff at Highgate Medical Group is here to help with all needs, including:

- Illness and injury
- Wellness visits, such as sports physicals and check-ups
- Referral to specialists, if needed
- Medication Management
- Health Insurance
- Social Issues
- School/Work forms

We want to instill in our next generation the importance of having a primary care physician to maintain physical and mental health. It is best to be seen yearly for wellness appointments, even when in good health, so that any ailments can be treated quickly and appropriately as they may develop.

Our office actively participates in a medical home model. Our online patient portal is a tool to assist in scheduling appointments, retrieving test results, and communicating with your clinician as the need arises. Patients above the age of 13 will be given the opportunity to manage their own patient portal.

Thank you, and remember, we are here for you!

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PATIENT REGISTRATION

Patient Name: _____Date of birth: _____

Mailing Address: _____

Phone Number: _____ Phone Carrier: _____

Pharmacy Name & Address: _____

Sex: Male Female Other **Ethnicity**: Hispanic/Latino Not Hispanic/Latino

Race: White/Caucasian Black/African American American Indian/Alaska Native Asian
Native Hawaiian or Other Pacific Islander

Primary Language: _____

Mother's Name: _____

Address (if different from above):

_____

Telephone: _____

Father's Name: _____

Address (if different from above):

_____

Telephone: _____

Guardian's Name (if different from birth parents): **_____** Relationship: _____

Address (if different from above):

_____

Telephone: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Insurance Name: _____ ID # _____

Subscriber Name: _____ Relation: _____

Employer: _____ Occupation: _____

Secondary Insurance Name: _____ ID # _____

Subscriber Name: _____ Relation: _____

Who referred you to Highgate Medical Group? Are any family members or friends currently under our care?

_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or responsible party) Signature: _____ Date: _____

Patient Health History

Name: _____ **Date:** _____
SSN: _____ **DOB:** _____

Chief Complaint: What is the reason for the visit today? (Please describe the problem in detail):

_____
_____

Birth History:

Pregnancy complications _____
_____
Delivery complications □ Preterm or □ Full term _____
_____

Patient Medical History: Please check all that apply

□ Asthma	□ Eczema/Skin condition	□ Gastrointestinal problem	□ Other _____
□ Anemia	□ Epilepsy/Seizures	□ Psychiatric disease	_____
□ Concussion	□ Headache/Migraine	□ Thyroid	_____
□ Diabetes	□ Heart problems	□ UTI	□ None

Please describe:

_____

Previous Surgeries: Please list any surgeries with approximate date

_____
_____

Serious injury: Please describe any previous serious injuries (i.e. car accident, fractured bones)

_____
_____

Medications: Please list any medications including the dose and frequency (attach list)

Drug	***Dose/Frequency***
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: please list any allergies and reaction

_____
_____

Immunizations: Up to date? □ **YES** □ **NO** Please bring immunization record to appointment

Social History:

School and grade _____
Smokers in the household? □ **YES** □ **NO** If yes, who? _____
Pets in the household? □ **YES** □ **NO** If yes, which? _____
Other caretakers? □ **YES** □ **NO** If yes, who? _____

Family History: Any blood relative with the following

□ Asthma	□ Cancer	□ Inflammatory Bowel Disease	□ Psychiatric Disease
□ Aneurysm	□ Diabetes	□ Kidney Disease	□ Thyroid Disease
□ Autoimmune disease	□ Headache/Migraine	□ MS	□ Other: _____
□ Blood disorder	□ High Blood Pressure	□ Stroke	□ None

Please describe (condition and family member affected):

_____
_____
_____

Review of Symptoms: Please check any current or past problems or conditions

GENERAL HEALTH
- □ Recent weight change
- □ Loss of appetite
- □ Fatigue
- □ Fever/Chills

EARS, NOSE, MOUTH, THROAT
- □ Difficulty swallowing
- □ Earaches
- □ Loss of hearing/deafness
- □ Loss of smell
- □ Loss of taste
- □ Painful chewing
- □ Ringing in ears
- □ Sinus infection
- □ Sores in mouth
- □ Other _____
- □ None

EYES
- □ Blurred vision
- □ Double vision
- □ Loss of vision
- □ Glaucoma
- □ Injury
- □ Pain
- □ Other _____
- □ None

GASTROINTESTINAL
- □ Blood in stools
- □ Increasing constipation
- □ Nausea/Vomiting
- □ Painful bowel movements
- □ Persistent diarrhea
- □ Stomach or abdominal pain
- □ Ulcer
- □ Other _____
- □ None

GENITOURINARY
- □ Blood in urine
- □ Female: irregular periods
- □ Female: #pregnancies _____
  #miscarriages _____
- □ Male: testicle pain
- □ Painful or burning urination
- □ Sexually transmitted disease
- □ Kidney stones
- □ Other _____
- □ None

CARDIOVASCULAR
- □ Pain in chest
- □ High blood pressure
- □ High cholesterol
- □ Irregular heart beat
- □ Other _____
- □ None

MUSCLES/JOINT/BONES
- □ Back pain
- □ Difficulty walking
- □ Joint pain
- □ Muscle pain or tenderness
- □ Other _____
- □ None

PULMONARY
- □ Asthma
- □ Chronic or frequent cough
- □ Pneumonia
- □ Shortness of breath
- □ Other_____
- □ None

PSYCHIATRIC
- □ ADHD
- □ Anxiety
- □ Depression
- □ Eating Disorder
- □ Other _____
- □ None

