Total Pain Treatment Centers OF CONNECTICUT
136 Sherman Avenue – Lower Level • New Haven, Connecticut 06511
(Phone) 203-675-1199 (FAX) 203-675-0277
www.TotalPainTreatment.com

INJURED PATIENT INFORMATION PACKET

Completing these pages accurately will help us with your treatment, as well as provide the best documentation associated with your injury. You will be offered help and given an opportunity to ask questions at your first appointment. Please be sure to write your name clearly and sign on the bottom of pages 5, 6, 8, 9.

PERSONAL INFORMATION

Patient Name (First, Middle, Last): *Nombre*		Date of Birth: *Fecha de Nacimiento*	Today's Date: *La Fecha de Hoy:*
Street Address:		City, State, Zip Code:	
Gender: ❑Male ❑Female *Masculino Hembra*	Social Security Number:	Driver's License or Other ID Number:	State:
Home Phone Number:	Cell Phone Number:	E-mail Address:	
Marital Status: ❑Single ❑Married ❑Divorced/Sep. ❑Widowed ❑Other		If Married, Name of Spouse:	
Employer Name and Location:		Employer Phone Number:	
Emergency Contact Name and Relationship:		Emergency Contact Phone Number:	

Auto Insurance

Name of Automobile Insurance Company:		Name of Insured:
Insurance Company Address:		City, State, Zip Code:
Accident Claim Number:	Name of Adjuster:	Adjuster's Phone Number with Extension:

Health Insurance

Name of Health Insurance Company:		Name of Insured:
Insurance Company Address:		City, State, Zip Code:
Group, Plan, or Patient ID Number:		Insurance Company Phone Number:

Attorney

Name of Attorney And Law Firm:		
Attorney Address:		City, State, Zip Code:
Attorney Phone Number:	Attorney Fax Number:	Attorney E-Mail Address:

1. Is your injury the result of an accident?	❑Yes ❑No
2. Type of Accident? *(If car/truck crash, please complete page 4)*	❑Auto ❑Work-Related ❑Slip & Fall ❑Other
3. How long have you been experiencing the symptoms of your injury?	
4. Are your symptoms getting worse?	❑Yes ❑No ❑Constant ❑Comes/Goes
5. If your accident happened at work, what happened?	

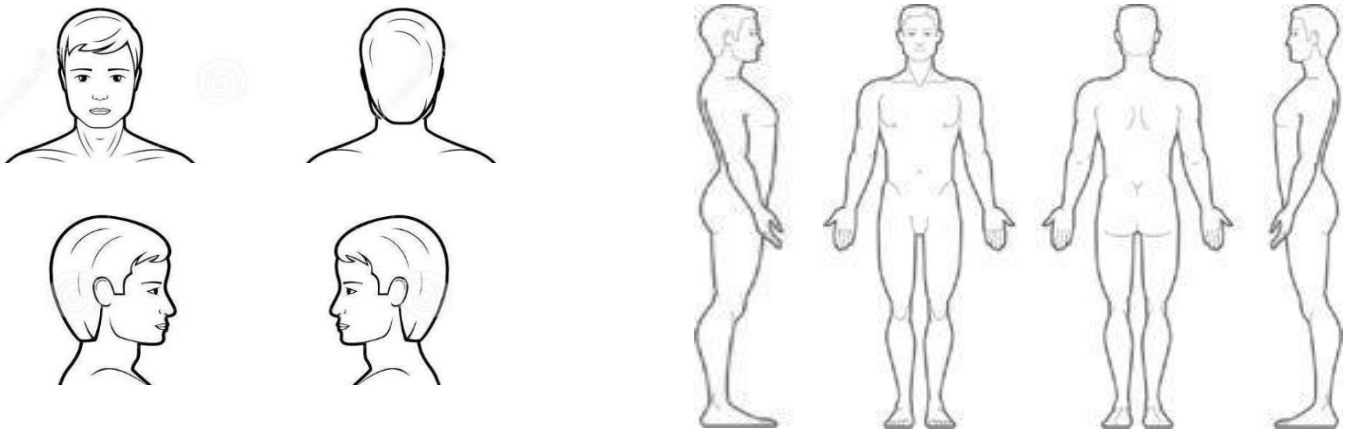
Please List Any Medications You are Currently Taking:

Please List Any Recurring Medical Problems You Have (Diabetes, High Blood Pressure, Cancer, Etc.):

Please List Any Recurring Medical Problems Your Family Has:

If Female, Are You Pregnant?	If Yes, How Long?		
❑Yes ❑No ❑Maybe	❑0-3 Mos. ❑3-6 Mos. ❑6-9 Mos. ❑Unknown		
Do You Smoke? ❑Yes ❑No	If Yes, How Often?	Do You Drink Alcohol? ❑Yes ❑No	If Yes, How Often?

