

One Long Wharf Drive, Suite 212
New Haven, CT 06511

Dwight P. Ligham, M.D.

Phone (203) 624-4208

Fax (203) 624-4301

**THIS PRACTICE DOES NOT PRESCRIBE
CONTROLLED ANALGESICS (Opioid/ Narcotic based) MEDICATIONS
AT THE FIRST APPOINTMENT.**

Dear New Patient:

Welcome!! We sincerely appreciate you selecting Advanced Diagnostic Pain Treatment Centers to provide you with the Pain Management care you require. As a reminder, based on the information you provided, **please bring the following to your appointment:**

- COMPLETED PATIENT REGISTRATION FORM (ENCLOSED) Please complete prior to your appointment. If not completed appointment may be rescheduled.**
- PHOTO ID, INSURANCE CARD(S), MEDICATION CARD(S)/CO-PAYMENT**
- CD AND REPORTS FOR ANY RECENT X-RAY, CT SCAN OR MRI'S**
- REFERRAL OR AUTHORIZATION (IF REQUIRED BY INSURANCE)**
- METHOD OF PAYMENT (CASH, CREDIT CARD OR CHECK).**

If your insurance policy requires a referral you must obtain one prior to your appointment time.

This means being sure your Primary doctor has called in a referral to your insurance company; otherwise your appointment will be rescheduled. If your policy requires a co-payment be prepared to pay this amount at the time of service. All self-pay balances are due at the time of service. If you have no coverage for pain service under your policy, please come to your appointment prepared to pay in full or call to make payment arrangements in advance.

Advanced Diagnostic Pain Treatment Centers accepts the responsibility for billing your insurance carrier on your behalf, as long as you provide us with the correct information. Unfortunately, it is impossible for us to understand each patient's individual benefits. **We strongly advise you to telephone the member services department for your carrier and ask them about your benefits for Pain Management.** Urine Toxicology (drug screening) is provided by Progressive Diagnostics, a provider which may be out of network with your medical insurance. If so, you will receive a written explanation of benefits from your insurance carrier. This is not a bill. Please contact Progressive Diagnostics directly for an invoice for payment.

If you are unable to keep this appointment, please call us **within 48 hours** of your scheduled appointment and we will work with you to reschedule a more convenient time. If you do not call 24 hours prior to your appointment you may be charged **\$75.00** or your appointment may **not** be rescheduled.

Patient Information:

Name: _____ Date of Birth: _____

Address: _____ Apartment/Floor: _____

City: _____ State: _____ Zip: _____

Phone: _____(home) _____(work) _____(cell)

Social Security #: _____ Male__ Female__ Marital Status: _____

Employer: _____ Phone: _____

Email Address: _____

Emergency Contact:

First Name: _____ Last Name: _____

Relationship: _____ Phone Number: _____

Referring M.D.: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Primary M.D.: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Insurance Information:

Name/Company: _____ ID#: _____ DOB: _____

Subscriber: _____ Subscribers SSN: _____

Group#: _____ Effective Date: _____ Employer: _____

Secondary Insurance Information (if applicable):

Name/Company: _____ ID#: _____ DOB: _____

Subscriber: _____ Subscribers SSN: _____

Group#: _____ Effective Date: _____ Employer: _____

Worker's Compensation Info: (If applicable) BOLD PRINT MUST BE COMPLETED

Contact person/Case Manager: _____

Date of Injury: _____ **Insurance Company Name:** _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ **Fax:** _____

W.C. Claim or Certificate #: _____

Attorney Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please read: All charges are due at the time of service unless we are participating providers with your insurance carrier.

Otherwise, I authorize direct payment of medical benefits from my insurance carrier be made on behalf of the providers at Advanced Diagnostic Pain Treatment Centers for any/all services furnished to me by them. I authorize the release of any medical information about me to Medicare (HCFA) its agents or any other third-party payers for the processing of medical insurance benefits.

I understand that my insurance plan may not cover some or all of the procedures, injections, office visits, medication, or other treatments that I might require. I, therefore, will be responsible for the payment of services not covered by insurance. I fully understand that without this signed waiver, treatment will not be made available to me.

I understand I am responsible for all co-pays, co-insurance, deductibles and other non-covered services as deemed by my insurance carrier.

