Comprehensive Pain & Headache Treatment Centers, LLC

Telephone 203 732-1570
Main Fax 203 732-1576

Referrals 203 732-1587
Referral Fax 203 734-4776

www.painandheadache.com
Prescriptions 203 732-1591

Mark Thimineur, M.D.
Monika Chaves, APRN
Ashley Dizney, APRN

Heather Alfonso, APRN
Jean Vulte, APRN

130 Division St. Derby, CT 06418
546 South Broad St. Suite 4-D
Meriden CT 06451

WELCOME TO OUR OFFICE!

Your appointment: _____ at _____

We would like to welcome you as a new patient and to thank you and your referring physician for choosing us to provide your care. In an effort to clarify any questions you may have please review the following information.

Before your first appointment you will need to ask your referring physician to send or fax all pertinent information to our office prior to your appointment. This will include any MRI's, CAT scans, X-ray's, lab tests or any other information regarding treatments.

Due to the number of insurance plans and their varied policies, you are responsible for being familiar with your own insurance company's requirements. If your insurance is a managed care plan that requires a referral authorization to see a specialist, **you** are responsible for obtaining that referral from your primary care physician. We will offer what help we can to assist you, but it is the **patient's** responsibility to obtain this information prior to your appointment. Bring your insurance card and a picture ID. **All co-pays must be paid at the time of your visit, for your convenience we do accept credit cards.**

A new patient's initial visit takes 1 hour. The visit includes a detailed review of your medical history, medications, current symptoms and an exam. Any additional testing, lab work or treatments deemed necessary at that visit will be discussed and scheduled with our staff.

We ask that you arrive 15 minutes prior to your appointment time. To cancel or reschedule your appointment, we ask that you notify our office 24 hours in advance. Failure to do so may result in you being billed for the appointment. If more than 1 appointment is missed you may not be rescheduled and your referring physician will be notified.

Please complete the enclosed forms and bring them to your appointment along with your insurance card, co-pay and picture ID.

COMPREHENSIVE PAIN AND HEADACHE TREATMENT CENTERS, LLC

PATIENT REGISTRATION FORM

Please complete all the information below in print. Please do not leave any questions blank. Thank You.

Primary Physician	**Thimineur**					
Patient's Name **Last** **First** **MI**		Soc Sec #	Marital Status	Sex M / F	Age	Date of Birth
Race: Ethnic:		Language:				
Patient's Address **City** **State** **Zip**					Patient Home Phone	
Whose Insurance will cover your claims? **Self** **Spouse**		Patient's Employer			Patient Cell Phone	
Patient Employer's Address (Street, City, State, Zip)					Patient Bus Phone	
Spouse's Name		Spouse's Date of Birth	Spouse's Social Security #			
Spouse's Employer			Spouse's Business Phone #			
Emergency Contact		Relationship to Patient		Phone #		
PHARMACY:		Address:			Phone:	
******Primary Care Physician LAST FIRST *Physician – NOT clinic*		Address	Phone			
******Referred By LAST FIRST *Physician – NOT clinic*		Address	Phone			
Primary Insurance Carrier **EFF DATE**		ID #	Group # **Copay**			
Secondary Insurance Carrier **EFF DATE**		ID #	Group # **Copay**			
Currently Active Work Injury: Employer at the time		Phone	Date / Nature of Injury			
Name and Address of Worker's Comp. Carrier		Case Manager: Name & Phone	File#			
Currently Active Motor Vehicle or Other Accident - Describe			Date of Accident			
Name and Address of Carrier			No Fault ID #			

→ → →→ To avoid a $10.00 administrative fee, you must pay your co-pay the day of your visit.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments, however the patient is responsible for all fees, regardless of insurance coverage.

Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance any balance not paid for by your insurance. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: Comprehensive Pain & Headache Treatment Centers, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. Data from treatment and testing may be used for scientific publication with our assurance that we will maintain strict anonymity of all patients and data will only be represented in aggregate form.

