Edward Rubin, M.D.
Infusion Wellness

Managed Services by KALYPSO WELLNESS CENTERS

NEW PATIENT QUESTIONAIRE

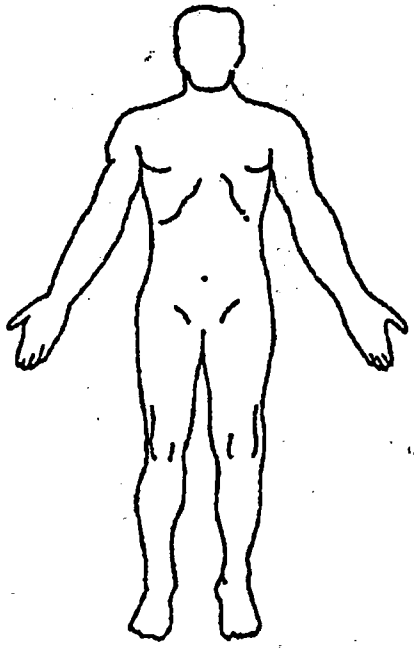
Date _____

Name_____ DOB _____ Age _____

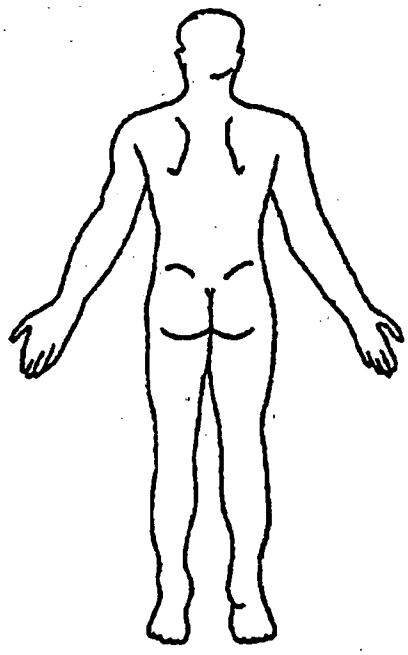
Referring Physician_____ Height_____ Weight_____

PAIN HISTORY

On the drawings below, shade in the areas in which you are having pain. Indicate the worst area with an X. **If you are here for Depression Please check this box** ☐



Front



Back

When did the pain or depression start and how long has this been present?

_____

_____

_____

_____

Does the pain radiate to anywhere in particular? _____

If so, where? _____

Have you received any of the following treatments for the pain or depression(s):

Physical Therapy Chiropractics Acupuncture Massage Physciatrist Infusion Therapy

Did an accident or other event precipitate your pain? If yes, please describe:

_____

_____

_____

_____

Describe the pain? Circle all that apply:

Burning	Sharp	Shooting	Throbbing	Aching	Pins/Needles
Numbness	Cutting	Cramps	Gripping	Electrical	Dull

How frequently do you feel your pain or depression? Circle one:

Continuously Intermittently

How do you rate the severity of your pain or depression?

On the line below, please mark with an **X,** how severe your depression or pain has been recently.

|----------|

0 1 2 3 4 5 6 7 8 9 10

NONE **WORST**

What makes your pain better?_____

What makes your pain worse? _____

_____

PAST HISTORY

Please list ALL current medications

Medication	Dosage & Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

List all medical problems:

_____

_____

_____

List all surgeries:

_____

_____

_____

Please List Allergies

Allergies to Medications	Reaction
1.	
2.	
3.	
4.	

Could you be pregnant? Yes ☐ No ☐ ☐N/A
Do you smoke? Yes ☐ No ☐ packs per day _____ years _____
Do you drink alcohol? Yes ☐ No ☐ How much: _____How often: _____
Do you use illicit (street drugs)? ☐ Yes ☐No Name of Drug(s)_____
Last used _____

Have you been treated with Infusions Therapy in the past for pain or depression? Yes No
If yes, when:_____

If yes: Physician Name:_____ Phone #_____

Were Epidural Injections performed? Yes No

Was pain medication prescribed ? Yes No

Were the Infusions Helpful?

