MedSur One Telemedicine, LLC

307-223-2955 Phone
512-688-3854 Fax
kmccoy@medsurone.com

New Patient Packet
Telehealth

- Please complete the New Patient packet and return by fax. The front desk team will contact you to schedule an appointment after reviewing your completed new patient packet.
- Please arrive to your first appointment 15 minutes early so that your vital signs can be obtained. If your telehealth site does not provide vitals, you will have to obtain them the day of your first appointment. Vitals include height, weight, blood pressure, and heart rate.
- If any information is missing or incomplete, a member of the nursing team will contact you with any questions or to clarifying any information.
- Insurance required Co-Pays can be paid by check and mailed, or by credit card over the phone prior to the time of service.

New Patient Checklist:

- Telehealth scheduling instructions
- Intake forms
- Patient no show policy forms, other insurance, or no insurance
- Consent for Treatment form, Medicaid, Medicare, or other insurance
- Consent for Teleheatlh form
- Release of Information form
- WYPOLST
- Privacy form
- Patient Screening – Staying healthy assessment, 8a, Pain assessment
- PHQ-9, GDS, suicide, Photography consent

Please include:

- Photocopy of your photo ID.
- Photocopy of your insurance card(s), front and back.
- Guardianship paperwork if appropriate.
- Referring provider and or behavioral health records if available.

******Please fax completed packet to 512-688-3854. Please keep in mind any incomplete section my result in delay of care.***

Welcome

MedSur One Telemedicine, LLC

CONSENT FOR TREATMENT	**STAMPER OR PATIENT LABEL**

HEALTH AND MEDICAL CARE CONSENT: I give my consent to all healthcare services performed by MedSur One Telemedicine its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate.

LEGAL RELATIONSHIP BETWEEN PROVIDER AND PATIENT: I understand that the Provider furnishing services to me, including the radiologist and phlebotomist, are independent practitioners. I understand that my relationship With my treating Provider is initiated, continued, and/or changed by me and is at my discretion. These providers may bill separately for their services.

RELEASE OF INFORMATION AND INSURANCE BENEFITS: I authorize MedSur One Telemedicine and my Provider to release my medical and/or financial records to individuals and entities as specified in the Notice of Privacy Practices and/or by federal and state law. I understand that MedSur One Telemedicine may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months unless I revoke it, in writing. I understand that any revocation will not be effective for disclosures necessary to effect payments for health care that has been provided. MedSur One Telemedicine may release medical information to an electronic health information exchange (HIE); you may choose to opt-out of this information sharing and would need to contact the HIE to restrict access to health information unless a life threatening medical emergency exists. HIE contact information will be provided upon request.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I authorize and assign direct payment of insurance benefits to MedSur One Telemedicine and Provider involved in my care for all amounts due from my primary and/or supplemental insurance carrier(s). I understand and agree that I am financially responsible for payment of any charges which insurance does not pay. I further understand, lacking timely payment by my insurance, I will be required to assume responsibility for payment of my account. If financial assistance is requested for payment of my account, I hereby give my permissions for investigation of my credit including a receipt of my consumer report from a consumer reporting agency. I understand that services are provided to me, the patient, and not my insurance company. I understand and agree that I am totally responsible for payment of all MedSur One Telemedicine charges and the fees of other professional providers for care rendered to me at MedSur One Telemedicine. "By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages. If my bill is not paid in full thirty (30) days from the date services are provided, I agree to be responsible for all attorney fees and court costs in collecting any sums due and owing for services received.

PERSONAL VALUABLES: I understand and agree that MedSur One Telemedicine shall not be liable for loss or damage to personal property not deposited in the safe. MedSur One Telemedicine reserves the right to inventory items placed in the safe, to refuse to accept items, and to dispose of items after my leaving if unclaimed thirty (30) days after written notice is mailed to my last known address.

ACKNOWLEDGEMENTS (PATIENTS TO INITIAL EACH ACKNOWLEDGEMENT. IF APPLICABLE):

_____ I acknowledge receipt of the **Notice of Privacy Practices** _____ (Date Given)
_____ I acknowledge receipt of the **Patient Bill of Rights and Responsibilities**
_____ I acknowledge receipt of the **Medicare/TriCare Patient Rights and Responsibilities, and reminded of the Important Message from Medicare**
_____ I provided my **Ethnicity, Race and** what language I prefer to receive for medical or healthcare instructions.

I have read this form and understand its contents. I have had an opportunity to ask questions, which have been answered to my satisfaction.

_____ _____
Patient Signature **Date/Time**

_____ _____
Signature of Authorized Representative/Parent/Guardian **Date/Time**

_____ _____
Signature of Witness **Date/Time**

_____
Patient Address

MedSur One Telemedicine, LLC

Informed Consent for Telemedicine Services

Table to be completed by Provider:

PATIENT NAME:_____ LOCATION OF PATIENT: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
PROVIDER NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____		DATE CONSENT DISCUSSED: _____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Kathleen McCoy providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, my insurance carrier will have access to my medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Kathleen McCoy at MedSur One Telemedicine. As long as this consent is in force (has not been revoked) Kathleen McCoy may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to patient: _____

