INTEGRATED ANESTHESIA ASSOCIATES
PAIN MANAGEMENT

Ambulatory Bone & Joint
31 Seymour Street, Suite 201
Hartford CT 06106
P: (860) 430-2176
F: (860) 430-1217

Patient Name (First, Last) _____

Date of Birth ____/_____/_____

Address_____

Home Phone (____)_____ Message (circle) Yes | No

Cell Phone (____) _____ Message (circle) Yes | No

Email _____

Primary Care Provider _____ **Phone** _____

Address _____

Pharmacy _____

Address _____

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Cancellation/Missed/Late Appointment Policy - $50.00 Fee

Cancellations:

In order to be respectful of the needs of other patients, please call the office promptly if you will be unable to attend a scheduled appointment. While we ask that patients be courteous and provide the office with as much notice as possible, we require a minimum of 24 hours' notice of any cancellation. You can cancel an appointment by calling the office at 860-430-2176 and selecting option 2. This timely notification allows another patient the possibility of an appointment.

Missed Appointments:

A "missed appointment" is an appointment that is missed without you providing at least 24 hours' notice; this includes procedures at the surgery center locations as well as our office. If you experience a missed appointment, you will not be charged for the first occurrence. However, a $50.00 missed appointment fee may be charged for any additional missed appointment(s). If you experience three missed appointments in any one-year period, you may be discharged from the practice.

Late for Appointments:

If you are more than 15 minutes late for an appointment at our office, you may not be seen and thus may need to reschedule your appointment. While you will not be charged for the first late occurrence, subsequent late occurrences requiring the appointment to be rescheduled will result in a $50.00 fee.

Patient/Responsible Party Signature: _____

Date Signed: _____

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Authorization to Release Information and Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Blue Shield, HMO's and commercial insurance to Integrated Anesthesia Associates pain management and to specialty anesthesia if anesthesia is administered for procedures at a surgery center**. I understand that I am fully responsible for all charges whether they are covered by said insurance.** I hereby authorize assignee to release any information necessary to secure payment on my behalf.

_____ _____ _____

Patient / Patient Representative Signature | Date | Relationship

_____

Print Patient Name

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____E-mail address:_____

We will not share your e-mail address or use it to transmit medical or clinical information.

1) I have been offered or received a copy of Integrated Anesthesia Associates' "Notice of Privacy Practices."

2) I give my permission for Integrated Anesthesia Associates to contact me at the following numbers and to leave a message on my answering machine or voicemail (if none, please leave blank):

MESSAGES CONCERNING APPOINTMENTS Phone (___) _____
Home / Mobile / Work (circle)

MESSAGES CONCERNING MEDICAL INFO Phone (___) _____
(For example, lab or test results) Home / Mobile / Work (circle)

I give permission for Integrated Anesthesia Associates to communicate with the following persons regarding my health care:

Name: _____ Phone #:_____ Relationship: _____

Name: _____ Phone #:_____ Relationship: _____

This authorization will be valid from this date until written notice of changes and/or cancellations is received in the offices of HHC Medical Group.

3) Assignment of Benefits: I authorize direct payments to Integrated Anesthesia Associates or its designated billing agent for services rendered.

Guarantee of Payment/Precertification by Insurer: I will be responsible for payment for all non-covered services. If my health plan does not consider Integrated Anesthesia Associates to be a participating provider, I will accept full financial responsibility for payment of incurred charges. I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent for Treatment: I do voluntarily consent to the rendering of such care as the provider and/or medical personnel deem necessary for my health and wellbeing. This consent shall include medical examination and diagnostic testing as well as minor surgical procedures OR I may receive a practice specific consent form. The form may also include the carrying out of orders of my treating provider by office personnel. I acknowledge that neither the provider nor the office personnel has made any guarantee or assurance as to the results that may be obtained.

4) To better provide for your care and enhance your patient experience, we seek to coordinate and integrate our care delivery through our electronic medical record (EMR) which is paperless. We share access to the EMR across Hartford HealthCare (HHC) and some other HHC affiliated practices (accessed only as described in the Notice of Privacy Practices). Our current EMR does not functionally allow us to limit access to your record by blocking it from HHC or affiliates staff.

By signing this authorization form, you understand and agree that you are allowing disclosure of and access to all your health information, including information relating to alcohol and substance abuse/use, mental or behavioral health, and HIV/AIDS. If health information about you includes any of these types of information, you specifically authorize the release of such information to, and access to such information by, all authorized health care providers and professionals at HHC and affiliates. You may revoke this authorization at any time except to the extent it has already been relied upon. Unless earlier revoked, this consent will expire if and when Integrated Anesthesia Associates EMR no longer exists.

