ALGOS BEHAVIORAL HEALTH SERVICES, INC.

NEW PATIENT INFORMATION RECORD

Today's Date:		Referred By:	
Patient Full Legal Name:			
Date of Birth: / /	Age:	Male / Female	Male
SSN: / /		Marital Status:	Widowed
Address **(physical)**:		Drivers License#:	
City:	State:	Zip Code(9 digits):	
Home Phone: ( )	Cell Phone: ( )	Work: ( )	EXT#
Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail?			
◉ **YES** ○ **NO**	**If yes, which is best:**	Work	
Email Address**:**			
Employer's Name:		Occupation:	
Address:	City:	State:	Zip:

PRIMARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Primary Insurance:		Phone # *(Located on the back of card)*	
Subscriber ID#:		Group # :	
Name of Policy Holder:		**DOB**:	
Insured's Address:		☐ **same as patient**	
City:	**State:**	**Zip Code(9 digits):**	
Policy Holder's Employer:			
Patient Relationship to Policy Holder:	Partner		

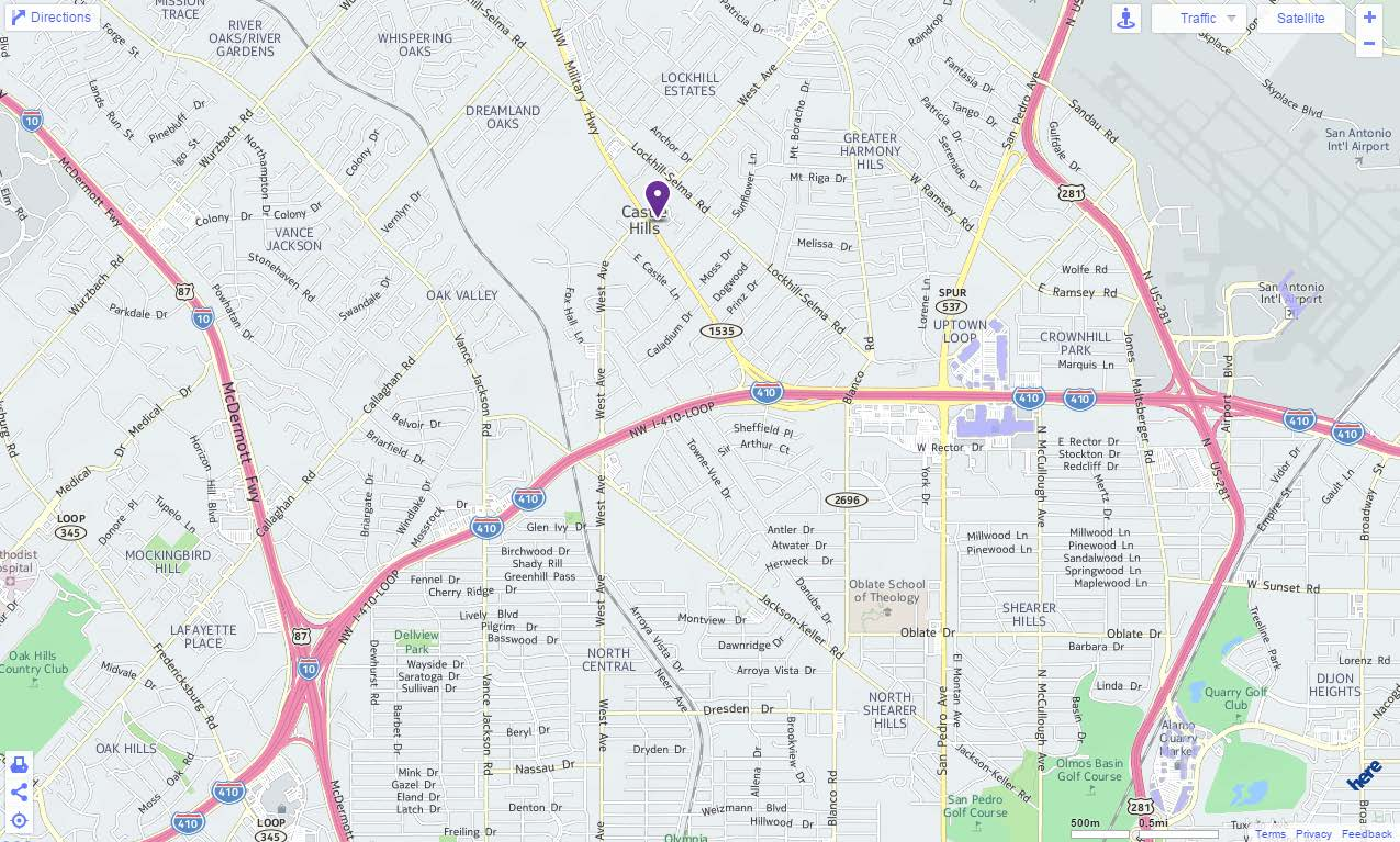
SECONDARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Secondary Insurance:		Phone # (*Located on the back of your card*):	
Subscriber ID#:		Group # :	
Name of Policy Holder:		**DOB**:	
Insured's Address:		☐ **same as patient**	
City:	**State:**	**Zip Code(9 digits):**	
Policy Holder's Employer:			
Patient Relationship To Insured: SEL	Partner		