I certify that I have been given, have read, understand and agree with the medication policy of the practice. rev. 10/9/13

Signature of Patient or Responsible Party	Relationship to Patient	**Date**

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Written Acknowledgement of Policy Regarding Patient's Maintaining a Primary Care Physician

Date: _____

Patient Name: _____

DOB: _____

It is our policy that all patients maintain a Primary Care Physician while being treated with Comprehensive Pain and Headache Treatment Centers. We, as Pain Specialists, only treat patient's with chronic pain problems.

It is the patient's responsibility to notify Comprehensive Pain and Headache Treatment Centers of any changes of their PCP.

If patient does not have a PCP, we will only be able to consult the patient and refer them back to their referring physician until a PCP has been established.

I, _____, hereby acknowledge that as the patient it is my responsibility to maintain a Primary Care Physician while under the care of Comprehensive Pain and Headache Treatment Centers, LLC. Also, understand that it is my responsibility to contact CPHTC with any changes.

Patient's PCP: _____

PCP Address: _____

PCP Tel #: _____

Patient's Signature: _____

DIRECTIONS/PARKING TO:

COMPREHENSIVE PAIN AND HEADACHE TREATMENT CENTERS, LLC

DERBY OFFICE
Griffin Hospital
130 Division Street
Derby CT 06418

Route 8 North and South to exit 17 and take left off exit. Hospital will be on your right with free parking and free valet parking with validation.

MERIDEN OFFICE
Birchwood Bldg.
546 South Broad Street, Suite 4D
Meriden CT 06450

91-N to exit 15 (Wallingford-Yalesville) turn left on Rt 68 to Rt 5 and bear right on Rt 5. Follow Rt. 5 approx. 1 mile and Birchwood Building will be on your left hand side across from Pier One Imports and Linen "N" Things. Take elevator to 4th floor.

91-S to exit 15 (Wallingford-Yalesville) turn right on Rt 68 to Rt 5 and bear right on Rt 5. Follow Rt. 5 approx. 1 mile and Birchwood Building will be on your left hand side across from Pier One Imports and Linen 'N' Things. Take elevator to 4th floor.

RT 15 (Merritt PKWY) in either direction take exit 66. Take right onto RT 5 and go approximately 1 mile. Birchwood Building will be on your left across from Pier One Imports & Linen 'N' Things. Take elevator to 4th floor.

RT 84 to RT 691. Take exit 8 onto Broad Street. Take left at end of exit. Continue down RT 5 approx. 10 lights. See PLANET FITNESS on right side. Next light Birchwood Building on right. Take elevator to 4th floor.

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or healthcare operation, in order to provide health care that is in you best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physician and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose you Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

COMPREHENSIVE PAIN AND HEADACHE TREATMENT CENTERS, LLC

TO OUR PATIENTS

Please take the time to read the following information. This will become effective immediately and followed strictly.

An overwhelming number of inappropriate calls come to our nurse's voicemails, therefore, we felt it was necessary to develop the outline for our patients to follow.

Calls that **SHOULD** go to the nurse:

1. An allergic reaction to a **NEW** medication. An allergic reaction is considered a rash, hives and/or itching. SHORTNESS OF BREATH, DIFFICULTY BREATHING OR THROAT FEELING LIKE IT IS CLOSING IS CONSIDERED AN EMERGENCY AND SHOULD BE TAKEN CARE OF AT AN EMERGENCY FACILITY. You should let your nurse know AFTER you have sought treatment.
2. **A problem following a recent procedure or surgery.** The site is red, swollen, hot to touch or draining. A fever greater than 100.5, worsening headache, persistent numbness and/or weakness or change in the area of stimulation. CHANGES TO BOWEL AND BLADDER CONTROL ARE CONSIDERED AN EMERGENCY AND SHOULD BE TAKEN CARE OF AT AN EMERGENCY FACILITY. You should let your nurse know AFTER you have sought treatment.
3. **Symptoms of withdrawl.** Vomiting, nausea, diarrhea. An allergic reaction is considered a rash, hives or itching.

