New Solutions
Pain Management Clinic

256 Seaside Ave.
Milford, CT 06460
1-475-882-6824

HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name:_____ DOB: _____

Signed (Patient or Legal Representative for Patient): _____

Legal Representative's Relationship to Patient: _____

Date: _____

Revised 2015

PATIENT REGISTRATION FORM

Date (Fecha): _____ **Date of Birth (Fecha de Nacimiento):** _____

First Name (Primer Nombre): _____ **Last Name (Apellido):** _____

Address (Domicilio): _____ **City (Ciudad):** _____

State (Estado): _____ **Zip Code (Codigo Postal):** _____

Race/Ethnicity (Raza/Etnia): _____ **Language (Idioma):** _____

Home Phone (Telefono de casa): _____ **Cell (Celular):** _____

OK to leave voice message regarding health information?: Yes (si) No (no)

Email Address: _____

Social Security (Seguro Social): - - **Age (Edad):** _____

Marital Status (Estatus Marital): _____

Patient's Employment Status (Empleador del Paciente): _____

Next of Kin in Case of Emergency (Contacto de Emergencia): _____

Relationship to Patient/Phone# (Relacion con el Paciente): _____

Description of Illness or Injury (Descripcion de enfermedad o lesion): _____

_____

Primary Care Doctor (Doctor Primario): _____

Phone #: _____

INSURANCE INFORMATION (INFORMACION DE LA ASEGURANZA)

Insurance Name (Nombre de la aseguranza): _____

Policy or Identification Number (Numero de Poliza o Identificacion): _____

Group Number: _____ **Policy Holder's Name:** _____

First Name (Primer Nombre): _____ Last Name (Apellido): _____

1. Are you allergic to any medication (Usted es alergico a un medicamento)?

_____

2. What Medication are you currently taking (Que medicamentos esta usando)?

_____

3. What are your current medical problems? _____

4. List previous surgeries and dates (Liste sirugias anteriores y las fechas):

_____

5. List any serious injuries and dates (Liste lesiones graves y las fechas):

_____

6. Do you smoke (Usted fuma)? No (No) Yes (Si)

If yes, # of packs/day (si usted confirmo si, # de paquetes al dia): _____

Years smoked (Años fumando): _____

7. Do you drink alcohol? (Usted consume alcohol)?: No (No) Yes (Si)

If yes, # of drinks/week (Si usted confirmo si, # de bebidas a la semana): _____

Any past history of alcohol use? (Alguna historia de uso de alcohol?) No (No) Yes (Si)

8. Do you have any history of overdosing on meds (Tiene usted un historial de sobredosis en medicamentos)? No (No) Yes (Si)

If yes, how long ago, and on what medication (Si confirmo si, hace cuanto y en que medicamento)?

_____

9. Do you have any history of illegal drug use (Tiene usted historial de uso de drogas ilegales)?
No (No) Yes (Si)

Drug used? _____

If yes, how long was use? (Si confirmo si, por cuanto tiempo)?: _____

When did you quit? (Cuando renuncio)?: _____

Current use? (Uso actual)? No (No) Yes (Si)

10. Do you have any history of domestic violence (Tiene usted historial de violencia domestica)?
No (No) Yes (Si)

If yes, how long ago (Si usted confirmo si, hace cuanto)?: _____

11. Family history (medical problems):

Mother: _____ Father: _____

12. Current Weight: _____ Current Height: _____

13. Current pain level 0-10 (no pain - worst pain)?: _____

14. When did your pain start?: _____

15. Where is your pain located?: _____

16. How would you describe your pain (aching, throbbing, numbness, etc.)?:

_____

17. Does your pain radiate anywhere; if so where?: _____

18. What makes your pain worse (activity, movement,etc)?: _____

19. What makes your pain better (ice,heat, etc.)?: _____

20. Have you experienced any side effects when taking opioids?: _____

21. Any recent MRIs, X-rays or Lab tests?: _____

22. Previous treatments used (prescriptive/non-prescriptive/Physical Therapy/Chiropractor)?:

_____

23. What do you have difficulty doing (getting dressed, bathing, grocery shopping)?:

_____

24. Are you or have you ever been under psychiatric care? If so who/where?:

_____

25. Spiritual or religious beliefs?: _____

26. What hobbies do you enjoy?: _____

27. Do you exercise?: _____

28. Any dietary restrictions?: _____

29. Have you previously tried Pain Management?: _____

If so, where?: _____

New Solutions Pain Management, LLC - Credit Card Policy

With the implementation of The Affordable Healthcare Plan, deductibles and copay costs are now being transferred to you. Previously, employers absorbed much of this cost. However, this is no longer the case. It is our office policy to keep a credit card on file.