Witness: _____ *Date:* _____

I have been offered a copy of this consent form (patient's initials) _____

MedSur One Telemedicine, LLC

Patient No Show Policy

We at MedSur One want to support our patients to keep their established appointments in order to help ensure that they receive excellent care. However, when our established patient's do not attend scheduled appointments, another member of the community has missed an opportunity to access treatment. Please keep the following guidelines in mind:

A. When patients are unable to keep their appointment, they will need to notify the clinic staff, or leave a message the night before the scheduled appointment. MedSur One may automatically charge a "No-Show" fee to the patient and/or responsible party if this expectation is not met. Please keep in mind, insurance companies will not cover these fees. With unavoidable emergencies there will be no charge. **You can reach the clinic by calling 307-223-2955.**
B. If a patient is rescheduled from a no-show appointment or a late cancellation, staff will explain the expectation that the no-show fee will be paid alongside any co-pay required at the subsequent appointment.
C. If a patient has **three** no-show appointments in a **three** month period we will send a termination of treatment letter by registered mail and an invitation to petition for return for treatment by provider agreement. At this time, all future appointments with your Provider will be cancelled.
D. If you would like to resume services, please complete the Petition to Resume Services form and return completed document to MedSur One Telemedicine by fax @ 512-688-3854. Keep in mind, once services have been closed you may be placed back on a waitlist before resuming services.
E. If the cause for a missed appointment is due to technical failure of equipment on either party's end, there will not be a "No Show" charge.

I have been informed of the above procedures.

_____ _____

Signature of patient or Guardian Date

_____ _____

Print Name Date of Birth

Telehealth Scheduling Instructions

What is a telehealth visit?

- Uses videoconferencing technology to connect patient and provider to improve a patient's health status in the same manner as an in-person visit.
- Patient can be seen in the comfort of their own home or in another location authorized by the third party payer – no drive time or waiting time
- You will talk with and be evaluated by a medical professional just as if you were seen face to face in one of a brick and mortar clinic.

Terms and Conditions:

Please read the indicated terms and conditions. You must agree to the terms and conditions before scheduling your telehealth appointment.

Is a telehealth visit RIGHT for you? Telehealth visits are NOT for medical emergencies. If you have chest pain, abdominal pain, or a diabetic, psychiatric or other medical emergency, call 911 now.

We are not able to prescribe controlled substances such as narcotics with a telehealth visit.

Can you answer "Yes" to the following questions?

- Do you have a chronic medical condition.
- Do you have a computer with Internet connectivity, a webcam and audio, or mobile device with video sharing abilities and Internet connectivity?
- Is the computer/device located or able to be located in a private area? The telehealth appointment must be conducted in an area free from interruptions and where others cannot hear.
- Are you physically located in the state of Wyoming?
- Do you have a valid credit card?
- Are you over the age of 18?

I consent that I meet all the terms and conditions listed above

_____ _____

Signature of patient (or guardian) Date

Types of Primary illnesses treated during a telehealth visit:

- Cold/flu
- Cough
- Sore throat
- Rash
- Urinary tract infection
- Vomiting
- Chronic medical conditions
- Other

How to schedule a telehealth visit:

- Call (307) 655-1666 to speak with the telehealth appointment scheduler
- You will be asked:
  - To consent to the terms/conditions on the previous page by reading, signing, dating and returning page one.
  - To sign and return the Telehealth Consent Form.
  - To provide credit card payment information. This is for co-pays and other payments not covered by insurance. You will NOT be billed until after your visit has been completed.
  - To discuss your general health information, including the reason for your visit. This may involve filling out and emailing or faxing a medical history, questionnaire, etc.
  - Provide an email address where you can receive information pertinent to your appointment
- If you meet the terms and conditions, you will be sent information on when and how to connect to the provider using videoconferencing technology.

How to connect to the medical provider:

- Check your email and note the date and time of your scheduled telehealth appointment.
- At least 5 minutes before your scheduled appointment, when you are in a private area free from interruption, click on the link provided in the email.
- Follow the directions on your screen to be connected. If the medical office has not yet joined, you may be prompted to wait until they join the meeting.
- The facility staff member will ensure your computer/device is set-up correctly and ready for your telehealth visit. If you have any questions about your telehealth visit, this is a good time to ask!
- The facility staff member will verify your identification. When asked to do so, hold your driver's license or other form of government issued photo identification close to the camera until verification is complete.
- The facility staff member will ask you to verify you are physically located in a private area and in the state of Wyoming (or a state where your provider is licensed).
- The provider will then join the virtual exam room for your telehealth visit. At this time you can discuss your health concerns with your provider.

Patient Intake Form

PATIENT INFORMATION

Name _____ Social Security # _____
Last Name *First Name* *Middle Initial*

Sex □ Male □ Female Date of Birth: _____ Advanced Directive: _____

□ Other Medical Power of Attorney: _____

Street Address/City/State/Zip _____

Mailing address (if different than above) _____ Occupation: _____

Home Phone ( )_____ Cell Phone ( ) _____Can we leave messages? □ Yes □ No

E-mail address: _____ Level of Education: _____

Tobacco use: _____ Alcohol use: _____ Nonprescription drug use: _____

Interpreter Needed? □ Yes □ No

Marital Status □ Divorced □ Legally Separated □ Married □ Single □ Widowed □ Other _____

Ethnicity: CI American Indian □ Hispanic or Latino □ Patient Refused □ Unknown □ Other_____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ White or Caucasian
□ Native Hawaiian or Other Pacific Islander □ Other □ Patient Refused □ Unknown