Calls that **should** be made after hours:

1. A complication following a RECENT surgery or procedure as described above.
2. An allergic reaction to a NEW medication, as described above.

There are no changes made to medications after hours

NUMBERS YOU SHOULD HAVE:

Derby Main Office:	**203-732-1570**
Meriden Main Office:	**203-630-1872**
Nurse Line:	**203-732-1566**
Stimulator Dept:	**203-686-0403**
After hour calls:	**203-732-1570**
Prescription Refills:	**203-732-1591**
Medical Records:	**203-732-1586**
Billing office:	**203-732-1580**
Practice Manager:	**203-732-1594**

Over

Calls that **SHOULD NOT** go to the nurses:

1. Requests to authorize a medication will **ONLY** be accepted by the pharmacy or in writing from the patient assistance programs.
2. If your prescription was filled for less than the written amount **ONLY** the pharmacist should call our prescription line to report.
3. Requests for an early refill for travel are done at the discretion of your physician during an office visit. Please call the front desk to schedule an appointment.
4. As stated in the Medication Policy that you have read and signed, you are responsible for your prescriptions and medications. If they are lost, stolen, altered or destroyed they will **NOT** be replaced.
5. An increase in pain is evaluated during an office visit. Please call the front desk to schedule an appointment.
6. Report of a new injury brought on by an accident or any other reason is considered an acute incident and needs to be evaluated by your PCP, an urgent care facility or an emergency room. You should notify your nurse **AFTER** you have sought care and request that a copy of their office note is forwarded to our office.
7. Test results are reviewed with your physician during an office visit. Please call the front desk to schedule an appointment.
8. Requests for letters and forms to be completed are done at the discretion of your physician. There may be a charge for this service.
9. Requests for your medical records should be made to the medical records department at 203-732-1586.
10. We require 7-business days notice for **medication refills.** You must call our prescription refill line (203-732-1591) 7 business days in advance. If you call after 3:00 pm your call will be considered the next business day.

*****THERE ARE NO CHANGES MADE TO MEDICATIONS OVER THE PHONE*****

This is only done at the discretion of your physician during an office visit. Please call the front desk to schedule an appointment.

This is just a guideline for your calls. When in doubt, call the front desk.

I _____ (print) have read the above document and agree to follow it.

