KENNETH S. ZIMMERMAN, M.D.
Internal Medicine
6760 Main Street
Williamsville, New York 14221
716-626-0030

Welcome to our practice!

We know that there are many options for primary care for you to choose from, and we are happy that you have chosen our office for your care.

Our office is run by our practitioner, Kenneth S. Zimmerman, M.D. Our care and treatment is supported and supplemented by our physician assistant, Susan Bennett, RPA-C. Our team works closely together to provide you with high quality of care. We will coordinate your treatment with other specialists and facilities as may be required.

For your first appointment, please bring the following with you to the office:
- New Patient Paperwork Packet
- Photo ID
- Insurance Card
- Medication List
- Any records you have from any previous physicians

Please follow us on Facebook for up-to-date office information!
https://www.facebook.com/kennethzimmermanmd

Office Hours / On call Availability

We have office hours on Monday 8:00am - 4:30pm, Tuesday 9:00am - 5:00pm, Wednesday 9:00am - 5:00pm, Thursday 7:00am - 3:00pm and Friday from 9:00 AM to 4:00 PM.

However, if you have an urgent or pressing matter, please call our office to have one of our providers paged. Our staff or on-call provider will call you back as appropriate for these matters.

Please contact us first for:

Common Illnesses: cold, flu, ear aches, sore throats, migraines, fever, rashes, or urinary tract infections.

Minor injuries: sprains, back pain, minor cuts and burns, or minor eye injuries.

Please go to your nearest emergency room or urgent care clinic for any condition you feel is serious or life-threatening.

For common illnesses and minor injuries, we can often offer advice over the phone and schedule you for an appointment in our office the next business day. If we direct you to an emergency room, we can provide the nurses and staff with important medical information about you and your current symptoms. If at all possible, we prefer the following hospitals; Millard Fillmore Suburban, Kenmore Mercy, South Buffalo Mercy, Buffalo General, or St. Joes.

Patient Portal Access

We also encourage all patients to activate their patient portal account. This allows you to send us updates on conditions, obtain lab results, request or cancel an appointment, and receive information from our providers or office staff. Please visit our website at **www.kennethzimmermanmd.com**.

Billing

If you have not already contacted your insurance company to inform them that we are your primary care physician, we urge you to do so as soon as possible. Wtih some insurance companies, your copay is higher if you have not contacted them to let them know we will be providing you with care.
All copays, coinsurances, deductibles, and pay due balances are expected to be paid at the time of service unless a prior arrangement has been made.

Laboratory Results

Initial laboratory results will be discussed with you after your labs are drawn. This will include a plan of care if one is warranted. Otherwise, most laboratory results will be available on the portal for you to view within three days of the blood draw. We will contact you for abnormal results and/or if any additional treatment is required. Normal lab results will not be followed with a phone call from our office.

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Kenneth S. Zimmerman, M.D. is your Patient-Centered Medical Home and is presently accredited has having achieved highest level of recognition through the National Committee for Quality Assurance (NCQA)

What is a Patient-Centered Medical Home?

- A team approach to providing total health care at our office for you.

Who is part of your Patient-Centered Medical Home team?

- Your health care provider
- All other staff at your health care provider's office
- Most-importantly-YOU! You are the most important person on your health care team. Patient-centered is a way of saying that you are the focus of your health care

What do you need to do as part of your Patient-Centered Medical Home team?

1. Keep your medical home providers informed!
   - Let your health care provider know about care you receive from other health care professionals
   - Call your medical home first with questions and appointment requests before you go to an Urgent Care or Emergency Room
     - Call our office during regular business hours at: 716-626-0030
     - After hours and on weekends call us at: 716-626-0030
   - Let your medical home know if you have been in the hospital. CALL YOUR PROVIDER AS SOON AS YOU ARE DISCHARGED FROM THE HOSPITAL
   - Let your medical home know of any change in your medications after a hospital stay or from another health care provider
   - Bring all your medications (or a list of all your medications) with you to each visit at your medical home

2. Take an active role in your own health
   - Follow the health care plan that you and your team agreed on
   - Set goals that you can reach. Once these goals have been reached discuss new goals
   - Tell your team if you're having trouble staying with your care plan or it is not working for you

What can your Patient-Centered Medical Home do for you?