EMERGENCY CONTACT PERSON

Name:	Relationship:	Other
Home Phone: ( )	Work Phone: ( )	EXT:



Directions
Traffic
Satellite
MISSION TRACE
RIVER OAKS/RIVER GARDENS
WHISPERING OAKS
LOCKHILL ESTATES
DREAMLAND OAKS
GREATER HARMONY HILLS
San Antonio Int'l Airport
Castle Hills
VANCE JACKSON
OAK VALLEY
SPUR 537
UPTOWN LOOP
CROWNHILL PARK
San Antonio Int'l Airport
1535
410
NW I-410-LOOP
2696
LOOP 345
MOCKINGBIRD HILL
Oblate School of Theology
SHEARER HILLS
LAFAYETTE PLACE
Oak Hills Country Club
Dellview Park
NORTH CENTRAL
NORTH SHEARER HILLS
DIJON HEIGHTS
Quarry Golf Club
Alamo Quarry Market
Olmos Basin Golf Course
San Pedro Golf Course
OAK HILLS
Forge St
Lands Run St
Pinebluff Dr
Igo St
Wurzbach Rd
Northampton Dr
Colony Dr
Vernlyn Dr
Stonehaven Rd
Swandale Dr
Powhatan Dr
Parkdale Dr
McDermott Fwy
Callaghan Rd
Medical Dr
Vance Jackson Rd
NW Military Hwy
Lockhill-Selma Rd
Anchor Dr
West Ave
Mt Boracho Dr
Sunflower Ln
Mt Riga Dr
Melissa Dr
Moss Dr
Dogwood
Prinz Dr
E Castle Ln
Caladium Dr
Fox Hall Ln
Patricia Dr
Raindrop
Fantasia Dr
Tango Dr
Serenade Dr
W Ramsey Rd
San Pedro Ave
Sandau Rd
Gulfdale Dr
Skyplace Blvd
Wolfe Rd
E Ramsey Rd
Lorene Ln
Blanco Rd
Marquis Ln
Jones Maltsberger Rd
N US-281
281
Airport Blvd
Belvoir Dr
Briarfield Dr
Sheffield Pl
Sir Arthur Ct
Towne-Vue Dr
W Rector Dr
E Rector Dr
Stockton Dr
Redcliff Dr
Mertz Dr
York Dr
N McCullough Ave
Horizon Hill Blvd
Tupelo Ln
Donore Pl
Briargate Dr
Windlake Dr
Mossrock Dr
Glen Ivy Dr
Antler Dr
Atwater Dr
Herweck Dr
Danube Dr
Millwood Ln
Pinewood Ln
Sandalwood Ln
Springwood Ln
Maplewood Ln
W Sunset Rd
Vidor Dr
Empire St
Gault Ln
Broadway St
Birchwood Dr
Shady Rill
Greenhill Pass
Fennel Dr
Cherry Ridge Dr
Lively Blvd
Pilgrim Dr
Basswood Dr
Montview Dr
Jackson-Keller Rd
Oblate Dr
Barbara Dr
Treeline Park
Lorenz Rd
Midvale Dr
Fredericksburg Rd
87
10
Dewhurst Rd
Wayside Dr
Saratoga Dr
Sullivan Dr
Arroya Vista Dr
Dawnridge Dr
Neer Ave
Dresden Dr
Brookview Dr
El Montan Ave
Linda Dr
Basin Dr
Nacogdoches
Barbet Dr
Beryl Dr
Dryden Dr
Allena Dr
Nassau Dr
Mink Dr
Gazel Dr
Eland Dr
Latch Dr
Denton Dr
Weizmann Blvd
Hillwood Dr
Freiling Dr
Moss Oak Rd
Olympia
500m
0.5mi
Terms
Privacy
Feedback
here