Member	Alive/Deceased	Age	Diabetes	HTN	Heart Disease	Stroke	Psychiatric Illness	Cancer	Unknown
Father									
Mother									

Comments: _____

Infusion Wellness 1103 Stewart Avenue, Ste.300 Garden City, NY 11530
Phone: 516- 739-0065 Fax: 516-492-3097

Full Legal Name

Last Name:_____ First Name:_____ DOB:_____

Address:_____City_____State_____ Zip_____

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

SS#:_____ Marital Status:_____

Nearest Relative for Emergency Contact:

Name:_____ Phone#_____

Address:_____

Referring Doctor:

Name:_____ Phone:_____

Address:_____

Primary Doctor:

Name:_____ Phone:_____

Address:_____

Primary Insurance:

Insurance Company:_____

Address:_____

Phone#:_____

Policy #:_____Group#_____

Secondary:

Insurance Company:_____

Address:_____

Phone#:_____

Policy #:_____Group#_____

Card Holder Name:_____

DOB:_____ SS#_____

Does your Ins. policy require a referral/authorization from your primary doctor to see a specialist: YES NO

KALYPSO
WELLNESS CENTERS

Edward S. Rubin, MD
PAIN MANAGEMENT

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.

Our Office uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Kalypso Wellness Centers.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website at www.kalypsowellness.com, calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

How Our Office May Use or Disclose Your Health Information

Following are examples of the types of uses and disclosures of your health care information that our Office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment. We may use and disclose your health information to provide you with medical treatment or services or to manage your health care and any related services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Healthcare providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance to us with your health care diagnosis or treatment.

For Payment. Our Office may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. This may also include certain activities that your health insurance plan requires to be undertaken before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval

for a hospital stay may require that your relevant health information be disclosed to the health plan to obtain approval for the hospital admission.

For Healthcare Operations. We may use and disclose health information about you in order to support the business activities of our Office. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

evaluate the performance of our staff;
assess the quality of care and outcomes in your case and similar cases;
learn how to improve our facilities and services; and
determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. Our Office may use your information to provide appointment reminders to you or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In addition, when you arrive at our Office, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician and/or your appointment time. We may also call you by name in the waiting room when your physician is ready to see you.

Required by Law. Our Office may use and disclose information about you as required by law. For example, our Office may disclose information for the following purposes:

for judicial and administrative proceedings pursuant to legal authority;
to report information related to victims of abuse, neglect or domestic violence; and
to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Coroners, Funeral Directors, and Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Your health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research. Our Office may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. For example, we may disclose your health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Inmates. We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Business Associates. We will share your health information with third party "business associates" that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Uses and Disclosures That We May Make Unless You Object

Family or Friends involved, in Your Healthcare. Unless you object in writing, the healthcare professionals, using their best judgment, may disclose to a member of your family, a relative, a close friend or any other person you identify, your health information that directly relates to that person's involvement in your health care. If you are unable to object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Uses. Other uses and disclosures will be made only with your written authorization, unless otherwise permitted or required by law, and you may revoke the authorization except to the extent that our Office has acted in reliance on it.

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 et. seq.

Your Health Information Rights

Although your health record is the physical property of our Office, the information belongs to you. Under the Federal Privacy Rules, 45 CFR Part 164, you have the right to:

request a restriction on certain uses and disclosures of your information as provided by 45 CFR §164.522; however, our Office is not required to agree to your requested restriction.

obtain a paper copy of the notice of our information practices upon request;

inspect and obtain a copy of your health record as provided in 45 CFR §164.524;

request an amendment to your health record as provided in 45 CFR §164.526; however, we are not required to do so.

request confidential communications from us by alternative means or at alternative locations;

revoke your authorization to use or disclose health information except to the extent that action has already been taken; and

receive an accounting of disclosures made of your health information after April 14, 2003, for purposes other than treatment, payment, health care operations as described in this Notice of Privacy Practices and as provided in 45 CFR §164.528, subject to certain exceptions, restrictions and limitations.