- Help you manage your health care
- Help answer all your health questions
- Listen to your concerns
- Coordinate your care if additional services are needed
- Encourage you to play an active part in your own health care

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Notice to All Patients:
New Cancellation/No-Show Policy

As of January 1, 2022, our office has established a No-Show/ Cancellation Policy. Patients who fail to keep a scheduled appointment will be charged a $75.00 cancellation fee, unless they call or leave a message cancelling the appointment at least 24 hours in advance.

Patients may leave a message cancelling an appointment with our answering service after regular business hours. If the message is left at least 24 hours before the scheduled time of appointment, no cancellation fee will be charged.

New Patients - If you fail to show for your new patient appointment or cancel with less then 24 hours notice, there is a charge of $165.00 to be paid prior to being able to reschedule that appointment.
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Patient Bill of Rights

1. The right to understand and use these rights. If you do not understand or need help understanding, the office will provide you assistance in understanding these rights, including the use of an interpreter.

2. The right to receive competent medical care delivered without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.

3. The right to be treated with consideration, respect, and dignity in a safe and clean environment.

4. The right to receive emergency care if needed.

5. The right to privacy and confidentiality of information and records regarding their care in accordance with applicable laws.

6. The right to know the name and position of the doctors, physician assistants, nurses, and other staff involved in your care.

7. The right to be informed of services offered at our offices.

8. The right to receive information about your diagnosis, treatment, and prognosis to include the risks, benefits, and alternatives to the care or treatment. It is not advisable to give such information to the patient for health reasons; it should be made available to a person designated by the patient or a legally authorized person.

9. The right to receive all information to give an informed consent prior to the start of any non-emergent procedure or treatment. An informed consent shall include the reasonable foreseeable risks involved, the alternatives for care or treatment, and the outcome if no treatment is done so the patient can make a knowledgeable decision.

10. The right to refuse treatment and procedures and to be made aware of the effect it will have on health.

11. The right to be informed of off-hour emergency coverage when the office is closed.

12. The right to change the practitioner if other qualified practitioners are available.

13. The right to refuse to take part in any research study. In deciding whether or not to participate, you have the right to a full explanation.

14. The right to inspect and obtain a copy of his or her medical records. In addition, the patient has the right to expect a reasonable and timely transfer of information from one practitioner to another when requested or required. Charges for copies of medical records shall not exceed charges provided for by Section 18 of the Public Health Law. A patient will not be denied a copy if unable to pay.

15. The right to request and receive information concerning the bill for services regardless of source of payment.

16. The right to authorize family members and other adults who will be given priority to visit you, consistent with your ability to have visitors.

17. The right to make known your wishes in regard to anatomical gifts. You may document your wishes on a Health Care Proxy.

18. The right to know about the expectations of the practice with regard to his or her behavior and the consequences of failure to comply with these expectations including the right to have reasonable arrangements made for continuation of care as necessary.

19. The right to voice any grievances with the care or services they received without fear of reprisals. The office will respond to issues and, if requested, will do so in writing. If you are not satisfied, you can file a complaint with NYS Health Department.

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Your Rights as a Patient of Kenneth Zimmerman, M.D.

As a patient in a New York State outpatient facility, you have certain rights and protection guaranteed by state and federal laws.

These regulations exist to help ensure the quality and safety of your facility care. To help understand your rights, the New York State Department of Health and its Consumer Health Information Council have developed this information.

Keep this information for reference. Review it carefully and share it with family and friends involved in your care.

You have the right to participate in decisions about your health care and to understand what you are being told about your care and treatment. For example, you are entitled to a clear explanation of tests, treatments and drugs prescribed for you. Don't hesitate to ask questions of your doctor, nurse or facility staff members. You have a right to know what is going on.

Every patient is unique; every facility stay is different. It is important to know what specific rights apply to you and what to do if you feel you need help. Some rights and protections, such as those that govern when you leave the facility, depend on receiving correct written notices and knowing where to call or write for help.

If you have a problem or if you don't understand something, speak to your nurse, doctor, a social worker or patient representative. They can:

Help get you answers.
Arrange special help.
Make contacts with your family.
Get foreign language and sign language interpreters.
Generally make your facility stay easier.

But you must speak up and ask questions. You can contact a patient representative before you enter the facility to be sure your special arrangements are made when you get there.