ALGOS BEHAVIORAL HEALTH SERVICES, INC.
Financial Policy

Thank you for choosing Algos Behavioral Health Services, Inc. as your mental health care provider. The following is a summary of our financial policies. Please read the information carefully and sign or initial where noted below. We must obtain a copy of your driver's license and a current, valid insurance card. Failure to provide a current, valid insurance card and/ or information prior to your visit will result in payment due in full at the time of visit.

Initial below please:

_____ 1. **PAYMENTS**. **All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment**.
Initial We accept cash or credit card (Visa, MasterCard, or Discover). Unpaid accounts may be referred to an outside collection agency.

_____ 2. **CANCELLATIONS**. To reserve the hour of the clinician's time, we request a credit card to assure you of the availability of the
Initial doctor. There is a fee of **$50.00** for a missed appointment or late cancellation. You can avoid this charge if you cancel 24 or more hours prior to the appointment. Your insurance carrier will not cover this fee.
____ ** When applicable, for individuals scheduled for a testing appointment – you will be charged **$50.00** for every hour of testing that is missed or not cancelled within 24 hours. For example, if you are scheduled for 3 hours of testing, and you cancel or do not show for that appointment time, you will be charged $150.

_____ 3. **CHANGE OF INFORMATION**. You are responsible to provide us with any change regarding your address, phone number or
Initial insurance information as soon as possible.

_____ 4. **PRIVATE INSURANCE AUTHORIZATION AND INFORMATION RELEASE.**
Initial I, the undersigned, authorize payment of mental health benefits to Algos Behavioral Health Services, Inc for any services rendered. **I understand that I am financially responsible for any amount not covered by my insurance policy including but not limited to co-payments, co-insurance and deductibles.** Any payments denied by the insurance company will be forwarded to the undersigned, and the undersigned will be held responsible for payment. I also authorize Algos Behavioral Health Services, Inc to release to my insurance company any information concerning health care, diagnosis or treatment provided to me. This information will be used only for the purpose of evaluating and administering claims of benefits.

_____5. **POTENTIAL NON COVERAGE**
Initial Although other medical services may be covered by your insurance, this psychological service may not be covered and, in that case, you will be fully responsible for the entire amount**.** If the clinician is *out-of-network* with your insurance policy, you will be required to pay the full amount of the service rendered. We will NOT file claims for out-of-network services.

_____ 6. **NON-COMPLIANCE.** We reserve the right to discontinue care with you for non-compliance with any of the above
Initial policies.

_____ 7. The undersigned agrees that in the event of **default in payment** or if the account is placed with a collection agency for
Initial collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, and court costs, at the interest rate of 18% per annum.

For all services rendered to minor patients, the adult accompanying the patient, or the policy holder, is responsible for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X _____ **Date:** _____
Signature of Patient OR Responsible Party if a Minor

_____
Printed Patient Name

I WILL NOT BE USING INSURANCE FOR THIS SERVICE AND WILL PROVIDE ANOTHER FORM OF PAYMENT.

SIGNED: _____ **DATE:** _____

Form E

Algos Behavioral Health Services, Inc.

Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., Sandy Zamora, LPC-S

CONSENT TO TREATMENT AND CLINICAL ASSESSMENT SERVICES

This is to certify that I give permission to Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., or Sandy Zamora, LPC-S at Algos Behavioral Health Services, Inc. to provide psychological and behavioral health services for myself and/or child(ren), or for an adult child for whom I am the legal guardian.