On The Figures Below, Please Mark Your Areas of Pain and/or Discomfort:



Please Further Identify Your Major Problem Areas:

Complaint Area	Intensity of Pain (1-10)	Type of Pain (Circle All that Apply)	Frequency (Circle All that Apply)	Duration of Pain in Days or Weeks
*Neck Pain	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Days _____Wks
Shoulder Pain	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Days _____Wks
*Mid-Back Pain	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Days _____Wks
*Low Back Pain	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Days _____Wks
Hip(s)	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Days _____Wks
Extremities (hands/feet)	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Days _____Wks
Other:	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Days _____Wks

**For neck and back pain complaints, please provide additional information on the following page.*

***NECK SYMPTOMS**

1. Are you experiencing neck pain?	❑Yes ❑No
2. What type of pain are you experiencing? (Stabbing, Throbbing, Sharp, Dull, Cramping, Grabbing, etc.)	
3. Is there pain in your…?	❑Left Arm ❑Right Arm ❑Left Shoulder ❑Right Shoulder
4. Do you feel numbness in your arms? L R	❑Yes ❑No
5. Do you feel numbness in your hands? L R	❑Yes ❑No
6. Do you have difficulty swallowing?	❑Yes ❑No
7. Do you have chest pain?	❑Yes ❑No
8. Has your nervousness increased?	❑Yes ❑No
9. Does the neck pain affect your vision, hearing, or balance?	❑Yes ❑No

***MID - LOWER BACK SYMPTOMS**

1. Are you experiencing lower back pain?	❑Yes ❑No
2. Do you have numbness or tingling in your feet? L R	❑Yes ❑No
3. Does the pain go down your legs? L R	❑Yes ❑No
4. Does the pain radiate into your stomach?	❑Yes ❑No
5. Is there impairment to bowel function?	❑Yes ❑No
6. Are you experiencing knee pain? L R	❑Yes ❑No
7. Are you experiencing ankle pain? L R	❑Yes ❑No

LIFESTYLE

1. How many days or weeks of work have you lost due to your injury?	
2. What physical restrictions do you have?	
3. In what other ways has your injury impacted your quality of life?	

SUPPLEMENTAL INFORMATION FOR AUTOMOBILE INCIDENT

AUTO CRASH

Date of Incident: *Fecha del Accidente*	Town of Accident: *Ciudad del Accidente*	State of Accident: *Ubicación del Accidente*	Were You The Driver or Passenger?: *¿Era usted el conductor o un pasajero?* ❑Driver *Conductor* ❑Passenger *Pasajero*
Were You Wearing a Seatbelt? *¿Tenía su cinturon de seguridad puesto?* ❑Yes *Si* ❑No *No*		Was The Seatbelt Equipped With a Shoulder Harness? *¿Estaba equipado con un arnés del hombro?* ❑Yes *Si* ❑No *No*	
Was The Head Restraint (Headrest) Adjusted? *¿Estaba el apoyo de la cabeza ajustado?* ❑Yes *Si* ❑No *No*		What Was The Seat Position? *¿Cuál era la posición del asiento?* ❑Vertical/90º *Vertical 90 Grados* ❑Reclined *Inclinado*	