We will charge your credit card under the following situations:

1. Your insurance is invalid and/or you are ineligible for services at our office at the time of your visit.

2. You have an outstanding balance due to one or more of the following:
   2A: Your insurance applied our office visit to your deductible amount.
   2B: Your insurance applied a portion of our office visit to your deductible and left a co-insurance/copay, which you are responsible for.
   2C: You have not provided us with the appropriate insurance information (for example: incorrect insurance card, incorrect order of insurances being billed, expired insurance cards or incorrect birth date of insured, etc.).

3. Our office requires a minimum **48 hour notice** of appointment reschedule or cancellation; if you no show the day of your scheduled appointment you will be charged a **$50.00 fee**.

Insurance companies typically allow offices 6 months to bill correctly for services; after this time limit they will deny paying us for our services to you. It is your responsibility to provide us and your insurance company with the appropriate information to process your claim. We appreciate your cooperation in helping our office get paid promptly for our services and alleviating our billing and collection fees.

I understand that a copy of my credit card will be kept on file and that it will be charged for any non-covered services, co-pays and deductible amounts. By signing below you are in agreement to the above stated.

_____ _____

Signature **Date**

Revised 8/2017

Credit Card Information

Type of Credit Card **(circle one)**:

VISA MASTERCARD AMERICAN EXPRESS DISCOVER
OTHER: _____

Credit Card Number: _____

Expiration Month: _____ Expiration Year: _____

Security Code: _____ Zip Code: _____

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

PainEDU.org

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

PainEDU.org

P TIENT HE LTH QUESTI NN IRE (PHQ-9)

N ME:_____ D TE:_____

ver 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. r the opposite — being so figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of T T L, T T L: *please refer to accompanying scoring card).*

10. 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 _____

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Agreement for Opioid Maintenance Therapy for Non-Cancer/Cancer Pain

The purpose of this agreement is to protect patient access to controlled substances and to protect our ability to prescribe for our patients. The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed upon by the below-signed patient, as consideration for, and a condition of, the willingness of a New Solutions Pain Management Clinic provider to consider the initial, and/or continued prescription of controlled substances to treat your chronic pain.

Please initial next to each point, as well as signing at the end of the agreement.

1._____ All controlled substances must come from a New Solutions Pain Management Clinic provider unless specific authorization is obtained for an exception. [Multiple sources can lead to untoward drug interactions or poor coordination of treatment.]

2. _____ All controlled substances must be obtained at the same pharmacy, whenever possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that I have selected is:

_____ Phone: _____

3. _____ You will be seen on a monthly/bi-monthly basis and given prescriptions for enough medication to last from appointment to appointment. ***Medication refills will NOT be given outside an office visit.***

4. _____ I agree that refills of my prescriptions for pain medicine will be made only at the time of a scheduled office visit. No refills will be available during evenings after hours or on weekends. Renewals are contingent upon keeping scheduled appointments.

5. _____ I understand I am expected to inform New Solutions Pain Management Clinic office within 24 hours of any new medications or medical conditions, and of any adverse effects experienced from any of the medication that I take.

6. _____You should not use any illicit substances, such as marijuana, cocaine, etc. while taking these medications. This may result in a change in your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the provider/patient relationship.

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7. _____ I understand that these drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

8. _____ You agree and understand that your provider reserves the right to perform random or unannounced urine/buccal drug testing. If required to provide a urine/buccal sample, you agree to cooperate. If you decide not to provide a urine/buccal sample you understand that your provider may change your treatment plan including safe discontinuation of your opioid medications when applicable or complete termination of the provider/patient relationship with New Solutions Pain Management Clinic. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine/buccal screen can be grounds for termination of the provider patient relationship. Urine drug testing is not forensic testing, but it is done for your benefit as a diagnostic tool in the accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

9. _____ The use of alcohol/illicit drug(s) and opioid therapy is contraindicated.