I have reviewed the **Statement of Office Policies for Clinical Practice** and the specific assessment and/or treatment procedures have been explained to me.

Service:

___ Psychological Evaluation
___ Psychoeducational Evaluation
___ Neuropsychological Evaluation
___ Behavioral Health Assessment
___ Biofeedback Therapy
___ Other: _____

___ Couple Psychotherapy
___ Group Psychotherapy
___ Family Psychotherapy
___ Individual Psychotherapy
___Group Behavior and Health Intervention

The specific treatment has been described in the written **Statement of Office Policies for Clinical Practice** and/or explained by the clinician. If applicable, alternatives to treatment have been explained to me. Due to the complex nature of psychotherapy and other behavioral health services, including discussing past and present emotional pain and the stresses in life, it is quite common for persons entering this type of treatment to have periods of time when they experience their feelings as more intense, and perceive their condition as possibly worse. This should be discussed as part of the treatment, and is usually temporary. Please note that it is impossible to guarantee any specific results regarding psychological treatment. However, every effort will be made to achieve the best possible results for you. Maximum benefits occur with regular attendance and your active emotional investment in the process.

The issues of confidentiality have been reviewed, and I have been assured that all communications between a professional and a client are held in strict confidence. However, I also understand that there are exceptions to those laws and regulations. I understand it is the clinician's legal responsibility to disclose certain issues for my protection and that of others, and these situations have been clarified to me. Every reasonable effort will be made to resolve issues through discussion and planning within the clinical setting, and I will be notified of any anticipated compromise of the client-therapist relationship.

I have the right to terminate the therapeutic relationship at any time that I desire, without fault, and I have the right to seek and obtain a second opinion on the procedures and/or treatment process.

I understand that I am fully financially responsible for my treatment provided by the clinician, and for any balance that is not covered by my insurance company. A billing service may be used for the

collection of insurance reimbursement and co-pay fees. Psychologists have the right to seek the services of a collection agency to obtain payment of past due balances.

My signature certifies that I have read and understand all the information provided by Algos Behavioral Health Services Inc., about the clinicians, the treatment to be provided, and the expense to be incurred. I hereby voluntarily give my informed consent for treatment. A copy of this authorization shall be considered valid. I understand that I will be informed of any changes concerning what is in this document and my consent will be obtained regarding these changes.

You are assured that the services will be provided in a professional manner, consistent with the rules and regulations of the Texas State Board of Examiners of Psychologists and the ethical principles of the American Psychological Association. Every effort will be made to provide services in a caring, supportive and trustworthy environment.

In addition to the specified procedure checked above, the initial goals of treatment will be established after the first or second session.

My signature certifies that I have been provided the opportunity to read/review the following relevant documents:

- **Notice of Privacy Practices**
- **Statement of Office Policies for Clinical Practice: Psychotherapy, Psychological or Neuropsychological Testing and Behavioral Health Assessments**

My signature certifies that I voluntarily give my informed consent to the clinical services offered by this psychological practice.

X_____ _____

Signature of Client/Patient Date

_____ _____

Signature of Responsible Party (if client is a minor) Date

Form A

Algos Behavioral Health Services, Inc.

Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., Sandy Zamora, LPC-S

Health Insurance Portability and Accountability Act (HIPAA) Consent

General Notice
When seeking psychological consultation and/or treatment in this practice, **P**rotected **H**ealth **I**nformation **(PHI)** will be gathered about you. This information may include a clinical history, medical history, personal information, and possibly performance/responses on psychological testing instruments.

Notice to Protect the Privacy of Your Health Information

A complete description of how your **PHI** may be used and disclosed is available for your review in the **"HIPAA Notice of Privacy Practices."** A copy of this document is available at the reception desk. You may request a copy for your records.

Individual Rights

You have the right to restrict the uses and disclosures of your **P**rotected **H**ealth **I**nformation **(PHI)** for the purpose of treatment and health care. A signed consent form is usually required. This practice is not required to agree to requested restrictions, but is bound by any restrictions to which it agrees.
You have the right to revoke this consent in writing, except to the extent that our practice has taken action on the reliance on this consent. You have the right to refuse to sign this consent. This practice has the right to refuse to provide the clinical services requested, if you refuse to sign the consent or if you revoke this consent at any time.