Our Responsibilities

We are required by the Federal Privacy Rules to:

maintain the privacy of protected health information;

provide you with this notice of our legal duties and privacy practices with respect to your health information;

abide by the terms of this notice;

notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;

accommodate reasonable requests you may make to communicate health information for reasons other than those listed above and permitted under law.

We reserve the right to change our information practices and to make the new provisions effective for all protected health information it maintains, including health information created or received prior to the effective date of any such revised notice. Should our health information practices change, we will post it in our Office and/or on our website, and/or provide you a copy of the revised notice, upon request.

For More Information or to Report a Problem

If you have questions, you may contact the Privacy Officer, at 4600 Lockhill-Selma, Suite 108, San Antonio, TX 78249, or by telephone at 800-RESET 20.

If you believe your privacy rights have been violated or you wish to report a problem, you can file a complaint with the Privacy Officer at the above address or by telephone. We will not retaliate against you for filing a complaint. Additionally, if you have not received a response to your complaint within a reasonable time period, you may complain to the Department of Health and Human Services.

KALYPSO
WELLNESS CENTERS

Edward S. Rubin, MD
PAIN MANAGEMENT

Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Kalypso Wellness Centers.

_____ _____
Print Patient Name Date

_____
Patient Signature

Please fill out and sign the following release form so we can obtain copies of any medical records that may be needed in order to assess your condition more thoroughly.

Date: _____

I, _____ hereby authorize the release of my medical records to:

Dr. Edward S. Rubin, M.D.
Kalypso Wellness Center
1103 Steward Avenue, 3rd Floor
Garden City, NY 11530

_____
Printed Patient Name

_____ _____
Patient Signature Date

Updated: June 2018

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PAIN MANAGEMENT

KETAMINE EDUCATION

Patient: _____

Please read carefully and initial each item

_____ I understand Ketamine is an approved medication by the FDA, but Kalypso Wellness Centers is using ketamine off-label

_____ I acknowledge I have read the consent form, understand the risks of ketamine infusions, have been offered the opportunity to ask any questions concerning ketamine, and agree to proceed with the planned infusion

_____ I understand and accept all risks associated with off label use of ketamine

_____ I understand and acknowledge I am choosing to have the ketamine infusion by my own choice, and at any time I can halt the procedure

_____ I understand and acknowledge I will contact Kalypso Wellness Centers with any unusual symptoms or concerning signs.

_____ I understand and acknowledge I will call 911 for any life-threatening symptoms I may experience after the infusion

_____ I understand and acknowledge ketamine is not guaranteed to provide any benefit, and I may not get any benefit or may have worse symptoms even after repeated infusions.

_____ I understand ketamine is effective in about 70% of patients, and I may get more or less benefit than expected.

_____ I understand and acknowledge potential side effects include dizziness, nausea, vomiting, euphoria, perceptual disturbances, bad dreams, confusion, changes in heartrate, changes in blood pressure, difficulty breathing, anxiety, increased saliva production, musculoskeletal disruptions, increased pressure in lungs, rash, double vision, unusual heart rhythms,

_____ I understand and acknowledge possible complications include seizures, low blood pressure, high blood pressure, bleeding, infections, damage to nerves or surrounding tissues, failure to provide benefit, heart attack, stroke, and death

_____ I understand and acknowledge there are no long-term studies involving ketamine infusions and accept all risks associated with long-term treatments of ketamine and will notify Kalypso Wellness Centers as soon as I believe a long-term complication is occurring

_____ I understand and acknowledge ketamine infusion is a part of my treatment plan, not a replacement, and will continue to be compliant with my other doctor's plans

_____ I understand and acknowledge Kalypso Wellness Centers has the right to refuse treatment to me at any time without cause

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KETAMINE EDUCATION

Patient: _____

_____I understand and acknowledge Kalypso Wellness Centers is a cash based business, and I will pay my balance as agreed with Kalypso Wellness Centers. If I don't maintain my financial responsibility and compliance, Kalypso Wellness Centers may refuse treatment

_____I understand and acknowledge I will give Kalypso Wellness Centers 72 hrs notice if I plan to cancel or miss my scheduled treatment; If not, I will be charged $100 for failure to notify Kalypso Wellness Centers of my cancelation/need to reschedule.