10. _____ There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleep abnormalities, sweating, edema, sedation, or the possibility of impaired cognition (mental status) and/or motor ability that affect your ability to drive. Overuse of opioids can cause decreased respiration (breathing).

MALES ONLY: The use of chronic opioids has been associated with low testosterone levels in males. This may affect your mood, stamina, sexual desire and physical and sexual performance. You should have your primary care provider monitor your testosterone levels regularly.

FEMALES ONLY: If you are or are planning on becoming pregnant, you must immediately call our office. Should you carry a baby to delivery while taking opioid medication, the baby will be physically dependent on them upon birth. Opioids are generally not associated with a risk of birth defects, however birth defects can occur.

11. _____Physical dependence and/or tolerance can occur with the u of opioid medications.

Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed; withdrawal symptoms can occur. This is a normal physiological response. Withdrawal syndrome could include but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.

It should be noted that physical dependence does not equal to addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or the prednisone.

Addiction is a primary, chronic neurobiological disease with genetic, psychological and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: Impaired control over drug use, compulsive use, continued use despite harm or cravings. This means the drug decreases one's quality of life.

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Tolerance means as state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces a maximum function and a realistic decrease of the patient's pain.

12. _____ If you have a history of alcohol or drug misuse/addiction, you must notify the provider of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most cases, disqualify one from opioid treatment for pain, but starting and continuing a program for recovery is a must.

13. _____ Original containers of medications will be brought in to each office visit for pill count.

14. _____ You may not give or sell your medications to any other person under any circumstance. If you do, you may endanger that person's health. It is also against the law.

15. _____ You are responsible for keeping your pain medications in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to a New Solutions Pain Management Provider immediately. If your medications are lost, misplaced or stolen, your provider may choose not to replace the medications or to taper and discontinue the medications.

16. _____ Prescriptions may be issued early if the provider or patient will be out of town when a refill is due, at the discretion of the New Solutions Pain Management Provider. These prescriptions will contain instructions to the pharmacist that they should not be filled until the appropriate date.

17. _____ I waive my right to confidentiality, specific to my controlled substance prescriptions and administration, if New Solutions Pain Management Clinic is approached by law enforcement authorities.

18. _____ I agree to allow my provider to contact any health care professional, family member, pharmacy, legal authority or regulatory agency to obtain or provide information about your care if the provider feels it is necessary.

19. _____ I understand that all medical treatment is initially a trial, and that continued prescription is contingent upon evidence of benefit.

20. _____ I understand the risks and potential benefits of these therapies.

21. _____ I understand that New Solutions Pain Management Clinic will share patient health information according to federal and state law for treatment, payment, and operations.

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22. _____ I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patent incurs the charges. I authorize the insurance provider to pay New Solutions Pain Management Clinic. Please be advised that a separate co-pay for services may be applied by your insurance company, in addition, to any facility co-pay you may have already paid.

23. _____ Medication is only prescribed in conjunction with other forms of treatment.

24. _____ I understand that it is my responsibility to call at least 24 hours in advance of my scheduled appointment if I am unable to make it.

25. _____ If I "no-show" an appointment; which means not contacting the office staff directly in advance of my appointment to cancel, then I will be responsible for a "no-show" fee of $50.00. This fee will be billed to me, not my insurance company-and it will be due at my next scheduled appointment.

26. _____ It is my responsibility to keep track of my appointment date and time, and to contact the office if I am unable to keep the appointment.

27. _____ Termination will occur if patient has 3 "no show" appointment.

28._____ I understand the risk associated with opioid therapy; including overdose.

29. _____ Any disrespect of any kind to any staff member can lead to termination.

30. _____ Medications need to be taken ONLY as prescribed if they are taken any other way it may lead to termination.

31. _____ *Failure to comply with any of the above terms, may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the provider/patient relationship. If termination is deemed appropriate by the practice you will be given 30 days written notice.*

The above agreement has been explained to me by a New Solutions Pain Management Provider. I agree to its terms so that a New Solutions Pain Management Provider can provide quality pain management using opioid therapy to decrease my pain and increase my function.

Patient Signature/Legally authorized representative: _____

Date: _____

Witness: _____ Date: _____

Provider Signature: _____ Date: _____

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