Rahul S. Anand, MD
Medical Director
Pain Specialist
Anesthesiologist

Christopher Moore, PA-C
Physician Assistant

Fairfield Medical Center
52 Beach Road -Suite 204
Fairfield, CT 06824

Satellite Office:
300 Seymour Avenue -Suite 105
Derby, CT 06418

Phone: (203) 319-9355 (WELL)
www.ctpainandwellness.com
FAX: (203) 292-3434

Dear New Patient:

We would like to take this opportunity to welcome you to our office.

Your scheduled appointment is on _____.

PLEASE NOTE EARLY AM APPTS /REAR BUILDING ENTRY ONLY

Enclosed you will find the following forms:

- **Patient information form (please read this form thoroughly and retain for your records)**
- New Patient Initial Assessment Form
- Financial Responsibility Form
- HIPPA Privacy Form
- Patient Demographic Sheet
- Directions to our office

Please be sure to review and complete all of the above forms and remember to bring the forms with you to your scheduled appointment.

a. As previously mentioned, you will also need to bring your **Photo ID/license (If the address on the patient's photo ID is different from your present address, a copy of a utility bill or other correspondence showing your current address), Insurance cards, and any recent radiology films or discs** you may have. **All co-pays are due at the time of the visit including patients that are under letters of protection using their health insurance.**

b. If you do not have medical insurance and are treating with our office as a result of a motor vehicle accident and have retained a personal injury attorney; **it is the patient's responsibility to contact their attorney and inform them of the appointment and procure a letter of protection (LOP). Patients should contact our office prior to their scheduled appointment and confirm that their letter of protection has been received. If there is No LOP we will be unable to see you for this appointment.**

We look forward in assisting you with your pain management needs.

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Patient Information

Please review and retain for your records

- **Appointments:** Please remember to make your future appointments prior to leaving our office. Please remember we require 24 hours notice of cancellation. **There is a $50.00 fee for missed appointments**.
- **Insurance Referrals**: Please be aware that it is the patients responsibility to contact the primary care physician to if you have a referral based health insurance plan. Please check your insurance card or call your insurance company for confirmation.
- **Workmans Compensation**: It is the patients responsibility to provide our office **prior** to your visit all workmans compensation insurance information, company name, phone number, claim#, and adjustors name.All visits must be authorized prior to your appointment. Please check with your referring doctor, workers comp adjustor or attorney to ensure that you are authorized at the time of visit.
- **Letters of Protection**: It is the patients responsibility to have a letter of protection signed by both yourself and your attorney at the time of the visit. We will be unable to see you for your evaluation until this document has been provided. **All personal injury and motor vehicle injuries using their health insurance are responsible for making their copays at the time of the visit inspite of a letter of protection**.
- **X-RAY**: X- rays do not require prior authorization. You may walk into any imaging center without an appointment to obtain your x-ray.
- **MRI/CT SCANS**: MRI and CT-SCANS require prior authorizations from insurance companies. **This process may take 5-7 buisness days. The imaging center of your choice will contact you directly for an appointment.**
- **Therapy and Physician Referral**: Our office will provide you with the address and telephone number to the facility and or physcian. The facility or physcians office will contact you directly. **Please allow our office 3-4 days to process and fax your referral.**
- **Non - Narcotic Medication Refills:** Please contact your pharmacy directly for all non-narcotic medication refill requests, even if you do not have any refills left. The pharmacy will fax over your request and our office will process your refill request within 24 to 48 hours.

>>>>>>>> PLEASE DO NOT WAIT UNTIL YOU ARE COMPLETELY OUT OF MEDICATION TO REQUEST A REFILL.

