ADVANCED DIAGNOSTIC PAIN TREATMENT CENTERS

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

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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.

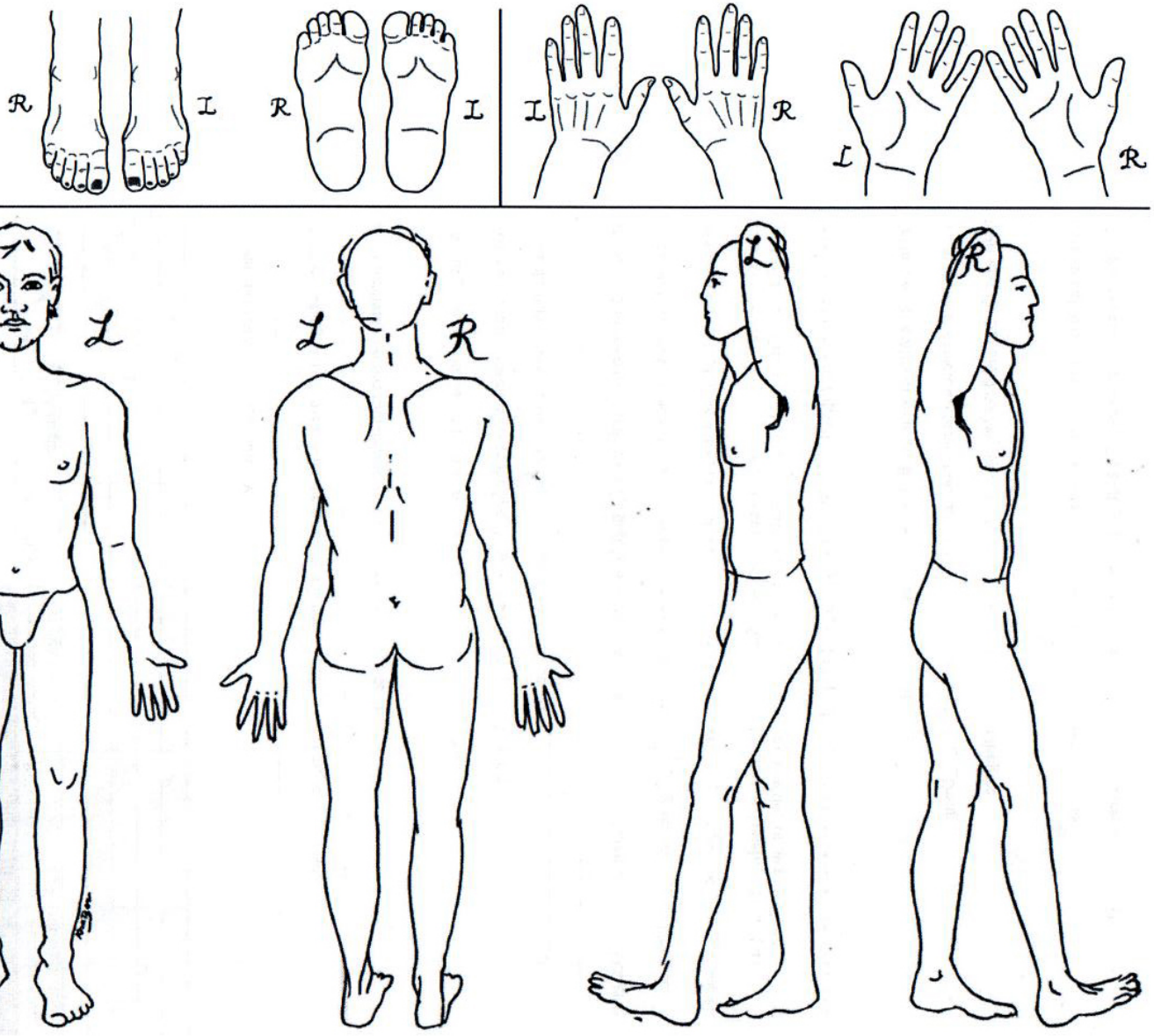
We charge a fee for "bouncing" a check. If more than one check is returned for nonpayment we will not be able to accept your check for services here.

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.)