If you have a question about any information, any suggestions, or any grievances regarding your care at Dr. Kenneth Zimmerman's Office, please feel free to speak to an employee or contact us at (716) 626-0030.

The following page is a Release of Records from your previous primary care provider.
Please fill our your information at the top, and list your previous provider on line #7.
Sign the Bottom of the Page and return this for your first visit.

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Name _____
(Last) (First) (M.I.)

Address _____
(Street) (City) (Zip)

Birth date _____ Gender: ☐M ☐F Marital Status ☐Single/Never Married ☐Married ☐Widowed ☐Divorced

Social Security # _____ Who resides in your home? _____

Home Phone_____ Work phone _____ Cell:_____ E- mail:_____

Kenneth Zimmerman, M.D. may use the above contact information to confirm and/or communicate with you.

Work History (Please check the following)

☐Working Full Time **Employer/Your Title/Position**_____

☐Working Part Time **Employer/Your Title/Position**_____

☐Student (Not working) Current School_____

☐Disabled (Not working) Reason for Disability_____

☐Retired(Not working) Year of Retirement_____

****** Pharmacy Name / Location & Phone Number** _____

Emergency Contact _____ Address _____ Phone _____

Relationship to patient: _____

INSURANCE RESPONSIBLE PARTY: _____ (Check if same as patient information and skip)

Name _____
(Last) (First) (M.I.)
Address _____
Street City Zip
Birth date _____ SS# _____ Home Phone _____ Work Phone_____

_____

REFERRAL SOURCE: _____ Personal Referral _____Other Physician_____

INSURANCE INFORMATION

Primary Insurance _____ Insurance ID # _____ Group _____

Subscriber's Name _____ Date of Birth _____

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Name: General Doc General Docs **DOB:** 01/01/2015

Ethnicity: ☐Hispanic
☐Non-hispanic
☐I do not wish to say

Race: ☐White
☐Black/African American
☐American Indian/Alaska Native
☐Asian
☐Native Hawaiian/Other Pac Islander
☐Other
☐I do not wish to say

Primary Language ☐English
☐ Other
(Please Specify)_____

☐**Secondary Language**

(Please Specify)_____

ALLERGIES: ____ None List any medicines, foods, or other substances to which you are ALLERGIC and describe the allergic reaction: _____

_____

CURRENT DAILY MEDICATIONS: ____ None Please list any medications, including non-prescription drugs and birth control pills that you have taken in the last three months.

_____

_____

Do you smoke?
☐Yes ☐No

OR: Are you a former Smoker?
☐Yes ☐No

If yes, how many cigarettes/cigars per day and how often? _____

If yes, please indicate the month and year you quit. _____

Do you use alcohol?
☐Yes ☐No

OR: Did you formerly use alcohol?
☐Yes ☐No

If yes, how much and how often per day? _____

If yes, please indicate the month and year you quit. _____

Do you use recreational drugs?
☐Yes ☐No

OR: Did you formerly use recreational drugs?
☐Yes ☐No

If yes, how much and how often per day? _____

If yes, please indicate the month and year you quit. _____

Hand Dominance: Right ☐ Left ☐
In the Home: Smoke Alarm ☐ Carbon Monoxide Detector ☐

Seat Belt Use: Always ☐

Are you currently sexual active? Yes ☐ No ☐
Contraceptive Methods? _____

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Initial Patient Medical History Questionnaire

Name: General Doc General Docs **DOB:** 01/01/2015

What is the Reason for Your Visit today?_____

Please check Yes or No for each item listed below. If you check **Yes,** please explain in the space provided.

Previous Primary Care Doctor : ☐No ☐Yes **Provider Name**:_____

_____

Surgery: ☐No ☐Yes **Provider Name**:_____

_____

Cardiac (Heart): ☐No ☐Yes **Provider Name**:_____

_____

Pulmonary (Lung): ☐No ☐Yes **Provider Name**:_____

_____

Renal/Urology (Kidneys/Urinary System): ☐No ☐Yes **Provider Name**:_____

_____

GI (Stomach/Intestinal): ☐No ☐Yes **Provider Name**:_____

_____

Dermatology (Skin): ☐No ☐Yes **Provider Name**:_____

Neurologic (Brain/Nervous System): ☐No ☐Yes **Provider Name**:_____

_____

Ophthalmology (Eyes): ☐No ☐Yes **Provider Name**:_____

Gynecologic: ☐No ☐Yes **Provider Name**:_____

_____

Oncology (Cancer): ☐No ☐Yes **Provider Name**:_____

_____

Skeletal/Orthopeadics (Bones/Arthritis): ☐No ☐Yes **Provider Name**:_____

_____

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Name: General Doc General Docs **DOB:** 01/01/2015