Primary Language □ English □ Spanish □ Other _____Religion: _____

Primary Care Provider: _____

Address: _____

Phone Number: _____

Emergency Contact _____ Phone ( )_____ Relationship _____
Additional Contact _____ Phone ( )_____ Relationship _____

Employer: _____

Address: _____

Phone Number: _____

Employment Date: (From) _____ (To)_____

Status: □ Disabled Full Time □ Part Time □ Retired □ Other

Guarantor (Party Responsible for Bill) □ Self □ Employer □ Spouse □ Father □ Mother □ Other
Name: _____ SSN#: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: □ Male □ Female

Patient Intake Form

Patient Registration Form

INSURANCE INFORMATION

Primary Insurance _____
ID# _____ Group # _____
Telephone ( ) _____
Insured Name _____
Insured DOB _____ Sex □ M □ F
Relationship to Patient: _____

Secondary Insurance
ID# _____ Group # _____
Telephone ( ) _____
Insured Name _____
Insured DOB _____ Sex □ M □ F
Relationship to Patient: _____

Third Insurance (if any) _____

* * * A copy of your insurance card and photo ID is required for billing***

_____

If this is a Workman's Comp/Injury (more information may be requested)
Date of Injury _____
Docket/Claim number _____ Contact Person _____

Surgical History

Appendectomy _____
Cholecystectomy _____
Heart bypass _____
Heart Stents _____
Pacemaker _____
Hysterectomy _____
Prostate surgery _____
Hip Surgery _____
Breast surgery _____
Knees _____
Brain _____
Cataracts _____
Other _____
Other _____

Past Medical History

Pneumonia _____
Cough greater > months _____
None _____
Diabetes _____
Hypertension _____
Hepatitis _____
Seizures _____
Tuberculosis _____
Arthritis _____
Back pain _____
Thyroid problem _____
Prostate problems _____
High cholesterol _____
Heart attack _____
Stents/angina _____
Heart murmur _____
Blood clots _____
Blood disease _____

Patient Intake Form

Family Medical History

Relationship	Alive or Deceased	Hypertension	Diabetes Type 2	Diabetes Type 1	Heart Failure	Heart Attack	Atrial Fibrillation	Cancer	Kidney Failure	Dementia	Depression	Pacemaker	Prostate Cancer
Mother													
Father													
Sister													
Brother													
Maternal grandmother													
Paternal grandmother													
Maternal grandfather													
Paternal grandfather													

Patient Intake Form

Family Medical History (continued)

CVA/TIA _____
HIV/Aids _____
Alzheimer's Disease _____
Stomach ulcers _____
Hernia _____
Kidney disease _____
Liver disease _____
Herniated disc _____
Glaucoma _____
Cancer _____
Osteoporosis _____
Pacemaker _____
Asthma _____
COPD _____
Syncope _____
Irregular heartbeat _____
Open wound infection _____
Neuropathy _____
Depression/Anxiety _____
MRSA _____
Sepsis _____
SARS _____
Falls _____
Hearing loss _____
Blindness _____
Crohn's disease _____

Known Allergies

Allergen	Reaction

Medications	Dose	Route	Schedule

Patient Intake Form

Most recent hospitalization Date _____ Hospital _____ Diagnosis _____

Length of stay _____ days _____ weeks _____ months _____ unknown

Permission to release/or obtain medical records

☐ Please do not release my medical records

☐ Yes, I give my permission to release and/or obtain my medical records with other providers.

Immunizations

Flu shot past 12 months	☐ Yes	☐ No
Tetanus within past 10 years	☐ Yes	☐ No
Zoster vaccine (shingles)	☐ Yes	☐ No
PCV 13 (Pneumonia vaccine)	☐ Yes	☐ No
PCV 23 (Pneumonia vaccine)	☐ Yes	☐ No
Past reaction to vaccines	☐ Yes	☐ No

You may release my information to following people

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Patient Intake Form

Medications continued

Medications	Dose	Route	Schedule

Mother's maiden name _____

I acknowledge that I have been given the right to review and secure a copy of the notice of Privacy Practices. I understand that MedSur One Telemedicine, LLC reserves the right to change the terms of this notice _____ (initials)

_____ _____

Signature of parent/guardian Date

MedSur One Telemedicine
Authorization to Release
Health Care Information

(1) Patient	Name			Previous Name(s)
	Birth Date			Phone Number
(2) Information Released FROM	**FROM Other Clinic/Provider:**			
	Address	City	State	Zip Code
(3) Information Disclosed TO	Individual/Facility/Organization **OR** **SELF**			
	Attn/Dept:	Phone Number		Fax
	Address	City	State	Zip Code

(REQUIRED) Dates of Service FROM: **TO:** include:

(4) Health Information to be Released

Provider Dictation/Notes	Diagnostics	Miscellaneous	Miscellaneous Continued
☐ MD Notes	☐ Echo(s)(*)	☐ Progress Notes	☐ Radiology Images (CD)
☐ ER (*)/Urgent Care Record	☐ EKG/Tracings(*)	☐ Immunizations	☐ Billing Information
☐ History & Physical(*)	☐ LAB(s)(*)	☐ Medications	
☐ Consults(*)	☐ Pathology Reports(*)	☐ HIV test results	☐ Abstract Record (includes *)
☐ Operative/Proc Note(*)	☐ Radiology Reports(*)	☐ Treatment Plans	☐ Complete Record for locations
☐ Discharge Summary(*)	☐ EEG Reports	☐ Nursing Records	listed in Box 2 above
☐ Psych Eval	☐ Sleep Studies		
☐ BH Evals/Assessments	Other (please specify) _____		