_____I understand and acknowledge Kalypso Wellness Centers will hold my schedule apt for 10 minutes after it is scheduled. If I arrive more than ten minutes after my scheduled appointment, I may not receive my scheduled treatment.

_____I understand and acknowledge symptoms and benefits may fluctuate during and/or between my treatments, and will call 911 or go directly to the nearest ER with any symptoms of wanting to hurt myself or others.

_____I understand and acknowledge Kalypso Wellness Centers recommends 6 treatments in the first 2-3 weeks to maximize benefit, however, I may choose to alter the recommended treatment guidelines based on my availabilities with the understanding this may decrease my benefit.

_____I understand and acknowledge I have been informed not to drive or operate any heavy machinery on the day of my treatment, consume any alcohol, make any financial, business, or other decisions requiring my signature, or engage in activities requiring motor skills as ketamine may affect my mentation, memory, and motor skills. By doing any of these activities, I am going against medical advice and will be solely responsible for any accidents or problems that may arise by my actions

_____I understand and acknowledge I have provided Kalypso Treatment Centers with all of my medical history, medications, and pertinent medical information

_____ _____

Kalypso Team Member

Updated: June 2018

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WELLNESS CENTERS

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PAIN MANAGEMENT

CONSENT FORM

I, _____, have been educated about ketamine infusions. I have been offered to address any of my questions and all questions have been addressed. I understand Kalypso Wellness Centers suggests providing an IV infusion of ketamine to me in an attempt to provide benefit for my diagnosis/diagnoses:

- ☐ Depression
- ☐ PTSD
- ☐ Mania
- ☐ Migraine/Headache
- ☐ Post-partum Depression
- ☐ Cancer Pain and/or Depression
- ☐ Neuropathic Pain
- ☐ Bipolar
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Pelvic Pain
- ☐ Other

I understand ketamine has been used for decades as a medicine and is FDA approved as an anesthetic agent. However, for the purposes of my infusion, ketamine has not been approved by the FDA. I understand my treatment is not a clinical study, but a procedure performed by Kalypso Wellness Centers and is not followed by any Institutional Review Board (IRB) or FDA. I also understand Kalypso Wellness Centers plans to use ketamine as an infusion, or constant drip.

The most common side effects include increased nausea, vomiting, saliva production, vivid or changes in dreams, dizziness, nightmares, increased and /or decreased heart rate, increased and/or decreased blood pressure, unusual movements, altered perceptions during infusion. Less common side effects include rash, eye pressure increases, vision changes, seizure like movements, breathing changes or difficulties, rhythm changes of the heart, allergic reaction requiring other medical interventions, heart attack, stroke, and death. I understand these side effects are much more likely to occur at doses much higher than I will be receiving during my infusion, and these side effects are much more likely to occur with one quick administration of ketamine instead of the slow infusion like I will be receiving over approximately 60-90 minutes.

Patients with a history of drug non-compliance or abuse are at increased risk of developing dependence to ketamine. I understand, there is no guarantee of benefit, I may not obtain any benefit, and my symptoms may get worse. Possible complications of the procedure include but are not limited to bleeding, infection, bruising, damage to nerves or surrounding tissue, failure to provide benefit, requirement of hospitalization, heart attack, stroke, paralysis, and death.

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CONSENT FORM

I understand Kalypso Wellness Centers are recommending to follow published literature of 6 treatments over 2-3 weeks to maximize benefit, but I may choose to alter my treatment schedule at any time with the understanding this may decrease my benefit. I also understand my ketamine infusion treatment is a cash option only, and there will be no refunds for any failure of treatments. If I choose to give a testimonial about my treatment, Kalypso Wellness Centers has the right to share the testimonial on the company's social media or website.

_____ _____

Patient Signature Date

_____ _____

Kalypso Team Member Date

Updated: June 2018

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PAIN MANAGEMENT

PRE-TREATMENT INSTRUCTIONS

Welcome to Kalypso Wellness Centers! We are very excited to have you as a customer and want your experience to be the best it can be!