PATIENT NAME (PRINT) SIGNATURE DATE

Pharmacy: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient Height: _____ **Patient Weight:** _____

Patient No Show Policy

Effective January 2, 2013 this practice will institute a *No Show Fee*.

Patients are advised that if they need to cancel an appointment it must be 24 hours before appointment time for an *office visit or medication check*. Failure to follow this policy will result in a \$30.00 fee charged to your account.

Patients are advised that if they need to cancel a *procedure, pump refill, or stimulator reprogramming*, it must be 48 hours before appointment time. Failure to follow this policy will result in a \$30.00 fee.

Patients are advised that if they need to cancel a new patient consultation, it must be 48 hours before appointment time. Failure to follow this policy may result in a \$75.00 fee.

THESE CHARGES ARE NOT COVERED AND WILL NOT BE PAID BY YOUR INSURANCE COMPANY.

PATIENT NAME (PRINT)

SIGNATURE

DATE

Permission to Bill Medicare for Chronic Care Coordination

I give my permission for Advanced Diagnostic Pain Management, PC clinicians to bill Medicare for coordination of care that is required to provide medically necessary services to you. This care coordination is provided behind the scenes, outside or, and in addition to the regular visit and may include services such as preauthorization for medications, discussing your case with another clinician, and communicating with you by telephone or through email. There is a co-pay associated with this service that I agree to satisfy.

PATIENT NAME (PRINT)

SIGNATURE

DATE

Billing Policy

The intention of this form is to help you understand our payment policies.

We will bill your insurance carrier for services furnished to you. While this bill is pending with insurance you will not be billed for charges that you will be responsible for through the end of 2019. Starting January 1st, 2020, we will collect \$100 upon check-in for patients who have not met their deductible.

Copays are expected to be paid in full upon check in and we accept checks, cash or credit card. We also accept FSA/HSA credit cards. **We do not accept Care Credit.**

When your insurance carrier makes a payment or issues a denial, we will bill you for any copays, coinsurance or deductibles due according to the insurance explanation of benefit form (EOB). These amounts billed should match the EOB you received from your carrier.

We expect payment of your balance in full when you check in for your visit. You can also feel free to send us a check when you receive your billing statement or if you prefer you can pay by debit or credit card over the phone. **We do not accept online payments.** Payment is required in full for balances under \$200.00. Payment plans are available for patients with balances over \$200.00 but these balances must be paid off within six months of the payment plan agreement.

Our office charges patients for filling out forms. Most forms are \$25 and are not covered by your insurance. There are forms that require research, time, effort and thought to complete. The fee for these forms will vary depending upon the work involved.

Our office charges your insurance carrier for telephone correspondence with you regarding your care. There may be a copayment associated with these charges depending upon your carrier.

We charge a fee for “bouncing” a check. If more than one check is returned for nonpayment we will not be able to accept your check for services here.

Our office charges for missed appointment without 24-hour notice for follow-up appointments and 48-hours notice for new patient and procedure visits. These charges are \$30.00 for missed Office Visits and \$75.00 for missed Procedures or new patient Consultations.