(5) Purpose for Disclosure

☐ Personal ☐ Continuity of Care ☐ Worker's Comp ☐ Insurance ☐ Disability ☐ Legal
Other _____

(6) Delivery Method

*There may be a charge/fee for copies of records. **Information needed by: _____**
☐ FAX ☐ MAIL ☐ PICK UP BY Patient or Designee _____

(7) Authorization

I hereby authorize release of the health information indicated above that is contained in my patient record to the Provider named above. I understand and acknowledge the release to include by initialing: **_____Treatment for mental illness _____Alcohol/drug abuse _____HIV/AIDS test results or diagnoses.**
This authorization does not include permission to release outpatient Psychotherapy Notes as defined as notes that document private, group, or family counseling sessions that are separated from the rest of a patient's medical record. This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

_____ _____
Signature Date (Expires one year from signature date)

(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

_____ _____
Relationship to Patient *(if not patient)* Expiration Date

Wyoming

Advanced Directive – Also known as a living will, a power of attorney for healthcare: It is a legal document that allows you to place in writing your personal decision with regard to how you would like your agent, healthcare provider to arrange for end of life procedures in the event you are unable to communicate or act on your own behalf.

WYOPOLST –

Physicians' orders for life sustaining treatment—is designed for seriously ill individuals or those who are in very poor health regardless of age. Must be signed by patient and provider.

Wyoming Advance Health Care Directive Form for:

_____

(print your full name)

Please place the completed document on the front of your refrigerator or another location where an emergency responder might easily see it.

These materials have been prepared as a public service by AARP Wyoming and are for informational purposes only and should not be construed as legal advice or as official State of Wyoming documents.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

PLEASE NOTE: *Answering any of the following questions is optional, but the more information you provide on this form, the better your designated agent may act on your behalf. This form is not to be used to designate a financial power of attorney. It is for health care matters only. This form is in compliance with Wyoming State Statute 35-22-401 through 416.*

(1) Designation of agent: I designate the following person as my agent to make health care decisions for me:

_____
(name of person you choose as your agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone) (cell phone)

If I revoke my agent's authority, or if my agent is not willing, able or reasonably available to make a health-care decision for me, **I designate as my alternate agent:**

_____
(name of person you choose as your alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone) (cell phone)

(2) Agent's authority: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care, except as I state here:

_____

_____

_____
(Add additional sheets if needed.)

(3) When agent's authority becomes effective: My agent's authority to make health care decisions for me takes effect at the following time (**check and initial only one (1) option**):

Check Initial

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective only when my primary physician or, in his/her absence, my treating primary health care provider determines that I lack the capacity to make my own health care decisions; **OR**

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective only when my primary physician (and **not** when any then treating health care provider of mine) determines that I lack the capacity to make my own health care decisions; **OR**

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective as necessary immediately upon my execution of this Advance Health Care Directive Form.

(4) Agent's obligation: My agent shall make health care decisions for me in accordance with this power of attorney for health care using any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent that my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

PART 2: INSTRUCTIONS FOR HEALTH CARE

(5) End-of-Life decisions: I direct that those involved in my care provide, withhold or withdraw treatment in accordance with the choice I have checked and initialed below (check and initial only one option):

Check Initial

☐ _____ (a) **Choice to Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

OR

☐ _____ (b) **Choice Not to Prolong Life:** I do not want my life to be prolonged if:

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time;

(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness;

(iii) The likely risks and burdens of treatment would outweigh the expected benefits.

(6) Artificial nutrition and hydration: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (5) unless I have checked and initialed **one** of the boxes below:

Check Initial

☐ _____ I **want** artificial nutrition regardless of my condition.

☐ _____ I **do NOT** want artificial nutrition regardless of my condition.

☐ _____ I **want** artificial hydration regardless of my condition.

☐ _____ I **do NOT** want artificial hydration regardless of my condition.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

(7) Relief from pain:

Check **Initial**

☐ _____ I **want** treatment for the alleviation of pain or discomfort at all times;

OR

☐ _____ I **do NOT** want treatment for the alleviation of pain or discomfort.

(8) Other wishes: (If you do not agree with the choices above, you may write your own or add to the instructions above. Examples may include: blood or blood products; chemotherapy; simple diagnostic tests; invasive diagnostic tests; minor surgery; major surgery; antibiotics; oxygen; wish to die at home if possible; etc.) I direct that:

_____

_____

_____

_____

PART 3: DONATION OF ORGANS AND TISSUES UPON DEATH

(9) Upon my death (check and initial applicable boxes):

Check **Initial**

☐ _____ (a) I have arranged to give my body to science.

☐ _____ (b) I have arranged through the Wyoming Donor Registry to give any needed organs and/or tissues (For enrollment information, call 1-888-868-4747 or visit WyomingDonorRegistry.org).