INJURY INFORMATION

What Was the Mechanism of Injury?: *¿Cuál fué el mecanismo del acidente?* ❑Rear *Por Detras* ❑Side *De Lado* ❑Front *De Frente* ❑Other *Otro*	Did the Airbag Deploy? *¿Se saleron las bolsas de aire?* ❑Yes *Si* ❑No *No* ❑No Airbags *No bolsas de aire*	Where you Prepared for Impact? *¿Estaba preparado(a) para el impacto?* ❑Yes *Si* ❑No *No*
Was there a secondary Impact (other car, curb, barrier, etc)? *¿Hubo un impacto secundario (otro carro, un encintado o una barrera, una acera, etc.)?* ❑Yes *Si* What? *Que?* ❑No *No*		What direction was your head turned at impact? *¿En qué dirección estaba su cabeza o cuerpo girada/o durante el impacto?*
If you were wearing glasses or a hat, where did they end up after the impact? *¿Si usted tenía lentes o un sombrero puesto dónde quedaron después del impacto?*		Did you lose consciousness? *¿Perdió el conocimieto?* ❑Yes *Si* How Long? *¿Por cuánto tiempo?* ❑No *No*
Did you strike any part of your body on the inside of the car? If so, what/where? *¿Se lastimó alguna parte de su cuerpo con el interior del auto? (Qué, Dónde)* ❑Yes *Si* Where? *Qué Dónde?* ❑No *No*		Did an EMT Attend to You? *¿Fué atendido por un Paramédico?* ❑Yes *Si* ❑No *No*
Were you taken to The Hospital? *¿Fué llevado al Hospital?* ❑Yes *Si* ❑No *No*	Which Hospital? *¿Cuál Hospital?*	Were you Taken by Ambulance? *¿En ambulancia u otro transporte?* ❑Yes *Si* ❑No *No*
Were you X-Rayed? *¿Le radiografiaron?* ❑Yes *Si* ❑No *No*	If X-Rayed, What Body Part(s)? *¿Qué áreas del cuerpo?*	Were you Admitted Overnight? *¿Lo(a) admitieron por la noche?* ❑Yes *Si* ❑No *No*
Were you given Medication or Prescriptions? *¿Recibió alguna prescripción médica?* ❑Yes *Si* ❑No *No*	Were you given any Orthopedic Supports or Braces? *¿Recibió algun supporte ortopédico?* ❑Yes *Si* ❑No *No*	
What were your discharge instructions? Work, Rest, Exercise. ¿Cuáles fueron sus instrucciones de salida? trabajo, descanso, ejercicio.	Have you had any other medical care since the accident? *¿Ha tenido otra asistencia médica desde el accidente?* ❑Yes *Si* ❑No *No* When Consulted? *Cuándo fué consultado(a)*	
Name of Doctor or Clinic: *Nombre del Doctor o de la Clínica:*	Treatment Received: *Tratamiento:*	
Have you had any diagnostic tests since the accident? (MRI, CT Scan, Bone Scan, X-Ray etc.) *¿Has tenido pruebas de diagnóstico desde el accidente? (MRI, Escanografía ósea, Radiografía etc.)* ❑Yes *Si* ❑No *No*		
Have you tried any home treatments like hot packs, medication, massage, etc? Were they successful? *¿Has intentado tratamientos caseros? (Paños Calientes,Medicamento,Masajes etc.? ¿Fueron eficaces?* ❑Yes *Si* ❑No *No*		
Have you missed work? *¿Has faltado al trabajo?* ❑Yes *Si* ❑No *No*	From: *De:*	To: *A:*
Other Information: *otra información:*		

INFORMED CONSENT AND TREATMENT AGREEMENT

Patient Name:_____ **Date of Injury:**_____

Read this information carefully. You will be given an opportunity to ask questions of your provider during your first encounter, prior to any treatment being ordered, prescribed or administered.

I the undersigned consent to receiving evaluation and treatment from Total Pain Treatment Centers of Connecticut (TPTC). I have read and understand each section listed below as it applies to my rights in receiving treatment from TPTC.

As a patient of TPTC, the risks involved with your care is considered to be minimal due to the nature of the examinations and applied methods of treatment. However, it is TPTC's policy and preference that all patients are fully informed of the nature of care, purposes of examination / treatment, risks involved as well as alternatives available to them prior to beginning their care.

The nature of your examination with TPTC may be inclusive to evaluative and treatment procedures involving participation on the part of the patient. Movement on the patient's part to identify and diagnosis injury and/or illness may result in momentary and/or heightened discomfort. Additionally, in rare occurrences injuries may be further agitated by the evaluation process and result in pain or discomfort being protracted or exacerbated.

Treatment for injuries may include the use of injections. Although these procedures may involve a short period of discomfort at the point of injection, it is important to note that all precautionary measure have been taken and are observed during such procedures to minimize discomfort and combat risks of infection as outlined by OSHA regulatory standards.

I understand that during the course of my treatment my provider may recommend the use of injections (TrP, ESI, etc.) as part of my care. I give my consent to the use of such procedure should it be called for as part of my treatment.

Prescribed medications may also be included with care and can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance, self-discipline in not abusing the medicine and proper professional supervision.

Alternative methods of treatment can include self-administered over-the-counter analgesics and rest., hospitalization and surgery.

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risk inherent in surgery includes adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

No treatment can result in prolonged pain or discomfort steaming from injuries incurred by the patient. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read this document, was afforded the opportunity to ask questions, and fully understand my treatment plan, associated risks, and benefits, and agree to being treated.