You have chosen to have treatment with Kalypso Wellness Centers. We will be giving you an infusion of Ketamine through a vein. Please read the following instructions concerning your pre-treatment rules and guidelines.

- ☐ Please make sure you have disclosed all medical information to us. Different medical conditions or medicines can change the infusion dose or even preclude you from getting treated.
- ☐ Please arrive 45 minutes before your scheduled treatment. You will have some paperwork to complete and questionnaires to answer. Most importantly we will need some information about your baseline level of disease, (depression, nerve pain, fibromyalgia, etc.) so we can follow the benefit of your treatments. These questionnaires will be done before your first infusion and/or after each subsequent infusion depending on the interval duration of treatment.
- ☐ Please bring a valid identification (Driver's License, Passport). **YOU WILL NOT RECEIVE ANY TREATMENT WITHOUT VALID IDENTIFICATION.**
- ☐ Please do not eat or drink anything for 8 hours before the procedure. If you have to take some medicines, please take them with just a sip of water as far before the treatment as possible.
- ☐ Please bring a driver. **YOU WILL NOT RECEIVE ANY TREATMENT WITHOUT A DRIVER.** Due to the fact that ketamine can cause memory disturbances, motor function changes, disorientation, and confusion, it is our policy not to let any patient that has been treated to drive for the remainder of the day.
- ☐ After completing the required paperwork, you will be taken to a room where an IV will be placed.
- ☐ Next, you will be taken to the treating area where monitors will be placed on you. We will monitor your blood pressure, heart rate, breathing rate, and blood oxygenation levels.
- ☐ Now you are ready to start to receive the infusion of ketamine. The entire treatment takes about 60-90 minutes. Since we are giving such a low dose of ketamine spread out over this time, you may not feel any effects at all. It is possible you may start to feel some effects after a couple of minutes. You can report these to the attending KWC member.

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PRE-TREATMENT INSTRUCTIONS

- ☐ You may wish to bring a magazine, book, or music (with earphones/headphones) to help you relax. We recommend you simply relax and rest during the treatment.
- ☐ After your treatment, the IV will be removed and covered with a band aid. We will then give you some more paperwork to be completed and to help us determine your benefit or if any side effects are present.
- ☐ You can expect to be at the clinic for about 2 hrs for your first visit, and about 1.5 hrs for each subsequent visit.
- ☐ WE RECOMMEND YOU OBTAIN SIX TREATMENTS OVER THE FIRST 2-3 WEEKS AS REPORTED IN MEDICAL JOURNALS. However, we know how difficult it can be to schedule appointments and appreciate the value of your time; therefore, it is entirely voluntary when you schedule your next treatment. MANY PATIENTS WILL GET SIGNIFICANT BENEFIT AFTER ONE TREATMENT and may not need another treatment for a while. Other patients will find following our recommendations will maximize their benefit and want to schedule their appointments soon after their treatment. Simply discuss your desires with the KWC member. We are happy to work with your schedule!

After being released, we encourage you to take notes about your post treatment effects. Things you should monitor include level of activity, level of energy, level of enjoyment, amount and quality of sleep, severity of pain, amount of pleasant thoughts, amount of feelings of happiness, overall quality of life. In addition, please monitor for any side effects and/or worsening symptoms. If you have any concerns, please do not hesitate to contact us. If you have any concerns about your health or significant side effects, or if you have any thoughts of hurting yourself or anyone else, please call 911 or go directly to the nearest ER.

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WELLNESS CENTERS

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PAIN MANAGEMENT

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "√" to indicate your answer)*	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 or staying asleep, or 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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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 other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying
0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

THE PSYCHOLOGICAL CORPORATION®
Harcourt Brace & Company
SAN ANTONIO
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San Diego • Philadelphia • Austin • Fort Worth • Toronto • London • Sydney

Subtotal Page 1

Continued on Back

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Subtotal Page 2

Subtotal Page 1

Total Score

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Patient's Name:

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $_____**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE

☑ **Option 1. YES.** **I want to receive these items or services.**
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO.** **I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: **Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)