- **NARCOTIC Medication Refills:** Patients that are under going medication management that include pain medications and written narcotic prescription (controlled substances) **must be seen in the office for monthly appointments**. Please be sure to make your appointment prior to leaving our office to correspond with your prescription to avoid an interuption in your treatment.
- **Medication Authorizations:**Your pharmacy is responsible for contacting our office with the request for authorzation. Our staff will initiate the authorization with your insurance company. This process can take up to 72 hours. Our office will contact you with the insurance company's decision.
- **Medication Changes**: If you are requesting a change in your pain medication**; DO NOT THROW OUT the medication.** Please contact our office as some pain medication must be brought into our office for disposal prior to receiving a new prescription.
- **Stolen Prescriptions**: Please contact your local police department to file a report for stolen narcotic prescriptions. Our office requires a police file #, to be followed by a police report to replace stolen medication.
- **Compounding Cream Medication:**Our office will fax your presciption to the pharmacy. The pharmacy will contact you directly regarding payment for copays and shipping fees. If you do not hear from the pharmacy within a 3 day period, please call the pharmacy directly.

Please note all compounding creams are for topical use only.

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Please provide us with the following details to complete your patient record.

Name:_____ **DOB:**_____

Address:_____ **City, State/Zip:**_____

Phone #: _____ **Cell Phone #** _____

Referring Physician: _____

Primary Care Physician: _____

Attorney (if applicable): _____

HEALTH INSURANCE: _____

PLEASE CIRCLE ONE IF APPLICABLE: WORK INJURY MOTOR VEHICLE ACCIDENT

Emergency Contact Name: _____ **Relationship:** _____

Emergency Phone #:_____

Pharmacy Name: _____ **City/Town**_____

Pharmacy Phone Number_____

AUTHORIZATION RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical or other information for the purpose of treatment which may include disclosing medical information about me to doctors, nurses, technicians, students, or other health system personnel who are involved in taking care of me in the health system.

For Payment, I authorize release of medical information about myself so that the treatment and services I receive at **CONNECTICUT PAIN AND WELLNESS CENTER** or from other entities may be billed to and payment may be collected from me, an insurance company or a third party.

Workers' Compensation or Attorney's, I hereby authorize release of medical information about myself to these entities for the purpose payment and or treatment or similar programs as authorized or required by law.

Patient Signature_____ **Date**_____

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FINANCIAL RESPONSIBILITY FORM

Patient Name: _____

Type of Insurance Coverage: _____

Policy Holder: _____

Policy Holder DOB (if not self): _____

Please Note: Patient that have financial concerns regarding deductibles and co-insurance; should contact both the billing office @ 301-560-0843 and their insurance company prior to undergoing any procedures.

(X) I understand that CT Pain and Wellness Center does not participate with any MEDICAID. I agree to be financially liable for any charges that are not covered by my insurance company. It is my responsibility to be aware of my insurance benefits and the participating providers.

(X) A referral from my Primary Care Physician may be required for any kind and all non emergency Hospital/Specialist services. I acknowledge that if the appropriate referral has not been made at the time of service, I will be held responsible for any charges incurred after these services.

(X) I understand that if the doctor does not participate with my insurance company, or the insurance/billing information that I have provided is inaccurate, or a lapse in policy has occurred, I agree to be financially liable for any charges incurred for these services. It is my responsibility to be aware of my insurance benefits and the participating providers.

(X) I understand that I will be charged a fifty dollar fee for any "no show" non cancelled appointment. I understand that this is not a charge that will be covered by insurance.

Patient's Signature: _____ **Date:** _____

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APPOINTMENT PROTOCOL

Dr. Anand will be seeing you for your New Patient Visit and any Procedure appointments.

Follow up visits are generally scheduled with our PA-C.

Should you ever wish to see Dr Anand for a follow up visit, please inform the front desk when making your appointment.

I acknowledge that I have read and understand the above statement:

Patient's Signature: _____ Date: _____

WORKERS COMPENSATION PATIENTS

Our office will contact your insurance carrier to secure authorization for your treatment. However, we will not always receive a prompt response from your adjustor by your scheduled appointment.

Please contact our office 24-48 hours prior to your scheduled appointment to confirm that your treatment has been authorized.

Additionally, please do not take any valium prior to a procedure until you have confirmed that your treatment is authorized.

If you have Health insurance we must have this information on file. There are times when billing conflicts occur with workers compensation carrier.