Hematology (Blood): ☐No ☐Yes **Provider Name**:_____

_____

Thyroid: ☐No ☐Yes **Provider Name**:_____

_____

Vascular (Blood Vessels): ☐No ☐Yes **Provider Name**:_____

_____

Psychiatric History: ☐No ☐Yes **Provider Name**:_____

_____

Dentist : ☐No ☐Yes **Provider Name**:_____

_____

Have you had a **recent chest x-ray**? ☐No ☐Yes/Date_____

Have you had a **recent EKG**? ☐No ☐Yes/Date_____

Please describe any hospitalizations you have had_____

_____

Please tell us of any other medical history or personal information that you feel is pertinent to your care_____

_____

_____

Family History

Father Name:
☐Alive Age____ ☐Deceased Age____
List any medical conditions your father has/had

_____

_____

_____

_____

Mother Name:
☐Alive Age____ ☐Deceased Age____
List any medical conditions your mother has/had

_____

_____

_____

_____

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Siblings (w/ Names):
List any medical conditions your siblings have/had
List gender and **age** for **ALL** siblings, even if
no medical problems or deceased

_____
_____
_____
_____
_____
_____

Children (w/ Names):
List any medical conditions your children have
List gender and **age** for **ALL** children even if no
medical problems or deceased

_____
_____
_____
_____
_____
_____

Please review your medication list: If you have a list, please bring a copy and we attach it for you.
Please list **EACH MEDICATION AND THE TIME OF DAY YOU TAKE IT**; IE: every morning; every afternoon, every night; etc:

_____
_____
_____
_____
_____

Patients age 65+ ONLY:
Bladder:

Many people experience problems with urinary incontinence, the leakage of urine.
In the past 6 months, have you accidentally leaked urine?
☐ Yes ☐ No

If Yes to Urine Leakage:
How much of a problem, if any, was the urine leakage for you?
☐ A Big Problem ☐ A Small Problem ☐ Not a Problem

Advanced Directives

☐ Y ☐ N Do you have a health care proxy or living will?

☐ Y ☐ N If no, would you like us to provide you with a health care proxy form to complete?

☐ Y ☐ N Consent: 'I consent to discuss end-of-life issues with my health care provider.'

In the past 12 months, I . . .

☐ Y ☐ N Fell two or more times.

☐ Y ☐ N Was injured by a fall that limited my regular activities for at least one day.

☐ Y ☐ N Saw a doctor because I had a fall.

☐ Y ☐ N Found it to be hard to climb stairs or walk a short distance.

☐ Y ☐ N Had trouble getting up from a soft chair.

☐ Y ☐ N Have been unable to stand on one foot for 12 seconds without losing my balance.

☐ Y ☐ N Trouble with my eyesight.

☐ Y ☐ N Felt dizzy or light headed after a big meal.

☐ Y ☐ N Took medication that caused me to feel dizzy or light headed.

☐ Y ☐ N Took 9 or more diff. medications

☐ Y ☐ N Stopped some of my regular activities.

☐ Y ☐ N Have been taking a calcium supplement regularly. If "Yes," how much per day:

☐ Y ☐ N Have had my vitamin D level in my blood checked.

☐ Y ☐ N Danced, exercised, or practiced TaiChi at least 3 times a week.

☐ Y ☐ N Had my home checked for any dangers and modified as needed.