☐ _____ (c) **I do NOT** wish to donate my body, organs and/or tissues.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

PART 4: INFORMATION ABOUT MY HEALTH CARE PROVIDER

(10) The following physician is my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

More information about my health care can be obtained through:

_____
(name of health care institution/hospice)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

(11) Effect of copy: A copy of this form has the same effect as the original.

SIGNATURE (Sign and date the form here):

_____
(print your name)

_____
(sign your name) (date)

_____
(address)

_____
(city) (state) (zip code)

SIGNATURES OF WITNESSES or NOTARY PUBLIC:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is known to me to be the principal, and that the principal signed or acknowledged this document in my presence.

Please Note: *Under Wyoming State Statute 35-22-403 (b), a witness may not be a treating health care provider, operator of a treating health care facility or an employee of a treating health care facility.*

First witness

_____ _____
(print witness' name) (address)

_____ _____
(signature of witness) (date)

Second witness

_____ _____
(print witness' name) (address)

_____ _____
(signature of witness) (date)

OR

Notary (in lieu of witnesses)

State of Wyoming

County of_____ } SS.

Subscribed and sworn to and acknowledged before me by_____,
the Principal, this _____ day of _____, _____.

My commission expires: _____.

_____
Notary Public's signature

Wyoming Department of Health

WyoPOLST

Providers Orders for Life Sustaining Treatment

HIPAA PERMITS DISCLOSURE TO HEALTHCARE PROFESSIONALS AS NECESSARY FOR TREATMENT

FIRST follow these orders, **THEN** contact the Physician, PA, or APRN. This is a Provider Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Every patient shall be treated with dignity and respect.

Last / First / Middle Name (Place ID Sticker Here if Applicable):

Date of Birth: ____/____/____ Last 4 SSN: ___ ___ ___ ___ Gender: M / F

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ **CPR / Attempt Resuscitation** ☐ **DNR / Do Not Attempt Resuscitation (Allow Natural Death)**

When NOT in cardiopulmonary arrest, follow orders in **B and C**

B Check One

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **FULL TREATMENT:** Use intubation, advanced airway interventions, mechanical ventilation and defibrillation/cardioversion as indicated. Includes care described below.
Transfer *to hospital if indicated. Includes intensive care.*

☐ **SELECTIVE TREATMENT:** Use medical treatment, IV fluids, and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BIPAP). Includes treatments listed below. Includes care described below.
Transfer *to hospital if indicated. Avoid intensive care if possible.*

☐ **COMFORT-FOCUSED THERAPY:** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort.
Patient prefers no transfer*: Transfer if comfort needs cannot be met in current location.*

Additional Orders (e.g. dialysis, etc) _____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: *Oral fluids and nutrition must always be offered if medically feasible.*

☐ Long-term artificial nutrition by tube
☐ Trial period of artificial nutrition by tube
☐ No artificial nutrition by tube

Additional Orders/Patient Goals: _____

D

MEDICAL CONDITION / PATIENT GOALS:

E

___ In initialing this line, I indicate that my instructions on this POLST form may not be changed by my next of kin or medical decision maker if I am incapacitated.

SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences, and best known information.

Discussed with:	Print Primary Health Care Provider Name and Address:	Phone #:
☐ Patient ☐ Parent of a minor ☐ Legal Guardian ☐ Health Care Agent (DPOAHC) ☐ Spouse ☐ Other: _____	Primary Health Care Provider Signature:	Date:
	Patient (or Legal Representative):	Date:

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged, however photocopies and faxes of signed POLST forms are legal and valid.

HIPAA PERMITS DISCLOSURE TO HEALTHCARE PROFESSIONALS AS NECESSARY FOR TREATMENT

WyoPOLST – Providers Orders for Life Sustaining Treatment

Patient Name (Last, First Middle)	Date of Birth:	Gender:

Additional Contact Information (optional)

Name of Next of Kin, Guardian, Surrogate, or Patient Contact:	Relationship:	Phone Number:

Patient has: ☐ Advanced Directive (or Living Will) ☐ DPOAHC ☐ Organ Donor	**Encourage all advance care planning documents to accompany POLST**

Directions for Health Care Professional

Completing WyoPOLST

- Completion of WyoPOLST form is VOLUNTARY.
- WyoPOLST is recommended for patients with advanced illness or frailty.
- Must be completed by Wyoming Licensed Health Care Professional based on patient preferences and medical indications.
- WyoPOLST must be signed by a licensed provider and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by licensed provider in accordance with facility/community policy.
- Use of original form is strongly encouraged. Original form should be printed on yellow card-stock, and orignal form should accompany patient. Photocopies and FAXes of signed WyoPOLST forms are legal and valid.
- Additional copies of the WyoPOLST form can be obtained by contacting the Wyoming Department of Health, Aging Division, Community Living Section at 1-800-442-2766.

Using WyoPOLST

- Any incomplete section of WyoPOLST implies full treatment for that section.

Section A:

- No defibrillator (including AED) should be used on a person who has chosen “Do Not Attempt Resuscitation.”

Section B:

- Comfort-Focused therapies must always be offered to any patient regardless of level of care selected.
- When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Focused Therapy” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Focused Therapy”
- Non-invasive airway techniques includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate “Selective Treatment” or “Full Treatment.”

Section C:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing WyoPOLST

It is recommended that WyoPOLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person’s health status, or
- The person’s treatment preferences change.