To avoid any patient balances we must file any claims disputed with your commercial insurance in a timely manner. Once the conflicts have been resolved any money's needed to refund will be done so accordingly

I acknowledge that I have read and understand the above statement:

Patient's Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT AND RED FLAG NOTIFICATION

The Connecticut Pain and Wellness Center notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative **Date**

Print Name Relationship to Patient

Interpreter (if applicable)

Connecticut Pain and Wellness Center, LLC
BOARD RESOLUTION

IDENTITY THEFT PREVENTION PROGRAM

WHEREAS, it is the policy of CT Pain and Wellness, LLC to require compliance with the laws and regulations relating to the privacy and confidentiality of patient health and medical information and to assure that our functions are pursued in a manner consistent with the letter and the spirit of the laws.

NOW, THEREFORE, BE IT RESOLVED, that Our Medical Group is committed to compliance with such laws and regulations and intends to assure that its operations, as carried out by its employees and other staff and contractors, are conducted in compliance with such laws and regulations;

BE IT FURTHER RESOLVED, that the written Identity Theft Prevention Program attached hereto is hereby approved and adopted.

BE IT FURTHER RESOLVED, that CT Pain and Wellness Center, LLC requires that all members of the workforce, including employees, volunteers, trainees, and other persons whose performance of work is under the direct control of CT Pain and Wellness Center, LLC adhere to and comply with the policies and requirements of the Identity Theft Prevention Program.

ADOPTED this Monday, 8/31/ 2009.
CT Pain and Wellness Center, LLC

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Directions to our Fairfield office

SOUTH BOUND I95

1. I95 – South Bound: Take exit 22 (North Benson Road)
2. At end of ramp take a left
3. At 2nd light take a right onto Post Road/ Rt 1
4. At 1st light take a left on to Beach Road,
5. First office building on right is 52 Beach Road, Suite 204 second floor

NORTH BOUND I95

1. I95 North Bound: Take exit 22 Round Hill Road
2. At end of exit take a right- follow under railroad tracks
3. At traffic light, go straight onto Beach Road
4. First office building on right is 52 Beach Road, Suite 204 second floor

Directions to our Derby office

SOUTH BOUND I95 and NORTH BOUND I95

1. **Take exit 27A onto CT-8 N** toward ***TRUMBULL/WATERBURY***
2. Take **EXIT 17**.
3. Continue to the RIGHT on to WINTER ST.
4. Turn LEFT onto SEYMOUR AVE.
5. Our office is on **the left.**

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Initial Assessment Form

Patient Name: _____ Date Completed: _____

Date of Birth: _____ Sex: M or F How were you referred: _____

Your Height: _____ Your Weight: _____

CHIEF COMPAINT: Reason for visit today: _____

Nature of Injury: _____Date of Injury: _____

PLEASE PROVIDE A BRIEF OVERVIEW OF PAIN HISTORY

Location: _____

_____

_____

Duration: _____

Relieved or worse with: _____

CIRCLE ONLY ONE NUMBER

Rate your pain by circling one number that best describes your pain at its worst

0 1 2 3 4 5 6 7 8 9 10
No pain Moderate Pain Pain as bad as you can imagine

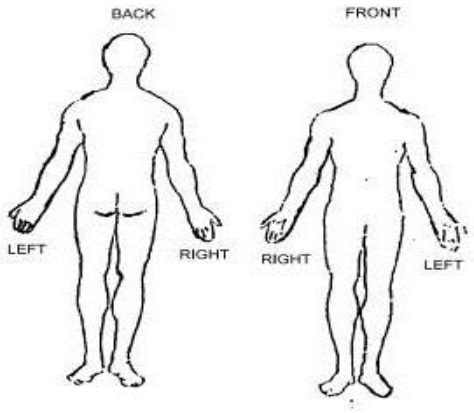
Rate your pain by circling one number that best describes your pain at its least

0 1 2 3 4 5 6 7 8 9 10
No pain Moderate Pain Pain as bad as you can imagine

Rate your pain by circling one number that best describes your pain right now

0 1 2 3 4 5 6 7 8 9 10
No pain Moderate Pain Pain as bad as you can imagine

Please indicate locations of your pain below



Please check qualities of your pain

Check with an X	Yes	No
Throbbing	__	__
Shooting	__	__
Stabbing	__	__
Sharp	__	__
Cramping	__	__
Burning		__
__		
Pressure	__	__
Aching		__
__		
Tender		