Sexual Orientation and Gender Identity

My current gender identity is:
☐ Male ☐ Female ☐ Transgender Woman / Transwoman
☐ Transgender Man / Transman ☐ Non-binary/Gender Non-Conforming
☐ Another identity: _____ ☐ Decline to answer

My sex assigned at birth is:
☐ Male ☐ Female
☐ Decline to answer

My pronouns are:
☐ He/him/his ☐ She/her/hers
☐ They/them/theirs ☐ Ze/hir
☐ Another pronoun: _____

My sexual orientation is:
☐ Straight ☐ Lesbian ☐ Gay
☐ Bisexual ☐ Pansexual ☐ Queer
☐ Asexual ☐ Questioning
☐ Another identity: _____
☐ Decline to answer

Romantic and Sexual Health Information

My relationship status is:
☐ Single, never married ☐ Divorced ☐ Married
☐ Civil union ☐ Domestic partnership / living with a partner
☐ Partnered, not living together ☐ Polyamorous / non-monogamous
☐ Widowed / grieving the loss of a partner ☐ Decline to answer

In the past, my sexual partners have been:
☐ None ☐ Men ☐ Women
☐ Transgender Woman / Transwoman
☐ Transgender Man / Transman
☐ Gender Neutral / Non-binary ☐ Two-spirit
☐ Genderqueer / Gender Fluid ☐ Intersex
☐ Decline to answer

Currently, my sexual partner(s) is/are:
☐ None ☐ Men ☐ Women
☐ Transgender Woman / Transwoman
☐ Transgender Man / Transman
☐ Gender Neutral / Non-binary
☐ Two-spirit O Genderqueer / Gender Fluid
☐ Intersex ☐ Decline to answer

Patient Name: General Doc General Docs Date of Visit: July 2, 2026

DEPRESSION/ANXIETY SCREENING

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please check the boxes.

	Never	Several Days	Half of the Days	All
PHQ9				
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching tv	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed OR Being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
10. If you chose 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?	☐	☐	☐	☐
GAD2				
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐

GAD7	Never	Somtimes	Half	All
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might	☐	☐	☐	☐

CAGE-AID QUESTIONNAIRE

		No	Yes
1.	Have you ever felt that you should cut down on your drinking and/or drug use?	☐	☐
2.	Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3.	Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4.	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Patient Name: General Doc General Docs Date of Visit: July 2, 2026

FAMILY HISTORY QUESTIONNAIRE

		No	Yes
1.	Does your mother have a history of a diagnosis of alcohol abuse?	☐	☐
2.	Does your mother have a history of a diagnosis of drug abuse?	☐	☐
3.	Does your mother have a history of a diagnosis of mental illness? Diagnosis:	☐	☐
4.	Does your father have a history of a diagnosis of alcohol abuse?	☐	☐
5.	Does your father have a history of a diagnosis of drug abuse?	☐	☐
6.	Does your father have a history of a diagnosis of mental illness? Diagnosis:	☐	☐
7.	Do your siblings have a history of alcohol abuse? Indicate which sibling(s):	☐	☐
8.	Do your siblings have a history of drug abuse? Indicate which sibling(s):	☐	☐
9.	Do your siblings have a history of a diagnosis of mental illness? Diagnosis and Indicate which sibling(s):	☐	☐

SOCIAL FUNCTIONING QUESTIONNAIRE

		No	Yes
1.	Do you feel that you have an adequate social life?	☐	☐
2.	Do you feel that you have an adequate network of family and friends?	☐	☐
3.	Do you feel isolated due to a limitation of resources?	☐	☐
4.	Do you feel that you have a lack of social skills?	☐	☐
5.	Does your declining health or medical issues affect your social life?	☐	☐
7.	Do you have the resources to meet your daily needs?	☐	☐
8.	Do you have any transportation issues which would prevent you from getting to the office?	☐	☐
9.	Do you have economic issues which would prevent you from receiving the care that you need?	☐	☐
10.	Do you have adequate food available to you?	☐	☐
11.	Do you have adequate shelter available to you?	☐	☐

***New York State requires at **least annual** screening of all patients concerning alcohol use, substance use, mental health history, and family history of mental health issues. This questionnaire was designed to be in compliance with all state and federal mandates for compliance of care. We appreciate your cooperation in sharing this information with our office.