Your signature below acknowledges:

- You have read and understand this consent;
- You have agreed to have your **P**rotected **H**ealth **I**nformation **(PHI)** used by this practice for the purposes of your consultation and treatment, to secure payment for your treatment, and for this practice's psychological care operations;
- Prior to signing this consent, you were given the opportunity to review the practice's **"HIPAA Notice of Privacy Practices;"**
- You are aware that you may now, or at any time in the future, request restrictions to the use and disclosure of your **P**rotected **H**ealth **I**nformation **(PHI)**;
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent.

X_____ _____
Signature of Client/Patient or Representative Date

Form C

Authorization Form to Release Protected Health Information (PHI)

This form when completed and signed by you authorizes this psychological clinic to release Protected Health Information (PHI) from your clinical record to the person(s) you designate.

I hereby authorize my psychologist and/or clinical associate, Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., or Sandy Zamora, LPC-S and their practice management company, Algos Behavioral Health Services, Inc. and/or their administrative and clinical staff to release *the following specific clinical record and/or administrative/payment information*: (please list which information you want released)
_____results of the psychological evaluation_____

**This information should be released to only the person(s) below:
_____
_____
_____

I am requesting the release of this information for the following reasons:
☐ at the request of the individual ☐ for continuing care ☐ for public agency use
☐ legal purposes ☐ other:_____

This authorization shall remain in effect until _____ (date),
or until _____
(specific purpose).

You have the right to revoke this authorization in writing at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist or clinical associate generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

X_____ _____
Signature of Patient Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

NAME: _____ DATE: _____

DOB: _____ AGE: _____

HANDEDNESS ☐ left ☐ right ☐ ambidextrous

COLOR BLIND? ☐ *Yes* ☐ *no*

WHAT BRINGS YOU IN NOW? (who, what, where, when, how, what circumstances)

and HOW IS THIS IMPAIRING YOUR FUNCTIONING?

_____

_____

_____

PHYSICAL COMPLAINTS (current, persistent symptoms)

_____

_____

COGNITIVE CHANGES

LANGUAGE DEFICITS:

Word-finding difficulties (does word come to you eventually?) - _____

Verbal Comprehension (Difficulty understanding what other people say to you, not due to hearing loss) - _____

ATTENTION DEFICITS: (present @ home, school/work, or both?)

Task maintenance (Difficulty staying focused? Able to finish tasks?) - _____

_____

Distractibility (When you zone out, is it due to something internal or external? Does anything/strategy keep you on task?) - _____

_____

Is your attention different with auditory or visual info.? - _____

Hyperactivity/Restlessness? _____

Impulsive behaviors? _____

Disorganized? _____

MEMORY DEFICITS:

Everyday Memory –

Do you misplace personal items frequently? ☐ YES ☐ NO

Do you lose your train of thought? ☐ YES ☐ NO

Do you forget what you are told? ☐ YES ☐ NO

Do you forget your intentions (like when you go into another room to get something)?

☐ YES ☐ NO

Do others tell you that you repeat yourself? ☐ YES ☐ NO

Recall of recent personal events (does it help when shown a picture?) - _____

VISUAL-SPATIAL DEFICITS:

Visual Perception (other than blurred vision or other visual changes) - _____

_____

Spatial Disorientation (get lost easily? Eventually find your way?) - _____

_____

COGNITIVE SPEED DEFICITS (does it take longer to do tasks? Do you believe your thinking is slower than other people or slower than it used to be?) _____

DIFFICULTIES MAKING DECISIONS, PROB. SOLVING, REASONING (small vs. big problems or decisions) -

_____

_____

EMOTIONAL CHANGES

How is your mood?