Modifying and Voiding WyoPOLST

- A person with capacity can, at any time, void the WyoPOLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new WyoPOLST form.
- To void WyoPOLST, draw a line through Sections A through D and write “VOID” in large letters. Sign and date this line.

Review of WyoPOLST:

Review Date	Reviewer Name/Signature	Reason for Review	Review Outcome
		☐ Change in Patient Status ☐ Transfer ☐ Annual Review	☐ No Change ☐ Form Voided ☐ New Form Completed
		☐ Change in Patient Status ☐ Transfer ☐ Annual Review	☐ Change in Patient Status ☐ Transfer ☐ Annual Review

Instructions for filling out the Telehealth Consent Form

Beginning October 1, 2017 Wyoming Medicaid will allow the client's home to be a valid Origination site. Written client consent is required.

Completion: The appropriate person at either the client's site or the health care practitioner site completes the form and obtains the client's signature prior to the services.

Distribution: The original form is completed by the provider of the telehealth service and is retained in the client's medical record. A copy is also given to the client or parent/guardian.

Field	Action
Client Name	Enter the client's name
Type of Service	Define the service to be provided as a telehealth service on the second line
Provider Name	Enter the name of the health care practitioner who will be seeing the client from the distant site
Facility Name and Address	Enter the facility name and address of the distant site where the health care practitioner is located
Alternative Services	Describe in writing any other options that are available to the client
Signature and date	The client, parent or legal representative must sign and date the form
Signature of Person Obtaining	Person obtaining consent must sign and date the form
Facility Name	Enter the Facility for the person obtaining consent
Facility Address	Enter the Facility address for the person obtaining consent

Wyoming Medicaid Telehealth Patient Consent Form

I (Client Name)_____agree to receive this health care service (type of service) _____, as a telehealth service. I understand that the health care provider (name) _____is located in another location (facility name and address) . A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for six months for follow-up telehealth services with the health care provider.

I also understand that:

- I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care provider in-person if I decline telehealth service.
- If I decline the telehealth services, the other options/alternatives available to me, including in person services are as follows:

_____

_____

- The same confidentiality protections that apply to my other medical care also apply to the telehealth service.
- I will have access to all medical information resulting from the telehealth service as provided by law.
- The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- I will be information of all people who will be present at all sites during my telehealth service.
- I may exclude anyone from any site during my telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the telehealth service in an urgent need arises OR I will be told ahead of time that this is not available.

I have read this document carefully, and my questions have been answered to my satisfaction. Signature of

Patient: _____ Date _____

Or

Signature of Parent or Legal Representative: _____ Date _____

Telehealth Consent:
Signature of Person Obtaining Consent: _____ Date _____

Facility Name: _____

Facility Address: _____

Wyoming Medicaid
PO Box 667 Cheyenne, WY 82003
(800) 251.1268

MedSur One Telemedicine

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we MedSur One Telemedicine practice manager and MedSur One Telemedicine the physician group practice) may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made if an of our protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

Staying Healthy Assessment For Adult & Geriatric

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

1903

Date: ☐☐ / ☐☐ / ☐☐
(month) (day) (year)

Subject's Initials : _____

Study Subject #: ☐☐☐☐

PLEASE USE BLACK INK PEN

Study Name: _____

Protocol #: _____

PI: _____

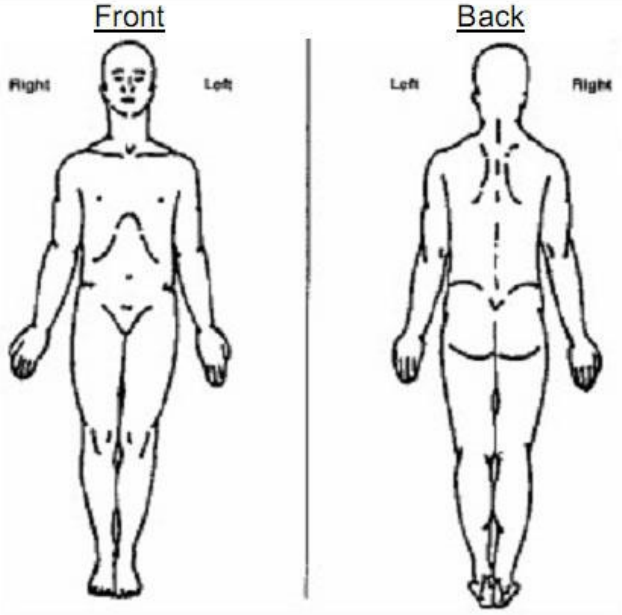
Revision: 07/01/05

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by marking the box beside the number that best describes your pain at its worst in the last 24 hours.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its least in the last 24 hours.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the average.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have right now.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

Geriatric Depression Scale (GDS)
Scoring Instructions

Instructions: Score 1 point for each bolded answer. A score of 5 or more suggests depression