NEUROLOGICAL
- □ Black outs/loss of consciousness
- □ Difficulty speaking
- □ Difficulty walking
- □ Headaches
- □ Injury to the brain/spine
- □ Lightheaded or dizziness
- □ Memory loss
- □ Numbness or tingling
- □ Paralysis
- □ Stroke
- □ Tremors
- □ Other _____
- □ None

Are you?
- □ right-handed
- □ left-handed
- □ both

SKIN
- □ Rash or itching
- □ Sun sensitivity
- € Hair loss
- □ Other _____
- □ None

SLEEP
- □ Snoring
- € Sleep walking
- € Nightmares

Highgate Medical Group, P.C.
Patient Financial Policy

Thank you for choosing Highgate Medical Group, P.C. as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policy, and your responsibilities. To prevent any billing delays or difficulties, the office must be notified of any patient information changes. (i.e., address, name, insurance information, phone number, etc.)

Insurance Claims

All services will be billed to responsible companies. If for any reason the claim is rejected, you will be responsible for payment. Payment is due upon receipt. A service charge of $10 will be applied after the first statement to your account if the balance is not paid in full within 30 days.

Co-pays

All copays are due at the time of check in. Otherwise, your appointment will be rescheduled.

Self-Pay Accounts

Self-pay accounts are payments without insurance coverage, or patients covered by insurance plans in which the office does not participate. Self-pay patient's will be required to pay for services at the time of their visit, where an estimate of cost will be presented.

Missed appointments & Same day cancelations

If you are a **new patient,** we require 48-hour cancelation notice to your scheduled appointment. Highgate Medical Group requires a 24-hour cancelation notice prior to your scheduled appointments. There is a $40 "no show" and "same day" cancelation fee. Repeated missed appointments may result in dismissal from the practice.

Returned Checks

The charge for a returned check is $25 payable by cash. This will be applied to your account in addition to the insufficient amount.

Completion of Medical Forms

There will be a $15 charge fee for the completion of ALL forms. (i.e., disability, school physicals, FMLA, etc.)
* This includes "just a signature"

Outstanding Balance Policy

It is our policy that all past due accounts will be sent 3 statements and a collection reminder letter. If payment is not made on the account, a single phone call will be made to try and make payment arrangements. If no resolution can be made, the account will be sent to the collection agency and possible dismissal from the practice. Regardless of any personal arrangements that a patient might have outside our office, if you are over 18 years of age and receiving treatments, you are ultimately responsible for payment of the service. Our office will not bill any other personal party. All costs associated with our collection efforts (including collection agency fee) will be passed on to you. This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification on any of the above policies, please feel free to contact us.

Consent/Authorization for treatment and Release Information/Disclosure Personal Information

I hereby agree that Highgate Medical Group, P.C. may perform care and treatment any may conduct such examinations, laboratory tests and procedures as directed by my physician or treatment practitioner.

I hereby consent to the use and disclosure of my Protected Health Information by Highgate Medical Group, P.C. for purposes of treatment, payment and health care operations. Any release of my medical records and Protected Health Information may be made according to the state and federal regulations. I understand that Highgate Medical Group, P.C. may release medical information to any third party which may be responsible for payment of my medical expenses.

I understand that I am financially responsible to Highgate Medical Group, P.C. for any balance not covered by the insurance carrier.

Assignment of Benefits

I hereby assign and authorize my insurance benefits to be paid to Highgate Medical Group, P.C.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

Name: _____ Date: _____

Signature: _____

Name: _____ DOB: _____

Date of screening: _____

Generalized Anxiety Disorder GAD-2

During the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐

Total Score: _____

PHQ-9: Modified for Teens

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom, check the box beneath that answer that best describes how you have been feeling.

1. Feeling down, depressed, irritable, or hopeless?
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

2. Little interest or pleasure in doing things?
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

3. Trouble falling, staying asleep, or sleeping too much?
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

4. Poor appetite, weight loss, or overeating?
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

5. Feeling tired, or having little energy?
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

6. Feeling bad about yourself - or that you are a failure, or that you have let yourself or your family down?
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

7. Trouble concentrating on things like school work, reading, or watching TV?

□ Not at all
□ Several days
□ More than half the days
□ Nearly every day

8. Moving or speaking so slowly that other people could have noticed?

-Or the opposite -

Being so fidgety or restless that you have been moving around a lot more than usual?

□ Not at all
□ Several days
□ More than half the days
□ Nearly every day

9. Thoughts that you would be better off dead, or of hurting yourself in some way?

□ Not at all
□ Several days
□ More than half the days
□ Nearly every day

10. In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

□ Yes □ No

11. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

□ Not at all
□ Several days
□ More than half the days
□ Nearly every day

12. Has there been a time in the past month when you have had serious thoughts about ending your life?

□ Yes □ No

13. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

□ Yes □ No

Depression Screening Result:

□ Positive □ Negative **Severity Score: _____**

The CRAFFT Screening Interview

PART A	**No**	**Yes**
During the PAST 12 MONTHS, have you;		
1.Drink more than a few sips of beer, wine, or any drink containing alcohol?	□	□
2.Use any marijuana (weed, oil, or hash by smoking, vaping, or in food) or "synthetic marijuana" (like "K2", "Spice")?	□	□
3.Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or# of days vape)?	□	□
4. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	□	□

Did the patient answer "*yes*" for all questions in Part A? **Yes** **or** **No**

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 1 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 9b

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/Finn 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.