Depression ☐ anxiety ☐ obsessing/worrying ☐ irritability ☐ anger

Details - _____

_____

Suicidal thoughts/Homicidal thoughts or attempts? _____

HALLUCINATIONS/DELUSIONS? _____

PANIC ATTACKS? _____

ADHD? _____

PSYCHIATRIC/SUBSTANCE ABUSE HX:

Past/Current Mental Health Talk Therapy - _____

_____

Medications for mood difficulties - _____

Psychiatric Hospitalization - _____

Alcohol use - _____

Tobacco use - _____

Illicit drug use - _____

BEHAVIORS:

a. Sleep habits (nightmares? Take meds? Do they help? How long has this been going on?) –

_____

_____

b. Eating habits - _____

_____

c. Exercise - _____

PERSONAL/SOCIAL HISTORY

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ cohabitating ☐ common-law

How long? _____ Married in past? _____

Children: _____

Birthplace: _____ Raised where? _____

Siblings: _____

Childhood trauma or abuse: _____

SOCIAL:

a. Relationship w/ partner (parents) – _____

_____

b. Relationship w/ children (siblings) – _____

_____

c. Work (school) Relationships – _____

d. Social Activities – _____

_____

e. Activities at home (Chores, Hobbies)– _____

MEDICAL HISTORY

CURRENT MEDICAL DIAGNOSES: _____

_____

CURRENT MEDICATIONS/SUPPLEMENTS: _____

_____

SURGERIES: _____

HX OF SPECIFIC NEUROLOGICAL EVENTS:

Head Injury (LOC? Coma? Sports Concussions? Falls? Car Accidents? Assaults?) - _____

_____

Rehabilitation - _____

Epilepsy/Seizures - _____

Stroke - _____

Diagnosis of Dementia/ALZ? - _____

Central Nervous System Tumor? - _____

Meningitis or Encephalitis - _____

High Fever requiring hospitalization - _____

FAMILY HISTORY:

☐ Heart Disease
☐ Hypertension
☐ Diabetes
☐ Thyroid
☐ Cancer
☐ Dementia/ALZ
☐ Autism/Asperger's
☐ Mental Illness
☐ Substance Abuse/Addiction
☐ ADHD or other learning disorder

Birth/Developmental History

YOUR BIRTH (Complications? Premature? Mother take meds/use drugs while pregnant with you?):

_____

_____

DEVELOPMENTAL MILESTONES (difficulty learning to crawl, walk, talk, toilet train): _____

_____

EDUCATIONAL HISTORY

Highest grade year achieved in high school: _____ Public or Private? _____

What kind of grades? _____ Failed any Years? _____

Best Grades in which class/subject? _____

Lowest Grades in which class/subject? _____

Special Education or 504 Plan? _____

Learning Disability? _____

College: _____

Vocational/Trade/Technical School: _____

EMPLOYMENT HISTORY

CURRENT EMPLOYMENT:

Occupation - _____ How long? - _____

PAST EMPLOYMENT: _____

LEGAL HISTORY

PAST Legal Involvement: _____

CURRENT Legal Involvement: _____

STRENGTHS

Personal _____

Social _____

Education _____

Sports/Activities _____

Algos Behavioral Health Services, Inc.
West Oaks Building
2161 NW Military Hwy., Suite 207
San Antonio, TX 78213
Tel. (210) 447-6363 Fax (210) 447-6364
www.thealgosgroup.com

Karri (Zumwalt) Lusk, Psy.D.
Sean Connolly, Ph.D.
Sandy Zamora, LPC-S

PATIENT NAME: _____

MEDICATION LIST

* Please list all prescribed meds, over-the-counter meds, herbals, supplements, vitamins

Medication Name	Dosage	Frequency	Route of Administration (oral, topical, injection)

NAME: _____ DATE: _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

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
☐	☐	☐	☐

NAME: _____
DATE: _____
DOB: _____

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**
☐	☐	☐	☐

NAME: _____
DATE: _____
DOB: _____

ELDER ABUSE SUSPICION INDEX © (EASI)			
EASI Questions **Q.1-Q.5 asked of patient; Q.6 answered by doctor** **Within the last 12 months:**			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES ◯	NO ◯	Did not answer ◯
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES ◯	NO ◯	Did not answer ◯
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES ◯	NO ◯	Did not answer ◯
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES ◯	NO ◯	Did not answer ◯
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES ◯	NO ◯	Did not answer ◯
6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES ◯	NO ◯	Not sure ◯

Submit Form

The EASI was developed* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated* for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.

*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 000-000. In Press. Haworth Press Inc: http: //www.HaworthPress.com

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