Patient Health Questionnaire For all Annuals

Patient Name: General Doc General Docs Date of Visit: July 2, 2026

Functional Status

Please indicate whether you are completely **independent**, **having difficulty**, or **depend on others** to perform the following tasks for you:

	Independent	Having Difficulty	Depend on Others
Walking	☐	☐	☐
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Feeding	☐	☐	☐
Grooming	☐	☐	☐
Standing	☐	☐	☐
Toileting	☐	☐	☐
Cooking	☐	☐	☐
Cleaning	☐	☐	☐
Food Prep	☐	☐	☐
Housekeeping	☐	☐	☐
Laundry	☐	☐	☐
Taking Medications	☐	☐	☐
Managing Money	☐	☐	☐
Shopping	☐	☐	☐
Using the Telephone	☐	☐	☐
Traveling/Transportation	☐	☐	☐

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Review of Systems

Name: General Doc General Docs DOB: 01/01/2015

Do you currently have any problems related to the following systems? Circle **Yes** or **No**

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other _____

Allergies/Immunologic
Hay Fever Y N
Drug allergies Y N
Other_____

Endocrine
Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Eyes/Ears/Nose/Throat/Mouth
Blurred vision Y N
Double vision Y N
Pain Y N
Other_____

Ear infection Y N
Sore throat Y N
Sinus problems Y N
Other _____

Cardiovascular
Chest pain Y N
Varicose veins Y N
High blood pressure Y N
Other _____

Respiratory
Wheezing Y N
Frequent cough Y N
Short of breath Y N
Other_____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/hrtburn Y N
Other _____

Genitourinary
Burning w/urination Y N
Weak stream Y N
Get up at night Y N
Daytime frequency Y N
Retention of urine Y N
Kidney stone pains Y N
Erection problems Y N
Urinary Leakage Y N
Other _____

Neurological
Tremors Y N
Dizzy Spells Y N
Numb/tingling Y N
Other _____

Integumentary
Skin rash Y N
Persistent itch Y N
Infections Y N
Other _____

Musculoskeletal
Joint pain Y N
Neck pain Y N
Back pain Y N
Other_____

Hematologic/Lymphatic
Swollen glands Y N
Blood clotting problem Y N
Lymph node enlargement Y N
Other _____

This form has been completed by the patient. Date _____

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Offer of HIV Testing

New York State Public Health Law requires that an offer of HIV-related testing be made to all persons between the ages of 13 and 64 receiving hospital or primary care services except under specific circumstances. This includes inpatients, persons seeking services in emergency departments, those receiving primary care on an out-patient basis at a clinic or from a physician, physician assistant, nurse, practitioner or midwife.

HIV is the virus that causes AIDS and is passed from one person to another during unprotected sex (oral, anal, or vaginal sex without a condom) with someone who has HIV. HIV is also passed through contact with blood as in sharing needles (piercing, tattooing or injecting drugs of any kinds) or sharing 'work' with a person who has HIV.

If your test result is negative, you can learn how to proceed yourself from being infected in the future. If you are positive, you can take steps to prevent passing the virus to others, and you can receive treatment for HIV and learn about other ways to stay healthy.

☐ Yes, I would like to speak to someone about HIV testing.

☐ No, I do not wish to have an HIV test today.

Patient Name: General Doc General Docs

Date:_____

Signature_____

KENNETH S. ZIMMERMAN, M.D.
Internal Medicine
6760 Main Street
Williamsville, New York 14221
716-626-0030

Signature/Consent Page

General Doc General Docs DOB: 01/01/2015
Please sign in the **six** areas as indicated.

CONFIRMATION OF MEDICAL HISTORY
I have read the questions on pages 1, 2, and 3 and have completed them truthfully and to the best of my ability.

_____ _____
Required Signature of Patient and/or Responsible Party Date

TREATMENT WAIVER FOR BILLING INSURANCE COMPANIES
I understand that if I have not listed Kenneth Zimmerman, M.D. or Christine Krol, M. D. as my primary care physician, I will assume responsibility for paying the bill.

_____ _____
Required Signature of Patient and/or Responsible Party Date

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR MEDICARE/INSURANCE BILLING
I request that payment of authorized Medicare and/or other insurance company benefits be made on my behalf for any services furnished me by Kenneth Zimmerman, M.D., including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and/or other insurance companies and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Required Signature of Patient and/or Responsible Party Date

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS
I hereby consent to the use and disclosure of my Protected Health Information by Kenneth Zimmerman, M.D. for purposes of treatment, payment and/or health care operations. I hereby consent to the use and disclosure of my Protected Health Information by Kenneth Zimmerman, M.D. to arrange for treatment by another provider or for the referral of another provider or entity, including a Business Associate of Kenneth Zimmerman, M.D. and for business operations of Kenneth Zimmerman, M.D. or its related treatment entities.

I understand that my signature on the consent is required in order for me to receive care from the Physician Practice and that the Physician Practice may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for its treatment, payment and health care operations.

_____ _____
Required Signature of Patient and/or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF CANCELLATION POLICY
I have read and understand the no-show/cancellation policy and that if I do not cancel my appointment in the time specified in the notice that I will be billed for $75.

_____ _____
Required Signature of Patient and/or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I understand that further information on the Physician Practice's uses and disclosures of my Protected Health Information is included in the Physician Practice's Notice of Privacy Practices. I acknowledge receipt of Kenneth Zimmerman's Notice of Privacy Practices.

_____ _____
Required Signature of Patient and/or Responsible Party Date

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About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1.This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.

2.Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.

3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.

4.Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

* If I become terminally ill, I do/don't want to receive the following treatments...
* If I am in a coma or unconscious, with no hope of recovery, then I do/don't want...
* If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want...
* I have discussed with my agent my wishes about_____, and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may leave instructions:

* artificial respiration
* artificial nutrition and hydration (nourishment provided by feeding tube)
* cardiopulmonary resuscitation (CPR)
* antipsychotic medication
* electric shock therapy
* antibiotics
* psychosurgery
* dialysis
* transplantation
* blood transfusions
* abortion
* sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. You do not need a lawyer to fill out this form. You may choose any adult (over 18), including a family member or close friend, to be your agent. If you select a doctor as your agent, he/she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home, or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask the staff at the facility to explain those restrictions.

You should tell the person you choose that he/she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

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Health Care Proxy

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him/her or your health care proxy provided orally or in writing.

Filling Out the Proxy Form

Item (1) Write your name and the name, home address, and telephone number of the person you select as your agent.

Item (2) If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

Item (3) You may write the name, home address, and telephone number of an alternate agent.

Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses of at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

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Health Care Proxy

(1) I, _____ hereby appoint

_____
(name, home address, and telephone number)
_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he/she otherwise knows. (Attach additional pages if necessary.)

_____

_____

_____

_____

(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. (See instructions for filling out the proxy form.)

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent.

_____
(name, home address, and telephone number)
_____

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below.
This proxy shall expire (specific date or conditions, if desired):

_____

(5) Signature _____

Address _____

Date _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his/her own free will. He/She signed (or asked another to sign for him/her) this document in my presence.

Witness 1 _____

Address 6760 Main Street Williamsville NY 14221

Witness 2 _____

Address 6760 Main Street Williamsville NY 14221

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Notice to All Patients:
UPDATED OFFICE POLICIES

Yearly Annual

As your Primary Care Provider, it is our duty to handle your day-to-day health needs. It is our office policy to see you for your annual physical at least once every calendar year, and/or *every 6 months*, even if you're feeling great.

X_____ X_____
Signature of Patient or Representative Authorized by Law *Date*

Medical Clearance

If you are in need of a medical clearance appointment, you must have your annual done prior to that appointment. These are two seperate appointments that cannot be done at the same time. This resets every calendar year.

*X*_____ *X*_____
Signature of Patient or Representative Authorized by Law *Date*

ER/Urgent Care Guidelines

Please remember that during non-business hours, you may call our office regarding *urgent/emergency issues* at 716-626-0030 and have us paged so that we may assess whether a visit to an urgent care center or emergency room is necessary.

Please contact us first before going to Urgent Care or ER for:

Common Illnesses: cold, flu, ear aches, sore throats, migraines, fever, rashes, or urinary tract infections.
Minor injuries: sprains, back pain, minor cuts and burns, or minor eye injuries.

For common illnesses and minor injuries that you feel need to be addressed after normal business hours, we can often offer advice over the phone and schedule you for an appointment in our office the next business day, or refer you to the correct specialist. If we direct you to an emergency room, we can provide the nurses and staff with important medical information about you and your current symptoms.

Please go to your nearest emergency room or urgent care clinic for any condition you feel is serious or life-threatening.

As always, if you have any questions, please contact our office.

*X*_____ *X*_____
Signature of Patient or Representative Authorized by Law *Date*
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