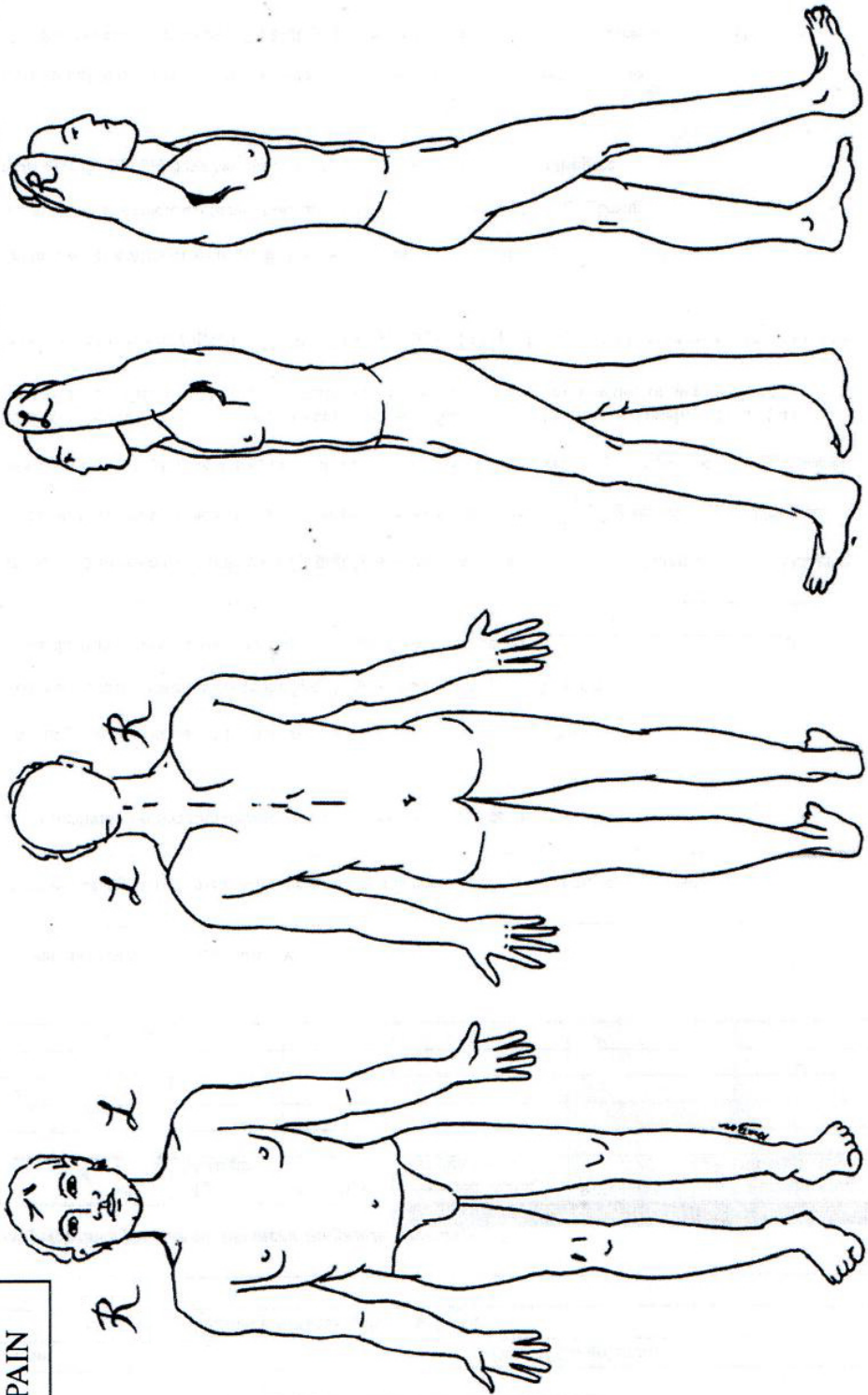
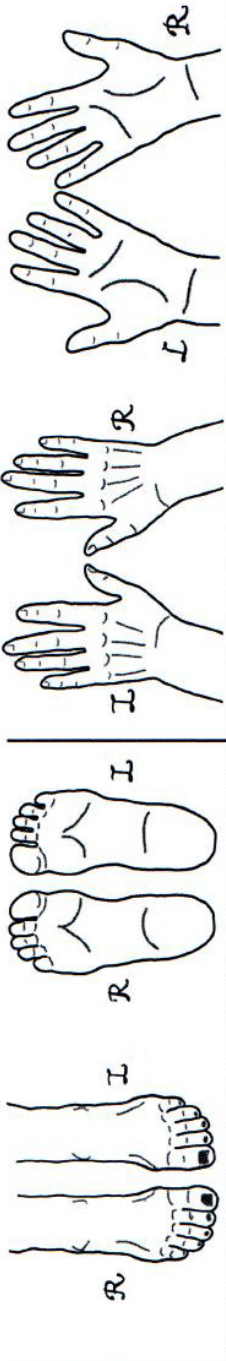
PATIENT NAME (PRINT)

SIGNATURE

DATE

NAME _____ . DOB _____ . DATE OF VISIT _____

PLEASE SHADE IN ALL THE AREAS WHERE YOU FEEL PAIN



Please list your allergies. These will be entered into your chart.