Since we do not use a paper system for documenting the care of patients, we can only use our EMR. We hope that you will find the EMR system facilitates your care. If you don't want your medical information stored in our EMR, we unfortunately cannot care for you in this practice. If you have any questions, please do not hesitate to ask us about our EMR.

□ I choose to opt out and by doing so understand I decline to receive care at Integrated Anesthesia Associates.

_____
Patient Signature / Date

_____
Parent or Guardian Signature / Date
If patient is a minor (under the age of 18) or has a guardian /conservator, this must be signed by the parent or legal guardian.

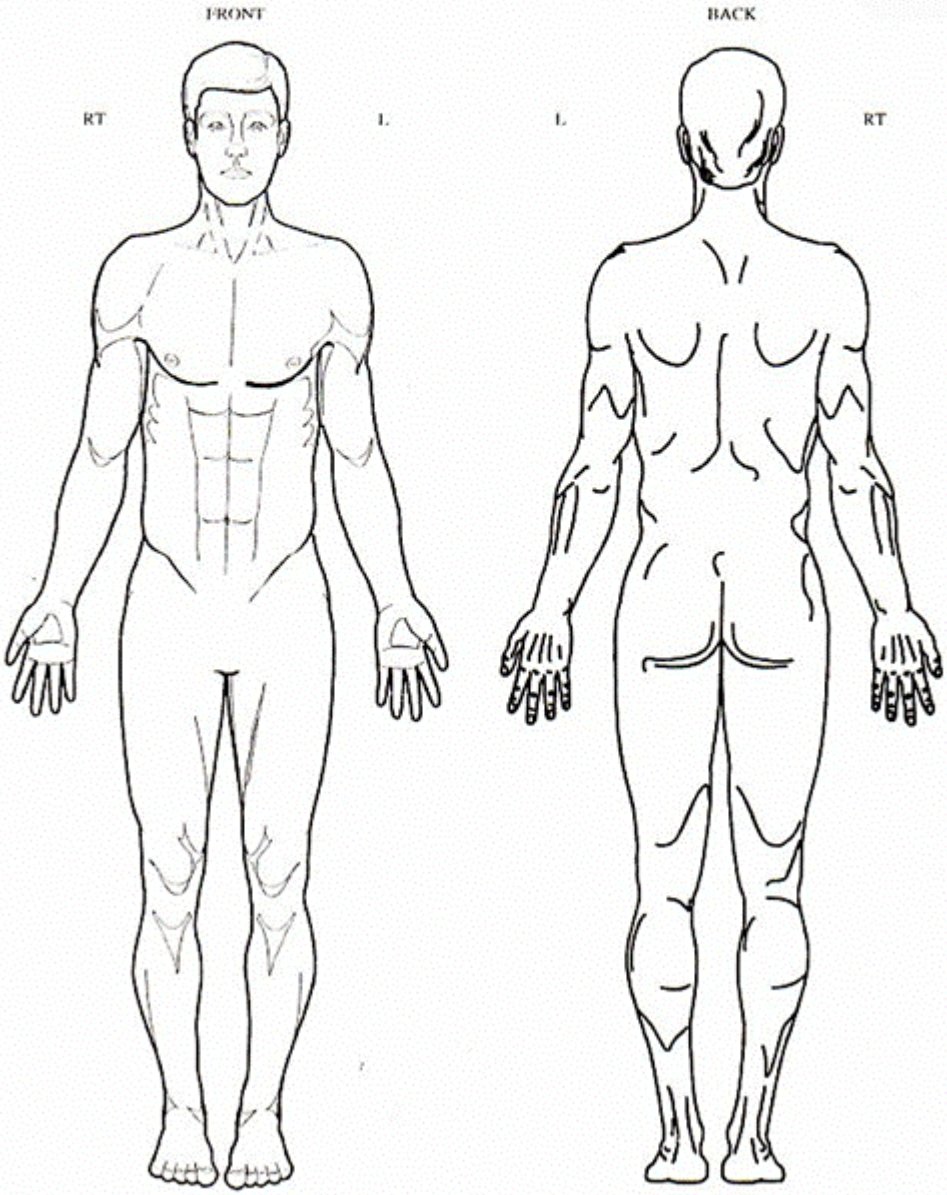
PAIN DIAGRAM

PATIENT NAME:_____TODAY'S DATE:_____

PLEASE COMPLETE THE FOLLOWING "***PAIN DIAGRAM***" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (P)
TINGLING (T)
NUMBNESS (N)
BURNING (B)
STIFFNESS (S)