Review of Systems

Please circle or add information as needed:

To your knowledge do you have or have you ever had any of the following:

- **Constitutional: f**ever –weight loss-sweats _____
- **Eyes: v**isual disturbance-eye pain _____
- **Ears, Nose-** hearing loss- loss of smell _____
- **Mouth, Throat Pain** -difficulty swallowing _____
- **Cardiovascular-** chest pain- palpitations _____
- **Respiratory-** cough-shortness of breath-wheezing _____
- **Gastrointestinal**- abdominal pain-diarrhea-constipation-nausea-vomiting _____
- **Genitourinary-**frequency-urgency-sexual dysfunction _____
- **Musculoskeletal-w**eakness-paralysis in arm or legs _____
- **Integument-** skin rashes-lesions-ulcers _____
- **Neurological-**headache- seizure-dizziness _____
- **Psychiatric-**depression, anxiety, psychosis _____
- **Endocrine-**increased night time urination, night time thirst, heat or cold intolerance
- **Hematological /Lymphatic-**enlarged lymph nodes-excessive bleeding _____
- **Are you currently pregnant or considering getting pregnant**? Yes or No

---

PMH **Please *circle* any medical problems that you have now or have had in the past.**

High blood pressure	Liver disease	Cancer	Angina/Coronary	Heart Disease
Kidney Disease	Diabetes	Heart Attack	Heart Failure	Asthma
Other GI Illness	Depression	Migraines	Thyroid disease	Stroke
Peptic Ulcer	Skin Condition	Seizures	Taking blood thinners	HIV/AIDS
Rheumatologic Disease	Bleeding Disorder	Other: _____		

Physical Therapy

Please list any physical therapy/conservative treatment that you have had or currently are receiving?

Facility/Therapist	Month/Year Seen	How long did you receive treatment

Previous Treatment

Please list all doctors you have treated with for this injury/incident/condition

Doctors Name	Month/Year Seen	How long did you receive treatment

FAILED/Medications

Please list ALL MEDICATIONS including ALL NON-PRESCRIPTION medication you have tried in the past for this injury/incident/condition that did not work for you. Please include dates.

Surgeries

Please list Surgeries/Dates

Family History: please list any significant medical problems

Mother Alive/Current Age _____ Deceased Age _____ Medical_____

Father Alive/Current Age _____ Deceased Age _____ Medical_____

Sibling Alive/Current Age _____ Deceased Age _____ Medical_____

Sibling Alive/Current Age _____ Deceased Age _____ Medical_____

Sibling Alive/Current Age _____ Deceased Age _____ Medical_____

Social History:

1. **What is your most recent occupation?** _____
2. **What is your current work status?** _____
3. **Are you currently receiving any type of disability payments?** _____
4. **What is your marital status?** Single Married Widowed Divorced Separated
5. **With whom do you live?** Self Spouse Children Parents Friends other
6. **Do you have a history of drug or alcohol abuse? (Circle) YES NO**
   Alcohol -- Marijuana – Heroin – Cocaine -- Crystal Meth
7. **How often do you drink?** _____**and how much?** _____
8. **Do you use tobacco products now?** _____ **If so how much do you use?** _____
9. **Did you use tobacco products at one time?** _____**How long ago did you quit?** _____

10. **Is there any litigation connected to this injury? (Circle) YES** or **NO**
    If yes - name of attorney: _____**Address** _____
    Phone #_____ _____

11. **Are you or have you ever been treated by a psychiatrist/ or psychologist? (Circle) Yes** or **NO**
    If yes, name and address of MD_____
    Treatment diagnosis _____

Medications

Please list medication you are taking right now *(PLEASE PRINT)*

Medication Name	Strength	Dosage	**Medication Name**	Strength	Dosage

Please list all medications you are allergic to or had an adverse reaction to. Please include dates.