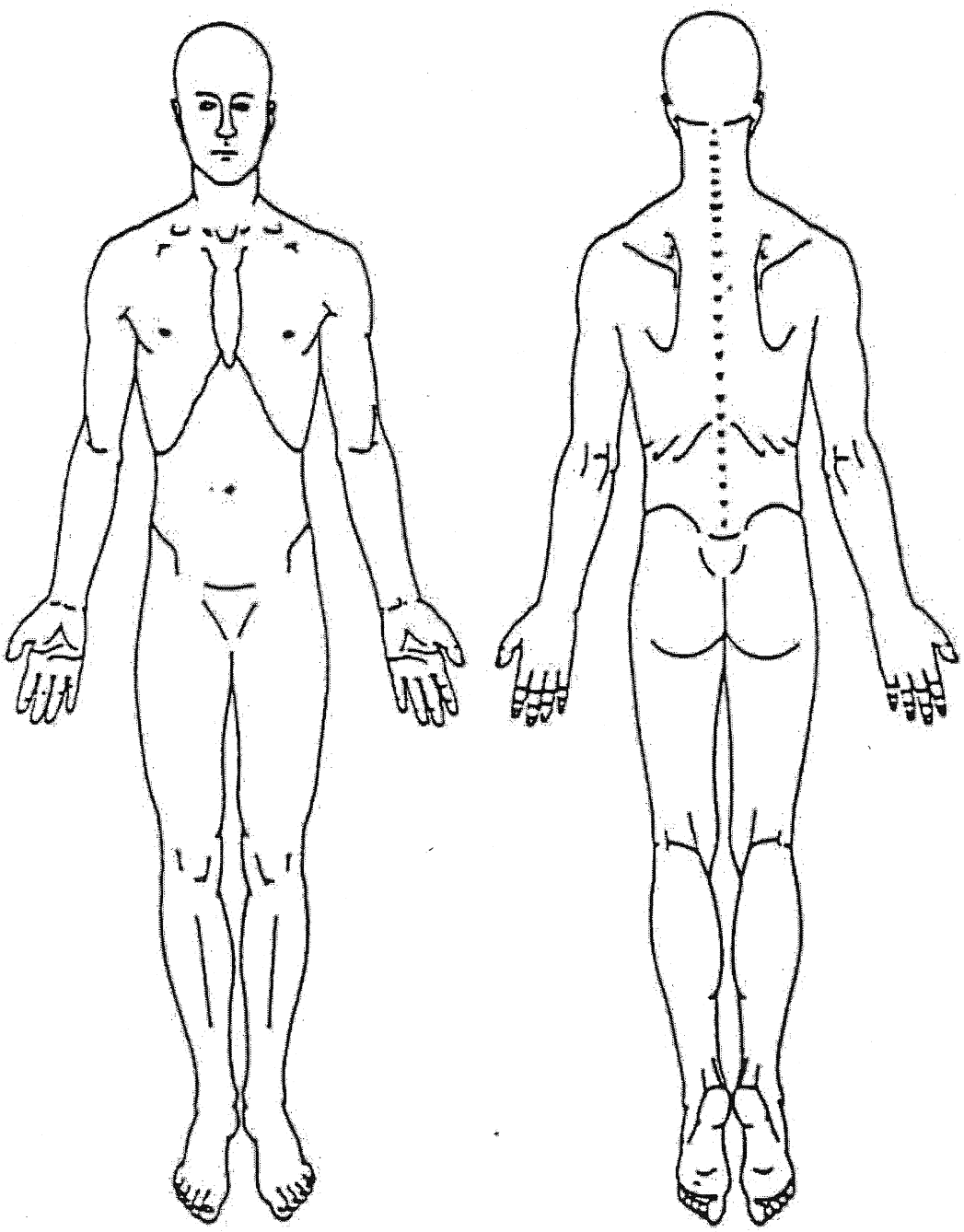
Signature _____ Date _____

Comprehensive Pain & Headache Treatment Centers, LLC

Date:_____

Name:_____(print)

Please shade in all the area of your body where you experience pain.



Please provide the following information (Social History)

Name: _____ Occupation: _____

Hobbies: _____

Habits: ___Tobacco (packs per day____) ___Alcohol (Drinks per day____) of _____

Marital status: ___Married ___Single ___Divorced ___Separated ___Widowed

Children: Number_____ Ages: _____

Are you in litigation for the problem we are seeing you for? _____Yes _____No

Indicate if you have any of the following symptoms

Constitutional
__Fevers
__Chills
__Night sweats
__Weight gain
__Weight loss
__Fatigue

Eyes
__Decreased vision
__Loss of vision
__Double vision
__Eye pain
__Flashing lights
__Cataracts
__Glaucoma

Ears, nose, mouth, throat
__Hearing loss
__Ringing in your ears
__Vertigo
__Ear pain
__Sinus pain
__Sinus infections
__Frequent nose bleeds
__Frequent sore throats
__Hoarseness
__Trouble swallowing

Respiratory
__Shortness of breath
__Wheezing
__Cough
__Coughing up blood

Cardiovascular
__Chest pain
__Palpitations
__Swelling of your legs

Gastrointestinal
__Nausea
__Vomiting
__Diarrhea
__Abdominal pain
__Incontinent of stool