PATIENT'S SIGNATURE:_____



Z

Name _____ **Date of Birth** _____

General Medical Information

Height:

Weight:

Allergies:

Allergy	Reaction

Medications- Including OTC/Supplements/Pain Medications:

Medications	Dosage	Frequency

Surgeries:

Problems with anesthesia? □ yes □ no

Name _____ **Date of Birth** _____

Past medical History:

Do you see a cardiologist? _____ How many times a year? _____.

Cardiologist name and address: _____

□ Cardiac Disease

□ High blood pressure □ Asthma

□ Chest pain/pressure □ COPD/Emphysema

□ Pacemaker □ Sleep apnea

□ AICD/ Defibrillator □ CPAP

□ High cholesterol □ Oxygen

□ Heart Attack □ Irregular heartbeat

□ Hepatitis □ Cirrhosis

□ Jaundice □ kidney disease/failure

□ Diabetes □ Dialysis

□ Anemia □ Bleeding/Clotting disorders

□ Taking blood thinner Name of blood thinner _____

□ Sickle cell □ HIV

□ Seizures □ Stroke

□ Acid Reflux □ Ulcers

□ Crohn's/Colitis □ Arthritis

□ Migraines □ Thyroid disease

□ Cancer Location/type _____
Treatment _____

Name _____ **Date of Birth** _____

Social and Psychological History:

□ Depression □ Anxiety

□ Bipolar disorder

□ Alcohol use Type of alcohol _____ frequency _____

□ Recreational drug use Name of drug _____ frequency _____

□ Opioid use

□ Smoking history Packs per day _____ Quit date _____ How many years _____

□ Attention Deficit Disorder

□ Obsessive Compulsive Disorder

□ Schizophrenia

□ History of sexual abuse Age _____

□ History of Alcohol Abuse

□ History of Illegal Drug Abuse

□ History of Prescription Drug Abuse

Family History:

□ heart disease

□ Cancer

□ Diabetes

□ Other

□ Family History of Alcohol Abuse

□ Family History of Illegal Drug Abuse

□ Family History of Prescription Drug Abuse

Name _____ **Date of Birth** _____

Present problem ONLY

1. **When did your problem start?**
2. **Pain level: (0:no pain; 10: worst pain)**
3. **Pain location:** _____**(For this visit only)**
4. **Pain Quality: (currently)**

□ Throbbing □ Cramping □ Shooting □ Numbness

□ Burning □ Stabbing □ Tingling □ Sharp

□ Aching □ Dull □ Other

5. **Pain orientation:** □ Right □ Left.

□ Anterior □ Inner □ Middle

□ Distal □ Lower □ Outer

□ Posterior □ Proximal □ Upper

□ Other

6. **Pain Patter:** □ Continuous □ Rarely □ Several days a week

□ Intermittent □ Once a week

7. **Pain radiates toward:** _____
8. **What makes your pain worse?**

□ Sitting □ Walking □ Bending □ Stairs

□ Standing □ Exercise □ Straightening □ Kneeling

□ Lifting □ Heat □ Stretching □ Squatting

□ Lying down □ Cold □ Other

Name _____ **Date of Birth** _____

Present problem ONLY cont.

9. Pain onset:

□ Awakened from sleep □ Gradual □ Progressive □ Unable to tell

□ Ongoing □ Sudden □ Unable to assess

10. Clinical progression:

□ Not changed □ Rapidly worse □ Rapidly improving

□ Gradually worsening □ Resolved

□ Gradually improving

11. **Result of injury** □ Yes □ No

12. **Work related injury** □ Yes □ No

13. What makes your pain better?

□ Heat □ Lying down □ Sitting □ Standing

□ Cold □ Walking □ Other

14. Pain Intervention:

□ Steroid injection – If yes, did it help:

□ Physical therapy □ Surgery □ Ambulation / increase activity

□ Massage therapy □ Acupuncture □ Elevate □ Tens

□ Other □ Medication □ Splinting

15. Hours of sleep per night:

□ 0-4 hours □ 4-6 hours □ 6-8 hours

□ Restful □ Disruptive □ Pain related

16. Multiple pain sites: □ Yes □ No