1.	Are you basically satisfied with your life?	yes	**no**
2.	Have you dropped many of your activities and interests?	**yes**	no
3.	Do you feel that your life is empty?	**yes**	no
4.	Do you often get bored?	**yes**	no
5.	Are you in good spirits most of the time?	yes	**no**
6.	Are you afraid that something bad is going to happen to you?	**yes**	no
7.	Do you feel happy most of the time?	yes	**no**
8.	Do you often feel helpless?	**yes**	no
9.	Do you prefer to stay at home, rather than going out and doing things?	**yes**	no
10.	Do you feel that you have more problems with memory than most?	**yes**	no
11.	Do you think it is wonderful to be alive now?	yes	**no**
12.	Do you feel worthless the way you are now?	**yes**	no
13.	Do you feel full of energy?	yes	**no**
14.	Do you feel that your situation is hopeless?	**yes**	no
15.	Do you think that most people are better off than you are?	**yes**	no

A score of $\geq$ 5 suggests depression ***Total Score*** _____

Ref. Yes average: The use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986

UCLA LONELINESS SCALE

Description of Measure:

A 20-item scale designed to measure one's subjective feelings of loneliness as well as feelings of social isolation. Participants rate each item as either O ("I often feel this way"), S ("I sometimes feel this way"), R ("I rarely feel this way"), N ("I never feel this way").

Scale:
INSTRUCTIONS: Indicate how often each of the statements below is descriptive of you.

C indicates "I often feel this way"
S indicates "I sometimes feel this way"
R indicates "I rarely feel this way"
N indicates "I never feel this way"

1. I am unhappy doing so many things alone O S R N
2. I have nobody to talk to O S R N
3. I cannot tolerate being so alone O S R N
4. I lack companionship O S R N
5. I feel as if nobody really understands me O S R N
6. I find myself waiting for people to call or write O S R N
7. There is no one I can turn to O S R N
8. I am no longer close to anyone O S R N
9. My interests and ideas are not shared by those around me O S R N
10. I feel left out O S R N
11. I feel completely alone O S R N
12. I am unable to reach out and communicate with those around me O S R N
13. My social relationships are superficial O S R N
14. I feel starved for company O S R N
15. No one really knows me well O S R N
16. I feel isolated from others O S R N
17. I am unhappy being so withdrawn O S R N
18. It is difficult for me to make friends O S R N
19. I feel shut out and excluded by others O S R N
20. People are around me but not with me O S R N

MedSur One Telemedicine

STAMPER OR PATIENT LAPEL

PATIENT HEALTH QUESTIONNAIRE PHQ-9

Patient Signature: _____ DOB: _____ Date: _____
Physician: _____ Admission / Discharge

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "4" to indicate your answers.)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4.Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(The staff will add the columns.) _____ + _____ + _____
Total: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Comments: _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Primary Care***

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you had any actual thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
If YES, ask: *Was this within the past 3 months?*	**Past 3 Months**	

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

Photography Consent Form

Patient Name:_____ Date of Birth:_____ MRN _____

I give my permission for the MedSur One Telemedicine clinicians and staff to obtain photographs of me, my insurance cards, and other documents deemed necessary. I understand that all photographs taken of me are part of my confidential medical record and will not be used or released to any other party without my written authorization. I understand I can revoke this permission at any time by submitting my request to the MedSur One Telemedicine office in writing.

_____ _____

Patient Signature Date

_____ _____

Patient's Representative Date

MEDICARE MSP QUESTIONNAIRE

NAME: _____ DATE: _____

• Are you currently active with a home health care agency?
□ YES □ NO Name of Agency:_____Dates of Service:_____

PART I

1. Are you receiving Black Lung (BL) Benefits?
   _____ Yes Date benefits began: **MM/DD/YYYY;** BL is primary only for claims related to BL.
   _____ No

2. Are the services to be paid by a government *research* program?
   _____ Yes Government program will pay primary benefits for these services.
   _____ No

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for *your* care at this facility?
   _____ Yes DVA is primary for these services.
   _____ No

4. Was the illness/injury due to a work-related accident/condition?
   _____ Yes Date of injury/illness: **MM/DD/YYYY**
   Name and address of WC plan:
   Policy and identification number:
   Name and address of your employer:
   WC is primary payer only for claims forms work-related injuries or illness.
   Go to Part III
   _____ No **Go to Part II.**

PART II

1. Was illness/injury due to a non-work-related accident?
   _____ Yes Date of accident: **MM/DD/YYYY**
   _____ No Go to Part III.

2. What type of accident caused the illness/injury?
   _____ Automobile Name and address of No-fault or Liability insurer:
   _____
   Insurance Claim Number: _____
   No-fault insurer is primary payer only for those claims related to the accident. Go to Part III.
   _____ Non-automobile
   _____ Other

3. Was another party responsible for this accident?
   _____ Yes Name and address of any Liability insurer: _____
   Insurance Claim Number: _____
   ***Liability insurer is primary only for those claims related to the accident. Go to Part la* No Go to Part III.**
   _____ No **Go to Part III**.

PART III

1. Are you entitled to Medicare based on:
   _____ Age **Go to Part IV.**
   _____ Disability **Go to Part V.**
   _____ End-Stage Renal Disease (ESRD) **Go to Part VI.**

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "Parts" associated with the patient's selections.