Genitourinary
__Urinary incontinence
__Painful urination
__Urinary frequency
__Urinary hesitancy
__Frequent urination

Musculoskeletal
__Joint swelling
__Generalized joint pain
__Muscle pain

Integumentary
__Skin rashes
__Skin ulcers
__Skin nodules

Neurological
__Headaches
__Light headedness
__Dizziness
__Decreased sense of smell
__Decreased sense of taste
__Neck pain
__Numbness of arm or hand
__Weakness of arm or hand
__Numbness of legs or feet
__Weakness of legs or feet
__Problems with balance
__Problem with coordination
__Problems with memory
__Tremors
__Involuntary movements

Psychiatric
__Depression
__Anxiety
__Panic attacks
__Thoughts of suicide
__Afraid to leave house
__Unable to enjoy things

ALLERGY HISTORY QUESTIONAIRE

NAME: _____

Please answer the following questions:

1. ***Do you have a history of allergies? Yes _____ No _____***
   If you answered yes, how many years have you suffered with these allergies? Approximately _____ years.

2. ***Please list allergies other than medication., e.g. pollens, ragweed, dust mites, perfurmes, latex, etc:***

   _____

   _____

   _____

   _____

3. ***Were you ever treated with injections for your allergies? Yes___ No___***
4. ***Do you currently take allergy medications? Yes _____ No _____***
   If yes, please list: _____

   _____

   _____

5. ***List all NARCOTIC MEDICATIONS you have taken, either in the past or currently:*** _____

   _____

   _____

6. ***List all medications you are allergic to and the reactions you had to that medication:*** _____

   _____

   _____

   _____

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Heather Alfonso, APRN
Jean Vulte, APRN

Karlene Jean-Pierre, APRN

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I herewith authorize the release of a copy of my medical record to The Comprehensive Pain & Headache Treatment Centers, LLC.

Name of Patient Requesting Records_____

Address: _____

_____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Telephone: _____

SIGNED: _____ Date: _____

Please send the records to:

Comprehensive Pain & Headache Treatment Centers, LLC
130 Division St
Derby, CT 06418

V022000

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I herewith authorize The Comprehensive Pain & Headache Treatment Centers, LLC to release a copy of my medical record to _____.

Name of Patient Requesting Records_____

Address: _____

_____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Telephone: _____

SIGNED: _____ Date: _____

Please send the records to:

To the attention of:

Address:

City, State, Zip:

V022000

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Controlled substance agreement and medication policy

Name_____Date: _____

The Purpose of this agreement is to provide information about the medications you will be taking for pain management and to assure that you and your provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of REDUCING pain and increasing function. It may not be possible to eliminate your pain. The goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the provider/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

Your medications may include opioids (narcotics), which have the potential for abuse and diversion. So that we all have an understanding of the rules under which these medications are prescribed, the providers of Comprehensive Pain and Headache Treatment Centers have written this medication policy. We will ask you to read and sign this paper in order to make it clear how these strong medications will be prescribed. **Stating that you did not remember the rules will not be an excuse, so please read this carefully before you sign it.**

1. You will receive all medication for the treatment of your CHRONIC pain from CPHTC only. This means no pain medications from other providers. If you fall and have a fracture, have surgery, teeth pulled; a short course of medications lasting under 2 weeks is acceptable, but the office must be notified within 72 hours. Anything you get while in the hospital is acceptable.
2. You will be subject to routine and random testing for both illegal substances and for your own medications. Any failure to comply with this testing **WHEN IT IS REQUESTED** will

result in our not being able to give you any further opioids. Most of these tests will be urine samples. If you cannot urinate within one hour of the request, we reserve the right to obtain a blood sample or oral swab. **Excuses will not be tolerated.**