❑ Numbness	❑ Weakness	❑ Tenderness	❑ Vomiting
❑ Redness	❑ Blurred Vision	❑ Night Time Movements	❑ Fatigue
❑ Swelling	❑ Nausea	❑ Sleep Apnea	❑ Anger
❑ Sexual Dysfunction	❑ 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)	Mitryptiline (Elavil)
Nortryptiline (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
Counselling (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 <u>you have</u> any of the following? (Check all that apply.) ❑ **NO PROBLEMS**

❑ High Blood Pressure	❑ Heart Attack	❑ Asthma	❑ Stomach Ulcer
❑ Kidney Disease	❑ Seizure	❑ Depression	❑ Arthritis
❑ Diabetes	❑ Stroke	❑ Hepatitis	❑ Cancer
❑ Thyroid Disease	❑ Liver Disease	❑ Lung Disease	❑ Fibromyalgia
❑ Pacemaker	❑ HIV	❑ A-Fib	❑ Peripheral Neuropathy
❑ GERD	❑ Bowel Disease	❑ Migraines	❑ On a Blood Thinner
❑ Low Blood Sugar	❑ Dialysis	❑ Glaucoma	

❑ 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 <u>had</u> mental health treatment? ❑ **No** ❑ **Yes** _____
Approximate date

Are you in <u>current</u> mental health treatment? ❑ **No** ❑ **Yes** _____
(Psychiatrist, Psychologist, Counselor) Name of Provider

Have you ever <u>been hospitalized for</u> 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 ½ 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 ❑ **NO PROBLEMS**

❑ Lack of energy ❑ Fevers
❑ Trouble sleeping ❑ Night sweats
❑ Poor appetite ❑ Weight Loss: Amount: _____ Was this intentional? ❑ No ❑ Yes
❑ Chills ❑ Weight Gain: Amount: _____ Was this intentional? ❑ No ❑ Yes

RESPIRATORY ❑ **NO PROBLEMS**

❑ Shortness of Breath ❑ Chronic Cough ❑ Wheezing
❑ Oxygen: @ _____ Liters (circle) Day/Night/Continuous
❑ Other: _____

CARDIOVASCULAR ❑ **NO PROBLEMS**

❑ Chest pain ❑ Leg pain/poor circulation ❑ Swelling in legs and feet
❑ Palpitations ❑ Irregular heart beats ❑ Cold hands and feet
❑ Blue/Red Color Changes in Hands and Feet ❑ Narrowing of Arteries of the Neck
❑ Other: _____

GASTROINTESTINAL ❑ **NO PROBLEMS**

❑ Difficulty chewing ❑ Poor appetite ❑ Diarrhea
❑ Constipation ❑ Blood in stool ❑ Dark or tarry stools
❑ Nausea / Vomiting ❑ Abdominal cramps/bloating ❑ Yellow skin
❑ Weight loss ❑ Incontinence of stool ❑ Change in stools
❑ Abdominal pain ❑ Other: _____

HEMATOLOGIC ❑ **NO PROBLEMS**

❑ Painful veins or arteries ❑ Trouble with blood clotting ❑ Easy bruising

ENDOCRINE ❑ **NO PROBLEMS**

❑ Weight Gain ❑ Always Cold ❑ Always Hot ❑ Other: _____

MUSCULOSKELETAL ❑ **NO PROBLEMS**

❑ Muscle Pain ❑ Joint Pain ❑ Muscle Loss ❑ Weakness ❑ Stiffness
❑ Cramps ❑ Bone Pain ❑ Other: _____

NEUROLOGICAL ❑ **NO PROBLEMS**

❑ Headache ❑ Fainting ❑ Difficulty finding words when thinking
❑ Difficulty walking ❑ Poor Memory ❑ Change in your thinking
❑ Falls ❑ Poor Concentration ❑ Numbness or tingling of face / arms / legs
❑ Other: _____

PSYCHIATRIC ❑ **NO PROBLEMS**

❑ Frequent sadness/feeling unhappy ❑ Panic ❑ Excessive worry
❑ Unusually high energy / excitability ❑ Ongoing problems in relationships with others
❑ Anger ❑ Other: _____

GENITOURINARY ❑ **NO PROBLEMS**

❑ Urinary Frequency ❑ Incontinence of Urine ❑ Pain when urinating
❑ Pain during sex ❑ Blood in Urine ❑ Other: _____

GYNECOLOGICAL ❑ **NO PROBLEMS**

❑ Period Irregularity ❑ Hot Flashes ❑ Heavy Periods ❑ PMS Symptoms
❑ Currently Lactating ❑ Absence of Periods ❑ Painful Periods ❑ 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.

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

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

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

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

Patient Name_____
Height_____ Weight_____
Age_____ Male/Female_____

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during the daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	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

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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: _____

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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**
☐	☐	☐	☐

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?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

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? *Please circle one response only.*

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?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○