PART IV — Age

1. Are you currently employed?
   _____ Yes Name and address of your employer:
   _____ No *If applicable,* date of retirement: **MM/DD/YYYY**
   _____ No *Never Employed*

2. Is your spouse currently employed?
   _____ Yes Name and address of spouse's employer:
   _____ No *If applicable,* date of retirement: **MM/DD/YYYY**
   _____ No *Never Employed*

If patient answered "NO" to both questions 1 and 2, Medicare is primary unless patient answered "YES" to questions in Part or II. Do not proceed any further.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?
   _____ Yes, *both*
   _____ Yes, *self*
   _____ Yes, *spouse*
   _____ No **Stop. Medicare is primary payer unless the patient answered yes to the questions in Part I or II.**

4. *If you have GHP coverage based on your own current employment,* does your employer that sponsors, or contributes to the GHP employ 20 or more employees?
   _____ Yes **Stop. GHP is primary. Obtain the following information.**
   Name and address of GHP:_____
   Policy identification number: _____
   Group identification number: _____
   Name of policy holder: _____
   Relationship to patient: _____
   _____ No **Stop. Medicare is primary payer unless the patient answered yes to questions in Part I or II.**

5. *If you have GHP coverage based on your spouse's current employment,* does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?
   _____ Yes **Stop. GHP is primary. Obtain the following information.**
   Name and address of GHP:_____
   Policy identification number: _____
   Group identification number: _____
   Name of policy holder: _____
   Relationship to patient: _____

If the patient answered "NO" to both questions 4 and 5, Medicare is primary unless the patient answered "YES" to questions in Part I or II.

PART V — Disability

1. Are you currently employed?
   _____ Yes Name and address of your employer:
   _____ No *If applicable,* date of retirement: **MM/DD/YYYY**
   _____ No *Never employed*

2. Do you have a spouse who is currently employed?
   _____ Yes Name and address of employer:
   _____ No *If applicable,* date of retirement: **MM/DD/YYYY**
   _____ No *Never employed*

3. Do you have group health **plan (GHP) coverage based on your own, or a spouse's, current employment?**
   _____ Yes, *both*
   _____ Yes, *self*
   _____ Yes, *spouse*
   _____ No **Stop. Medicare is primary unless the patient answered yes to questions in Part I or II.**

4. Are you covered under the GHP of a family member other than your spouse?
   _____ Yes Name and address of your family member's employer:
   _____ No

5. Does the employer that sponsors your group health plan (GHP) employ 100 or more employees?
   _____ Yes **Stop. GHP is primary. Obtain the following information.**
   Name and address of GHP: _____
   Policy identification number:_____
   Group identification number:_____
   Name of policy holder: _____
   Relationship to patient: _____
   _____ No **Stop. Medicare is primary unless the patient answered yes to questions in Part I or II.**

6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the **GHP, employ** 100 or more employees?
   Yes **GHP is primary. Obtain the following information.**
   Name and address of GHP: _____
   Policy identification number:_____
   Group identification number:_____
   Name of policy holder: _____
   Relationship to patient: _____
   _____ No

7. If you have **GHP** coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
   Yes **GHP is primary. Obtain the following information.**
   Name and address of GHP: _____
   Policy identification number:_____
   Group identification number:_____
   Name of policy holder: _____
   Relationship to patient: _____
   _____ No

If the patient answered "NO" to questions 5, 6, and 7, Medicare is primary unless the patient answered "YES" to questions in Part I or II.

PART VI —ESRD

1. Do you have group health plan (GHP) coverage?
   _____ Yes Name and address of GHP:
   Name and address of GHP: _____
   Policy identification number:_____
   Group identification number:_____
   Name of policy holder: _____
   Relationship to patient: _____
   Name and address of employer, if any, from which you receive GHP coverage:
   _____
   _____ No **Stop. Medicare is primary.**

2. Have you received a kidney transplant?
   _____ Yes Date of transplant: **MM/DD/YYYY**
   _____ No

3. Have you received maintenance dialysis treatments?
   _____ Yes Date dialysis began: **MM/DD/YYYY**
   If you participated in a self-dialysis training program, provide the date training started: **MM/DD/YYYY**
   _____ No

4. Are you within the 30-month coordination period?
   _____ Yes
   _____ No **Stop. Medicare is primary.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   _____ Yes
   _____ No

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
   _____ Yes **Stop. GHP continues to pay primary during the 30-month coordination period.**
   _____ No **Initial entitlement based on age or disability.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?

   _____ Yes **GHP continues to** pay **primary during the 30-month coordination period.**
   _____ No **Medicare continues to pay primary.**

FOR OFFICE USE ONLY: REVIEWED BY: _____ DATE: _____
COMMENTS:

Telemedicine
Services Evaluation

1. Is this the first time you have been seen by a health care provider via a telemedicine service?

   ○ Yes ○ No

   Please complete the following:

2. If a telemedicine service was not available or not an option for my problem today, I would have:

   ○ Driven to the practice to be seen in person.
   ○ Driven to an urgent care or emergency center.
   ○ Made an appointment for another day.
   ○ Chosen to not have been seen and treated.

3. If I had been required to travel to see a health care provider, (check all that apply)

   ○ I would have lost time at work.
   ○ I would have incurred additional expenses. (Please specify) _____
   ○ Other (Please specify) _____

4. I feel my health care provider was able to address my problem appropriately today.

   ○ Strongly Agree
   ○ Agree
   ○ Neutral
   ○ Disagree
   ○ Strongly Disagree

5. Overall, I am satisfied with my telemedicine encounter.

   ○ Strongly Agree
   ○ Agree
   ○ Neutral
   ○ Disagree
   ○ Strongly Disagree

   General Comments/Suggestions:
   _____
   _____
   _____
   _____