3. You will use only **one** pharmacy which is_____

_____

4. You will inform us of any and all medications or supplements you are taking as they can interact with opioids.
5. Prescriptions for pain medications will only be done during office hours or an office visit. Allow a minimum of 7 days for a refill. NO refills of any medications will be done after hours or on weekends.
6. At times you will be asked to bring all opioid and non-opioid medications prescribed by this office to an appointment.
7. You are responsible for keeping your 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. If your medications are lost, misplaced or stolen, your provider may choose not to replace the medications or to taper and discontinue these medications.
8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger another person's health. It is also illegal.
9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (this includes emergency rooms), increasing your medication without permission, loss of prescription, or failure to follow this agreement may result in termination of the provider/patient relationship.
10. Anyone who tests positive for any illicit substance such as cocaine, heroin or marijuana will no longer be given opioids/narcotics. These are illegal and may result in the discontinuation of your medication and termination of the provider/patient relationship.
11. The presence of any legal substance not known to the practice before the test will also be a problem. It is important in prescribing your medication that we know all the medication you are taking. Your medications are also monitored through Connecticut's prescription monitoring website, known as the CT PMP, a state database for monitoring controlled substances.
12. The use of Alcohol and opioid medications is contraindicated.

Initials_____ Date_____

13. This office reserves the right to perform random urine testing, blood testing and pill counts. When requested, you will agree to cooperate. If you decide not to, you understand this may result in the discontinuation of all of your medications and termination of the provider/patient relationship. The presence of non-prescribed drugs or illicit drugs can be grounds for termination of the provider/patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory material on the use of controlled substances to treat pain.
14. You agree to adhere to the plan of care set forth by your provider. This includes referral to psychology, physical therapy treatment, diagnostic testing, etc. Failure to do so may result in the termination of medications and/or the provider/patient relationship.
15. There are known side effects to opioid medications including, but not exclusively, constipation, nausea, vomiting, edema, sexual dysfunction, sleep abnormalities, sweating, sedation or the possibility of impaired mental status and or motor ability. Overuse of opioids can cause decreased respiration (breathing) and in severe cases, death.
16. If you have a history of alcohol or drug misuse/addiction, you MUST notify the provider of such history since treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one from opioid treatment of pain, but starting or continuing a program for recovery is a must.
17. You agree to allow our providers to contact any healthcare provider, family member, pharmacies, legal authority, or regulatory agency to obtain or provide information about your care or actions if the provider feels it is necessary. This may include a family conference or a conference with a close friend or significant other, if the provider deems it necessary.
18. Any urine or blood tests that do not fall in the correct range of values as determined by your provider may also be grounds for dismissal with no appeal. You must take your medications as prescribed on the bottle. If you find that you do not need that much medication, you must tell us that you have cut down and to what level. You also may not take more medication because you are hurting too much. This does not apply to

medications that you are allowed to take as needed. It only applies to the medications you are supposed to take routinely every day.

19. Any disturbance to the smooth working order of the practice or any upset to other patients in the waiting room caused by you will result in immediate dismissal from the practice.
20. Physical dependence and/or tolerance can occur with the use of opioid medications.
21. **Physical dependence** means that if the opioid medication is abruptly stopped or not taken as directed a withdrawal symptom can occur. This is a normal response by the body and is not life-threatening. This includes, but not exclusively, nausea, abdominal pain, cramping, diarrhea, chills, shakes and a change in one's mood.

    It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or steroids for treating asthma, but one is not addicted to the insulin or steroid.
22. **Addiction** is a primary chronic neurobiological disease with genetic, psychosocial 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, and cravings. This means the drug decreases one's quality of life.
23. **Tolerance** is a 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 maximum function and a realistic decrease of the patient's pain.
24. There will be a yearly limit of three **NO SHOWS** allowed per patient. After that, the patient will be dismissed form the practice. Calling to cancel at the time of the appointment or after the appointment is considered a **NO SHOW**.

Print Name: _____

Signature: _____

Date: _____

Initials_____ Date_____