_____ _____

Patient's Signature Date

SECURITY AGREEMENT & ASSIGNMENT OF INTEREST IN PERSONAL INJURY CLAIM

Patient Name:_____ **Date of Injury:**_____

In exchange for good and valuable consideration, services provided by Total Pain Treatment Centers of Connecticut (Hereinafter "TPTC") and the promise to provide services by TPTC the receipt of which is herby acknowledged, I hereby:

1. Grant a lien to TPTC for its professional services, medical bills, and charges for any and all treatment whatsoever, and costs against any and all settlement or judgment arising from my personal injury claim as a result of my accident. Cost such as medical report fees and record copying fees, which are incurred by TPTC in providing services to my attorney and me, will be deducted from any net recovery at the time of settlement or verdict in my personal injury case.

2. Understand that my basic reparation benefits or med-pay insurance may not be available to cover TPTC expenses, I may have no collateral or third party source of payment, and the courtesy of credit from TPTC will be extended only when payment is securely protected.

3. Assign an interest to TPTC for its professional services, medical bills, and charges for any and all treatment whatsoever, and costs against any and all settlement or judgment arising from my personal injury claim as a result of my accident. Costs such as medical report fees and record copying fees, which are incurred by TPTC in providing services to my attorney or me, will be deducted from any net recovery at the time of settlement or verdict in my personal injury case.

4. Assign my rights to receive health care payments from negligent parties or from insurance companies. Payments are made to: **Total Pain Treatment Centers of CT, 136 Sherman Avenue, LL, New Haven, CT 106511.**

5. Authorize and direct my attorney to pay from my personal injury proceeds such sums as may be due and owing for services rendered to me, by any reason, which are due to TPTC, and to withhold such sums from any settlement, judgment, or verdict from disbursement to me as may be necessary to adequately protect and pay TPTC

6. If the parties cannot agree upon the reasonableness of a bill or costs, or a dispute arises, I agree and understand that my attorney will be required under Professional Rule of Conduct 1.15(b) to hold the amount of money in dispute. If the parties cannot agree upon the reasonableness of a bill or costs, or a dispute arises, then the parties agree, and I, hereby, agree and stipulate to participate in binding arbitration within thirty days of receipt of personal injury proceeds by my attorney.

7. Understand that the bill for treatment and services are my responsibility and I am obligated to pay the bill regardless of the outcome of my case. My financial responsibility is not contingent upon a favorable settlement or judgment of a personal injury claim. I have been informed that, by acceptance of partial payment from a third party, TPTC does not accept the partial payment as payment in full. When partial payment occurs, it has been explained to me that TPTC will balance bill me for any outstanding balance. I have reviewed the fee schedule posted in the office and agree to receive services and be responsible for my bill. I acknowledge that this agreement is made for additional protection and in consideration of the courtesy of TPTC awaiting payment.

I have read this document and fully understand it and agree to the content

_____ _____

Patient's Signature Date

PRIVACY INFORMATION

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 (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patient's Signature:_____ Date:_____

Witness Name:_____ Signature:_____

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MEDICAL RECORDS REQUEST/RELEASE AUTHORIZATION

By signing this form below, I authorize Total Pain Treatment Centers to use, receive, release or disclose the below indicated protected health information. The patient or their representative may revoke this authorization by notifying in writing TPTC's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient. This Records Request/Release Form shall expire exactly one year from the signature date indicated below.

Person or Organization from whom records are being requested or to whom records should be released:

_____

Purpose for use, release or disclosure of protected health information:

_____

Protected Health Information to be sent to ***TPTC, 136 Sherman Ave LL, NH, CT 06511 – 203-675-0277 {Fax}***

- ❑ Copies of all medical records for the period of _____to _____
- ❑ Copies of the information described below for the period of _____ to _____
- ❑ Examination Reports
- ❑ Lab, X-Ray, ED, Etc. Reports
- ❑ Reports and records from other physicians
- ❑ Other: _____

I understand that the following protected health information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions of a sensitive nature.

I authorize this information to be transmitted by way of ground parcel, fax, certified mail, electronic or direct delivery to, or pick up from ***Total Pain Treatment Centers of CT.***

I am fully aware of my right under HIPAA regulations and have signed a copy of TPTC's Notice of Privacy Practices. I have discussed any concerns I have with the release, use or disclosure of my protected health information with TPTC's Privacy Compliance Officer and/or other appropriate office personnel.

I understand that TPTC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release TPTC form all legal liability that may arise from the authorization.

Patient's Name:_____ Signature:_____ Date:_____

Patient's Date of Birth:_____ Social Security Number:_____

If Minor, Parent/Guardian Signature:_____ Date:_____