Welcome to Shore Neurocognitive and Behavioral Health. We understand you may have some questions about your first visit.

**What happens on the first visit?**
First you will meet with Erin Young, our administrative assistant. She will ask you for your insurance cards and other information identified in the paperwork below prior to meeting with your provider.

In preparation for your first appointment, we ask you complete the following paperwork prior to arriving at our office. You will find several forms:

1. Release of Information form
2. Insurance policy
3. Patient Payment Policy
4. Telehealth Policy
5. HIPAA policy
6. PHQ9 Health Questionnaire

Please read these carefully, as we have late arrival and missed appointment policies that are important to be aware of. We understand that there are unforeseen circumstances that cause cancellations, or individuals to miss their appointment. We work with you as much as possible to ensure you make your appointment, but each time a patient misses an appointment without proper notice, another patient is prevented from our services. We try and help individuals remember their appointment by reminder phone calls, emails and texts, so missed appointments should not occur often. We ask you sign all the paperwork, and please keep a copy for your files.

***Next*** you will meet with your provider. Depending on the type of session, you may be meeting individually, as a couple or with a family member. If you are unsure, please ask prior to the visit who will be included.

Most first appointments last about an hour, unless otherwise indicated by the provider. The length of subsequent visits will be determined by you and your provider.

**Please arrive 15 minutes before your scheduled first appointment.**

*We look forward to meeting you soon.*

Shore Neurocognitive Health

*Shore Neurocognitive Health*
*29466 Pintail Drive, #9*
*Easton, MD. 21601*
*PH: 443-746-3698*
*Fax: 410-862-3013*

**Release of Information Authorization Form**
**For the Use & Disclosure of Protected Health Information**

Patient Name:_____

Patient Date of Birth: _____

Patient Social Security Number: _____

By signing this Authorization Form, I understand that I am giving my authorization to Shore Neurocognitive Health, designated medical record custodians to use and or disclose Protected Health Information (PHI) on the above captioned individual, as described in more detail in the paragraphs below, to the following person(s) or organization(s).

Name of person, organization or Physician: _____

Street Address: _____

City, State and Zip Code: _____

Telephone #: _____ Fax #: _____

I specifically authorize the use and disclose of the following PHI:

Primary Care Physician Records: _____

Clinic / Outpatient Records: _____

Consult Reports: _____

Lab & Radiology Reports: _____

Psychotherapy Records: _____

Other Information: _____

The information to be used or disclosed pursuant to this authorization form may include information relating to; treatment of drug or alcohol abuse, mental, behavioral health or psychiatric care.

I may revoke this authorization at any time by notifying Shore Neurocognitive Health, of my intent to revoke this authorization. However, I understand that such a revocation will not have any effect on any information already used or disclosed by Shore Neurocognitive Health before Shore Neurocognitive Health received my written notice of revocation. Unless earlier revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below.

If neither federal nor Maryland privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient as is no longer protected by federal or Maryland law.

I may inspect and receive a copy of information to be used and disclosed pursuant to this Authorization Form. I understand Shore Neurocognitive Health may charge, as allowed by law and regulation, a fee for providing a copy of this information. This authorization is voluntary, and I may refuse to sign this Authorization Form.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient

_____

Printed name & relationship of legally authorized representative
(If applicable)

SHORE
NEUROCOGNITIVE & BEHAVIORAL HEALTH

## Have you made any changes to your insurance?

You are responsible for informing us of any changes to your insurance coverage. If your new insurance, including if you have changed to a different Medicare plan (for example Medicare Part C), you may be responsible for part of the charges incurred at this office.

## Medicare and Insurance Deductible 2022 Reminder

As of January 1, 2022, the 2022 Medicare deductible is $233. Your private insurance may have a yearly deductible as well, individual to your plan. You are responsible for paying any charges, including the yearly deductible, your secondary insurance does not cover. **Please note: we do not participate in Railroad Medicare nor Medicare Advantage programs.**

## Co-Pays

All co-pays are due at the time of the appointment. If you do not have a secondary insurance to Medicare, you will be required to pay the 20% co-pay at the time of your appointment.

## Credit Card on File

We require that a credit card be kept on file. Credit card numbers are kept on an encrypted secure server. We do not keep a copy of your card in our office. If you have a balance, you may of course pay by cash or check. We will utilize your credit card only after attempting to notify you of the balance, including monthly statements. ***We reserve the right to charge your credit card if you have not paid your bill within 90 days, or set up a payment plan.*** Copies of the credit card receipt are available on our patient portal, by email or will be sent by mail upon request. Your credit card may state the payment is made to Shore Neurocognitive Health, LLC. You are responsible for any surcharges caused by credit card disputes or additional charges.

By signing this form, either on paper or electronically, you are aware you are responsible for any and all charges incurred at Shore Neurocognitive Health not covered by your insurance(s). You give permission for Shore Neurocognitive Health, LLC, to bill you card for any balances as stated above.

_____ _____

Name/signature Date

Updated Jan 1, 2022

**Shore Neurocognitive & Behavioral Health Patient Payment Policy**

Thank you for choosing our practice! We are committed to the success of your psychological treatment and care. Please understand that payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of commonly-asked financial policy questions below. *Please read this notice before you sign.* If you need further information about any of these policies, please ask.