Patient Name (Print): _____ Date: _____

Allergy	Reaction

Please list all medications that you are currently taking. These will be entered into your chart.

Medication Name	Strength	Number per day

WRITE LEGIBLY PLEASE!!!

Name: _____ Date: _____ Birthdate: _____

Who sent you here? _____ When did the pain start? _____

1. **Worker Compensation** Yes No **Motor Vehicle Accident/Personal Injury** Yes No

- Attorney Name: _____ Phone: _____
- Date of Injury: _____
- Body Part Injured: _____
- Are you at maximum medical improvement:
 Yes: Date of maximum medical improvement: _____
 No
- Have you been given a disability rating? If yes, what percent? _____
- Do you have work limitations? Please list: _____

2. **Pain Description**

Check the box(s) that **BEST** describes your **CURRENT PAIN**:

Sharp Shooting Stabbing Throbbing Cramping Stinging Squeezing
 Hot Burning Piercing Tingling Tender Aching Splitting
 Cold Dull Numb Gnawing Other: _____

Rate your pain by placing an "X" on the line to describe your **AVERAGE** pain in the past month:

NO PAIN											DEATH
1	2	3	4	5	6	7	8	9	10		

Which of the following make **your pain WORSE**? (Check all that apply.)

Sitting Standing Walking Bending/Twisting Lifting Inactivity Exercise
 Reclining Bright Lights Heat Stress Cold Loud Noise Alcohol
 Meals Menstruation Poor Sleep Weather Changes Other: _____

Which of the following make **your pain BETTER**? (Check all that apply.)

Cold Exercise Activity Warm Shower Relaxation Prayer Reclining
 Heat Distraction Medication: _____ Other: _____ Changing Position

Are there any other symptoms **associated with your pain?** (Check all that apply.)

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Tenderness | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Time Movements | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Nausea | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Other: _____ | | |

Is there a **time of day** that is most severe OR is **it related to your activity?**

- Just activity related; OR: Morning Later Day Evening Night

- What is the duration of your pain?
 - My pain is constant
 - Some of my day is without pain, but I have pain every day
 - My pain comes and goes. It is episodic with pain free intervals in between painful episodes
- Is your sleep intact?
 - Yes** **No**, Pain interrupts it **No**, I'm just a bad sleeper
- Do you have sleep apnea?
 - No** **Yes**, I wear a CPAP mask **Yes**, but I am not using any sleep apnea treatment
- Do you suffer any of the following? (check all that apply)
 - falls in the past 30 days due to leg weakness
 - falls in the past 30 days due to balance problems
 - foot drop
 - loss of bladder control
 - loss of bowel control
 - clumsiness: inability to hold a pen or drops items or breaks dishes inadvertently

3. Function (check all that apply)

- I need help dressing, bathing, toileting, self-care
- I can't do my heavy inside chores (lift laundry, sweep, vacuum, scrub)
- I can't do my light inside chores (cook, dishes, dust, fold laundry)
- I am disabled from work due to pain
- I cannot do outside chores (shoveling, mowing, raking)
- I am limited in going into the community to shop, socialize, eat
- I cannot drive due to pain
- My medications cause impairment: (circle impairment below)
sedation memory loss balance problems slowing of thought/action

- How limiting is your pain?
 - Active during waking hours without pain breaks
 - Some pain breaks required during waking hours
 - Inactive all day long except for bathroom breaks

4. Treatments (on-going or tried and discontinued)

- What **non-narcotic** medications have you tried in the past? (circle)

Meloxicam (Mobic) Nabumetone (Relafen) Celecoxib (Celebrex) Diclofenac (Voltaren)
 Gabapentin (Neurontin) Pregabalin (Lyrica) Duloxetine (Cymbalta) Mitriptyline (Elavil)
 Nortriptyline (Pamelor) Cyclobenzaprine (Flexeril) Tizanidine (Zanaflex) Methocarbamol (Robaxin)
 Tylenol Ibuprofen (Motrin, Advil) Naprosyn (Aleve) Medical Marijuana
 Keppra

- Please list any **Narcotic/Opioids** medications you've tried in the past:

- Please indicate any treatments you have tried for your pain and whether they helped your pain:

	On-going?	Helpful?		On-going?	Helpful?
Chiropractic	Y or N	Y or N	Acupuncture	Y or N	Y or N
Yoga	Y or N	Y or N	Tai Chi	Y or N	Y or N
Swimming	Y or N	Y or N	Home or Gym Exercise	Y or N	Y or N
Pulsed Electromagnetic Energy Treatment	Y or N	Y or N	TENS	Y or N	Y or N
Traction	Y or N	Y or N	Physical Therapy	Y or N	Y or N
Cognitive Behavioral Therapy	Y or N	Y or N	Mindfulness Based Stress Reduction	Y or N	Y or N
Counseling (Psychiatry, Social worker, etc.)	Y or N	Y or N	Braces/ Corsets	Y or N	Y or N
Cervical Collar	Y or N	Y or N	Inversion Table	Y or N	Y or N

- Have you had any injections to help with your pain? If so what kind? With which provider?

5. Medical History

Do you have any of the following? (Check all that apply.)		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizure	<input type="checkbox"/> Depression	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> HIV	<input type="checkbox"/> A-Fib	<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> GERD	<input type="checkbox"/> Bowel Disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> On a Blood Thinner
<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Other: _____			

6. Surgical History

Have you ever had any type of surgery? No Yes If yes, please list below:

Procedure: _____ Date: _____ Surgeon: _____

Procedure: _____ Date: _____ Surgeon: _____

Procedure: _____ Date: _____ Surgeon: _____

7. Past Mental Health History

Have you ever had mental health treatment? No Yes _____
Approximate date

Are you in current mental health treatment? No Yes _____
(Psychiatrist, Psychologist, Counselor) Name of Provider

Have you ever been hospitalized for psychiatric reasons? No Yes _____
Approximate date

If YES, general reason for hospitalization: _____

8. Employment

Current or Prior Occupation: _____ N/A

Present Employment Status: Full-time Part-time Student Retired Homemaker
 Workers Compensation Unemployed Leave of Absence Disability

If not working, when was your last day of work? _____

Date you returned to work after injury: _____

Would you return to work if you had less pain? No Yes

Have you tried to return to work? No Yes

Is your present or previous job remaining open for you? No Yes

Do you have an application pending for compensation or disability? No Yes

Do you have a pending lawsuit because of your pain or injury? No Yes _____
Name of your attorney

10. Family and Social history

- Preferred language: _____ Is an interpreter required? Yes No
- Have you used tobacco? (circle): Current Smoker Former Smoker Never Smoker
 Quit Date: _____
 Type (circle): Cigarettes, Pipe, Chew/ Snuff, Cigar
 Packs or cans per day: _____
 Number of years: _____
 Ready to quit? Yes No Do you Vape? Yes No

- Do you use Alcohol? Yes No
 How many days per week? _____
 How many glasses/ bottles per day? _____
 Preferred beverage? _____
 Have you previously or do you now have problems controlling your urge for alcohol? Yes No
- Non-prescribed or street drug use? Please list: _____
- Family History (List medical/ psychiatric problems for each)

Relation	How Many?	Alive?	Medical or Psychiatric Problems
Mother		Y or N	
Father		Y or N	
Brothers *		Y or N	
Sisters *		Y or N	
Sons *		Y or N	
Daughters *		Y or N	
Are you adopted?	Y or N	* Please include full or 1/2 siblings. Please include biological children.	

11. Personal Statistics

- What is your living status? (circle): Married Single Roommate w/Family Homeless

12. Review of Systems. PLEASE CHECK ALL CURRENT SYMPTOMS

CONSTITUTIONAL		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Lack of energy	<input type="checkbox"/> Fevers		
<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Night sweats		
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Weight Loss: Amount: _____	Was this intentional?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Chills	<input type="checkbox"/> Weight Gain: Amount: _____	Was this intentional?	<input type="checkbox"/> No <input type="checkbox"/> Yes

RESPIRATORY		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Wheezing	
<input type="checkbox"/> Oxygen: @ _____ Liters (circle) Day/Night/Continuous			
<input type="checkbox"/> Other: _____			

CARDIOVASCULAR		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Leg pain/poor circulation	<input type="checkbox"/> Swelling in legs and feet	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Irregular heart beats	<input type="checkbox"/> Cold hands and feet	
<input type="checkbox"/> Blue/Red Color Changes in Hands and Feet		<input type="checkbox"/> Narrowing of Arteries of the Neck	
<input type="checkbox"/> Other: _____			

GASTROINTESTINAL		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Difficulty chewing	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Dark or tarry stools	
<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/> Abdominal cramps/bloating	<input type="checkbox"/> Yellow skin	
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Incontinence of stool	<input type="checkbox"/> Change in stools	
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Other: _____			

HEMATOLOGIC		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Painful veins or arteries	<input type="checkbox"/> Trouble with blood clotting	<input type="checkbox"/> Easy bruising	

ENDOCRINE		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Always Cold	<input type="checkbox"/> Always Hot	<input type="checkbox"/> Other: _____

MUSCULOSKELETAL		<input type="checkbox"/> NO PROBLEMS		
<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Muscle Loss	<input type="checkbox"/> Weakness	<input type="checkbox"/> Stiffness
<input type="checkbox"/> Cramps	<input type="checkbox"/> Bone Pain	<input type="checkbox"/> Other: _____		

NEUROLOGICAL		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Headache	<input type="checkbox"/> Fainting	<input type="checkbox"/> Difficulty finding words when thinking	
<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Change in your thinking	
<input type="checkbox"/> Falls	<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Numbness or tingling of face / arms / legs	
<input type="checkbox"/> Other: _____			

PSYCHIATRIC		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Frequent sadness/feeling unhappy	<input type="checkbox"/> Panic	<input type="checkbox"/> Excessive worry	
<input type="checkbox"/> Unusually high energy / excitability	<input type="checkbox"/> Ongoing problems in relationships with others		
<input type="checkbox"/> Anger	<input type="checkbox"/> Other: _____		

GENITOURINARY		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Incontinence of Urine	<input type="checkbox"/> Pain when urinating	
<input type="checkbox"/> Pain during sex	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Other: _____	

GYNECOLOGICAL		<input type="checkbox"/> NO PROBLEMS	
<input type="checkbox"/> Period Irregularity	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Heavy Periods	<input type="checkbox"/> PMS Symptoms
<input type="checkbox"/> Currently Lactating	<input type="checkbox"/> Absence of Periods	<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Other: _____

Was this form completed by someone other than the patient?

No Yes, by whom: _____ Relationship: _____

Patient/Guardian Signature: _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
Please answer the questions using the following scale:	0	1	2	3	4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
Please answer the questions using the following scale:					
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Thank you.

©2009 Inflexxion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions questions: PainEDU@inflexxion.com. The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

Patient Name _____
 Height _____ Weight _____
 Age _____ Male/Female _____

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED , fatigued, or sleepy during the daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE ?	Yes	No

BANG		
BMI more than 35kg/m ² ?	Yes	No
AGE over 50 years old?	Yes	No
Neck circumference more than 16 inches?	Yes	No
Gender: Male ?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5-8
 Intermediate risk of OSA: 3-4
 Low risk of OSA: Yes 0-2



One Long Wharf Drive, Suite 212
New Haven, CT 06511

929 Boston Post Road, Suite 9
Old Saybrook, CT 06475

Dwight P. Ligham, M.D.

Phone (203) 624-4208
Fax (203) 624-4301

SECONDARY CONTACT

I _____ give my permission to

Advanced Diagnostic Pain Treatment Center to discuss my medical condition,

ongoing treatment, and medication with (name) _____

(relationship) _____ (phone number) _____.

Patient Signature: _____

Date: _____

Witness: _____



One Long Wharf Drive, Suite 212
New Haven, CT 06511

929 Boston Post Road, Suite 9
Old Saybrook, CT 06475

Dwight P. Ligham, M.D.

Phone (203) 624-4208
Fax (203) 624-4301

NOTICE TO PATIENTS OPEN PAYMENTS DATABASE

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospital be made available to the public.

You may search this federal database for payments made to physicians and teaching hospitals by visiting this website:

<https://openpaymentsdata.cms.gov/>

Please sign to document receipt of this notification:

Patient signature: _____

Date: _____

**Advanced Diagnostic Pain Treatment Centers
Service and Emotional Support Animals Policy**

DEFINITION

Service Animals

The Americans with Disabilities Act (ADA) defines service animals as **dogs** (or a miniature horse in some cases) **individually trained to work or perform tasks directly related to a person’s disability**.

Service animals must be allowed into public areas of medical facilities except where special precautions for health and safety are required.

Emotional Support Animal

An emotional support animal is an animal of any species that *solely* provides companionship, comfort, and emotional support. Companionship, comfort and emotional support do not constitute “work” or “tasks” as defined by the ADA. Emotional support animals are not service animals under the ADA and are therefore not protected under the same laws.

For example: A dog that has been trained to sense an anxiety attack is about to happen and take a specific action to help avoid the attack or lessen its impact would qualify as a service animal. However, if a dog's mere presence provides comfort, that dog would not be considered a service animal. A *service dog* is trained to do a *specific task* related to a *disability*.

To determine if your animal is a service dog, we may ask you the following two questions:

1. **Is the animal a service animal required because of a disability?**
2. **What work or task has the animal been trained to perform?**

POLICY

- Advanced Diagnostic allows *service animals* in all *public* areas of the practice. For health and safety reasons, the Operating Suite and the pump refill rooms are restricted areas where service animals are not permitted.
- Service animals must be under the control of their handler at all times and must be leashed or harnessed unless using these devices would interfere with the animal performing its task.
- A service animal can be excluded or removed from a facility, program or activity when:
 - there is a direct threat to the health and safety of others, or the animal has a history of such behavior
 - the animal is not under the control of the person using the animal
 - the animal is not housebroken, is visibly unclean or ill, or has an extremely unpleasant odor
 - the animal’s presence fundamentally alters the nature of services
- *Emotional support animals and pets* are not allowed in any area of the practice. If you are accompanied by a pet or emotional support animal, your appointment can be rescheduled, or you can have another person care for your animal outside our office during your appointment. Please do not leave your animal unattended in your car as this can be life-threatening to the animal.
- Advanced Diagnostic employees are not responsible for caring for or cleaning up after animals accompanying our patients.

I have read and understood the Service and Emotional Support Animals Policy.

Print Name: _____

Signature: _____

Date: _____

Name: _____

Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over 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? Or the opposite — being so fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="radio"/>	<input type="radio"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="radio"/>	<input type="radio"/>
...you felt much more self-confident than usual?	<input type="radio"/>	<input type="radio"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="radio"/>	<input type="radio"/>
...you were much more talkative or spoke much faster than usual?	<input type="radio"/>	<input type="radio"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="radio"/>	<input type="radio"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="radio"/>	<input type="radio"/>
...you had much more energy than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more active or did many more things than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="radio"/>	<input type="radio"/>
...you were much more interested in sex than usual?	<input type="radio"/>	<input type="radio"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="radio"/>	<input type="radio"/>
...spending money got you or your family into trouble?	<input type="radio"/>	<input type="radio"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="radio"/>	<input type="radio"/>
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? <i>Please circle one response only.</i>		
No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>

Delivery Network/Location NAME: BIRTH DATE: MRN: DOS:	Advanced Diagnostic Pain Treatment Centers, PC (ADPTC) Telehealth Consent
--	--

Please read the following patient information regarding telehealth visits using the MyChart and Doxy.me platforms. If you have questions about this consent, please reach out to your provider. You will be asked to sign this consent on an annual basis.

SUMMARY (DETAILS CAN BE FOUND IN SUBSEQUENT SECTIONS)

Telehealth is the use of electronic information and communication technologies by healthcare providers to deliver Telehealth services to an individual when he/she is located at a different site than the provider. Telehealth services can include remote monitoring, tele-pharmacy and prescription refills per state law, appointment scheduling, regional health information sharing, and non-clinical services, such as education programs, administration, and public health. ADPTC-affiliated clinicians may include primary care practitioners, specialists, and/or sub-specialists, as well as physician assistants and advanced practice registered nurses.

I understand that if I am experiencing a medical emergency, I will be directed to dial 9-1-1 immediately and that ADPTC clinicians and employees are not able to connect me directly to any local emergency services.

I understand that ADPTC and its consulting providers offer telehealth services, but that these services do not replace the relationship between my primary care doctor and me. I understand that primary responsibility for my medical care should remain with my local primary care doctor, if I have one, as does my medical record. I also understand it is up to the ADPTC clinician to determine whether or not my needs are appropriate for a telehealth encounter.

I understand that records of my telehealth visits will be documented in my Epic Electronic Health Record (EHR) and acknowledge that my primary care provider and other providers may access these records.

I hereby certify that I (and my minor child or the patient named) am physically located in the State I choose/have chosen as my current location. I acknowledge that my ability to access and use the Service is conditioned upon the truthfulness of this certification and that the providers I access are relying upon this certification in order to interact with me.

I understand that I will not be prescribed any Drug Enforcement Agency controlled substances via telehealth if not allowed by state law, nor is there any guarantee that I will be given a prescription at all.

ELECTRONIC MEDICAL RECORD INFORMATION

Information transmitted may be used for diagnosis, consultation and treatment, therapy, follow-up, education, care management and self-management of patient’s physical and mental health, and may include any combination of the following: (1) patient health records or medical history; (2) medical images; (3) live two-way audio and video; (4) interactive audio; (5) asynchronous/store and forward transmissions; and (6) output data from medical devices, peripheral devices, and sound and video files.

Electronic systems used will incorporate appropriate protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

ACCESS TO HEALTH INFORMATION

I understand that my healthcare information may be shared with other individuals for treatment, payment and operational purposes. Persons may be present during the consultation other than the ADPTC clinician in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.

I understand that federal and state law requires health care clinicians to protect the privacy and the security of health information. I understand that ADPTC will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I understand video images and audio recordings of me may be captured and securely stored electronically. I understand that these recordings may be later viewed and used for purposes of quality assurance and training. I hereby understand and consent to the use of these images and audio recordings for purposes of quality assurance and training. As with in-person visits, insurance carriers will

Delivery Network/Location NAME: BIRTH DATE: MRN: DOS:	Advanced Diagnostic Pain Treatment Centers, PC (ADPTC) Telehealth Consent
--	--

have access to medical records for quality review/audit and patients will be responsible for any co-payments or coinsurances that apply to telehealth visits.

Additional State-Specific Consents: The following consents apply to users accessing the ADPTC website for the purposes of participating in a telehealth consultation as required by the states listed below:

Connecticut: I understand that my primary care provider may obtain a copy of my records of any telehealth interaction. CT Public Act No. 15-88 (2015).

PATIENT RIGHTS/RESPONSIBILITY

I have been given an opportunity to select a clinician from ADPTC prior to the interaction, including a review of the clinician’s credentials.

I understand that federal and state law requires health care clinicians to protect the privacy and the security of health information. I understand that ADPTC will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate access to the service at any time for any reason or for no reason.

I understand the alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the services involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the ADPTC consulting healthcare clinician (e.g. labs or blood work).

I understand that no results can be guaranteed or assured.

I understand that insurance carriers will have access to my medical records for quality review/audit.

I understand there is a risk of technical failures during the telehealth encounter beyond the control of ADPTC. I agree to hold harmless ADPTC for delays in evaluation or information lost due to such technical failures.

Possible Risks:

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.
- In rare events, the clinician may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or a face-to-face meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

I understand that in the event of any problem with the website, app, or related services, I agree that my sole remedy is to cease using the website, app, or terminate access to the service. Under no circumstances will ADPTC or any ADPTC subsidiary or affiliate be liable in any way for the use of the telehealth services, including but not limited to, any errors or omissions in content or infringement by any content on the website of any intellectual property rights or other rights of third parties, or for any losses or damages of any kind arising directly or indirectly out of the use of, inability to use, or the results of the use of the website, and any website linked to the website, or the materials or information contained on any or all such websites. I agree that I will not hold ADPTC, its subsidiaries or affiliates liable for any punitive, exemplary, consequential, incidental, indirect or special damages (including, without limitation, any personal injury, lost profits, business interruption, loss of programs or other data on my computer or otherwise) arising from or in connection with use of the website or app, whether under a theory of breach of contract, negligence, strict liability, malpractice or otherwise, even if we or they have been advised of the possibility of such damages.