**How May I Pay?**

We will bill your insurance if we are in network, but you may have a balance following your insurance payment. We accept payment by cash, check, VISA, Mastercard, American Express and Discover. We require all patients for a credit card to keep on file for all balances. Credit card numbers are kept on an encrypted secure server. We do not keep a copy of your card in our office. If you have a balance, you may of course pay by cash or check. We will utilize your credit card only after notifying you of the balance. **We reserve the right to charge your credit card if you have not paid your bill within 90 days, or set up a payment plan.** Copies of the credit card receipt are available on our patient portal, by email or will be sent by mail upon request.

**Do I Need A Referral?**

Traditional Medicare does not require a referral, however some insurances may require a referral**. It is your responsibility to request a referral from your primary care provider if so needed.** *If your insurance does not pay as you have not obtained a referral, you will be responsible for the balance of your bill.*

**Which Plans Do You Contract With?**

We accept traditional Medicare and some Medicare Advantage programs. **We do not accept Medicare Part C (aka Medicare Advantage) or Railroad Medicare**. We do participate in some insurance companies programs, including Blue Cross (CareFirst) and Cigna. This does not guarantee payment. You are responsible for determining if we participate in your insurance plan and obtaining the referral from your physician if so required by your insurance. If we don't participate in your insurance plan, you are responsible for the all fees. We will provide you with a summary of services that you may submit to your insurance company for potential reimbursement. We do not guarantee that you will receive any reimbursement for services rendered.

**What Is My Financial Responsibility for Services?**

Your secondary insurance, also known as GAP insurance, may be all or part of the remainder of the bill. However, if it does not, you are financially responsible for any balance not covered by Medicare. We cannot guarantee your GAP insurance will cover our services.

**MEDICARE**
If you have Medicare, and have not met your yearly deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit. If you have Regular Medicare as

primary, but no secondary insurance, payment of your 20% copay is **required** at the time of the visit. You may pay by cash or credit card.

## MISSED APPOINTMENTS

We understand issues arise and you may need to reschedule your appointment. However, we require a 24 hour notice for missed appointments. Less than 24 hours and same day cancels will be charged $100, unless otherwise waived by Shore Neurocognitive Health. Missed appointments without notice will be charged $100. These charges will be billed to your credit card. If you miss more than 3 appointments, we reserve the right to discharge you from the practice. As of January 1, 2021, all no show fees MUST be paid prior to your next appointment.

***By signing this agreement, you are stating you understand this policy, and authorize us to bill your credit card for missed appointments.***

## LATE APPOINTMENTS

We reserve the right to reschedule appointments if you arrive more than ten minutes late.

*I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I authorize the use of my credit card for all balances. I understand I will receive a receipt upon request via the online portal, in person or via mail.*

*I authorize my insurance benefits be paid directly to Shore Neurocognitive Health.*
*I authorize (name of your practice) to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

*By signing this form, either on paper or electronically, you are aware you are responsible for any and all charges incurred at Shore Neurocognitive Health not covered by your insurance(s).*

| Date | Signature | Printed Name |
|---|---|---|

# Telehealth and Telebehavioral health Informed Consent

## Introduction

The following information is regarding telehealth and telebehavioral health (from here forward referred to as "telehealth") at Shore Neurocognitive & Behavioral Health (SNBH). Telehealth is the form of telemedicine that allows patients to access mental and behavioral health care using audio-video interface such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

## Expected Benefits:

- Improved access to mental and behavioral health care by enabling a patient to remain in his/her home or office.
- Obtaining expertise of a distant specialist.

## Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgmental errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of mental and behavioral health care may be available to me, and that I may choose one or more of these at any time.
5. I understand that it is my duty to inform my psychotherapist of any other healthcare providers involved in my medical/psychiatric care.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that telehealth services for SNBH are only available in the state in which the therapist is licensed. If I move to a state in which the therapist is not licensed, I am responsible for obtaining mental health care.
8. I understand that if I am not available at the time of the scheduled telehealth appointment, or more than ten minutes late, SNBH Health has the right to reschedule my appointment.
9. I understand all other SNBH policies apply to Telehealth.

**Patient Consent To The Use of Telehealth**

I have read and understand the information provided above regarding telehealth, have discussed it with my psychotherapist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical and mental health care. A copy of this consent form will remain available to me through this online patient portal.

I hereby authorize SNBH to use telehealth in the course of my diagnosis and treatment.

_____ _____

Name Signature

_____

Date

**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 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. You may request a revised version by accessing our website, or 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.

**1. 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 who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's 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.

**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 another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating 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. 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 with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake 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 protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care 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, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our 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.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for 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.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable
federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

**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. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**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.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:**
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

**Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

**Facility Directories:** Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

**Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or 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 protected 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.

**2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

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 laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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 health care 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 your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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 electronically.

**3. 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 Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.

**_____I have read this agreement** **_____ I understand a copy is available to me if so requested**

| **Name** | **Signature** | **Date** |
|---|---|---|

*may be signed electronically

# 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** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |