CONNECTICUT GO GREEN MEDICAL, PLLC
Specializing in Pain Management

Dear Patient,

Welcome to CT Medical Green. To help us take the best care of you, please complete the paperwork, and bring it with you to your scheduled appointment along with your insurance card (s), pharmacy card and a photo ID. If you have had a recent X-ray, MRI or CT scan with the written report, please bring it with you as this will help to expedite your care.
Please be advised that we do not prescribe ANY medication at the time of your first visit. If you are currently prescribed medication (s) by another Provider, please notify their office that they will need to provide you with the medication for up to 2 weeks after your initial consultation.
If you are scheduled for a procedure, please arrange for a companion or driver to bring you to and from the appointment unless other arrangements have been made and discussed.
Please arrive 15-30 minutes for your initial appointment and any additional paperwork to be filled out.
If you have any questions or concerns, please contact us at 203-874-7001
Thank you!

COVID GUIDELINES

To protect our patients, staff and to maintain a safe environment for all, the following will be required at the time of your appointment.

- While in our office and building, patients and guests must wear a mask at all times.
- Only patients will be allowed in our office. Exceptions must be approved prior to the appointment.
- If you have any symptoms of COVID, please call our office to reschedule your appointment.

Connecticut Go Green Medical
Pain Management
31 Cherry St Ste 1
Milford, CT 06460
Phone: 203-874-7001|Fax: 203-874-7002

CONTROLLED SUBSTANCE AND PAIN MANGEMENT AGREEMENT

Scheduled controlled narcotic substances are medications reserved for patients with severe refractory pain who have tried unsuccessfully to control their pain with more conservative measures. These medications are highly regulated at the local, state, and federal levels. These medications are intended to help patients treat their painful symptoms associated with their underlying conditions and return them to a more functional state. My Provider has discussed these medications with me, and he/she has asked me to read the following statements thoroughly and acknowledge each statement by signing this document showing my agreement.

By signing the document below the patient is entering into a contract with the Provider(s) of Connecticut Go Green Medical which includes, but not limited to the following:

_____ 1**. I acknowledge that CT Medical Green will only provide treatment and medications for chronic pain. I should consult my Primary care Physician/Provider for all other medical issues.**

_____ 2. **I acknowledge that I have a painful condition that my Provider/Nurse Practitioner may treat with narcotic medication (s)**

_____ 3. I acknowledge that I have tried more conservative measures in treating my painful condition and that these have been ineffective in controlling my pain.

_____4. **I acknowledge that I have no history of substance abuse or dependence.**

_____5. I agree that I will take my medication(s) exactly as they are prescribed by the Provider. Any adjustments must be approved by the Provider/Nurse Practitioner. **I understand that the Provider/Nurse Practitioner will not provide additional medication(s) if I run out early or ahead of schedule.**

_____ 6. I understand a controlled substance may be prescribed for the treatment of my painful medical condition. Controlled substances can cause sedation, mental fogginess, confusion, or other changes in mental state and thinking abilities**. I understand that my decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else if I am in any way sedated, feel drowsy, mentally foggy or not thinking clearly.** These activities may include but are not limited to driving or operating heavy or dangerous machinery, being responsible for another individual who is unable to care for **himself/herself or working in unprotected heights.**

_____ 7. **I acknowledge that the Provider/Nurse Practitioner will not prescribe any Benzodiazepines, Amphetamine or sleep aids (i.e., Xanax, Clonazepam, Adderall, Vyvanse or Ambien, etc.). I am aware that these medications will be prescribed by my Primary Care Provider or Psychiatrist.**

_____ 8**. I acknowledge that my Provider/Nurse Practitioner has discussed with me the risks and benefits of taking controlled substance (s) and the responsibilities that I have regarding this medication. I understand that depending on the controlled substance and dose, I can become physically dependent on the medication and develop withdrawal symptoms if the medication is stopped/discontinued suddenly, or the dose is reduced rapidly. I agree that should I wish to discontinue the medication; I will do so with the guidance and supervision of the Provider/Nurse Practitioner. I understand that although the risk is small, there is a chance of developing an addiction to controlled substances if placed on to control my pain.**

_____ 9**. I agree that I will not use ANY ILLEGAL substances, including but not limited to Street Marijuana, heroin, Methadone, cocaine. In addition, I will not drive under the influence of Alcohol. I agree that in doing so, this will be a violation of this controlled substance agreement and the relationship between myself, and CT Go Green Medical will be subject to immediate termination from this practice.**

_____ 10. I understand if I perform acts that are considered illegal regarding controlled substances either prescribed by my Provider/Nurse Practitioner at CT Go Green Medical or by another entity that I will be discharged immediately from this Practice and reported to the appropriate authorities. I will not share, sell, or trade my medication with anyone, including family members.

_____ 11. I understand that the prescriptions and medications are my responsibility or the responsibility to my designated guardian and once they are in my possession or that of my guardian, that if anything happens to my prescriptions (i.e. stolen, accidentally destroyed, left in a cab, airport or lost), I will not receive a replacement from my Provider/Nurse Practitioner. I acknowledge that I was instructed by my Provider/Nurse Practitioner to keep the medication in a secure and locked container or safe and that no one else may have access to them**. In the event there is a home invasion, and a police report was made, this report must be given to the Provider/Nurse Practitioner, this may be an exception**.

_____ 12. I acknowledge I will not take any prescription pain medication from any other Physician, Dentist, family member or friend. **I understand that the medication prescribed to me by my Provider/Nurse Practitioner is for my use only and is not to be shared or given to anyone else for any reason.** I further understand that my prescription pain medication treatment will be terminated or detoxification in a controlled environment will be recommended or required if I give away, sell, prescription forgery, distribute or transport with the intent to sell or dispense the medication(s) prescribed to me, or other diversion of my pain medication, I will be subject to discharge from care of this practice.

_____ 13. I understand that the policy of CT Go Green Medical regarding dispensing of controlled substances requires that I am seen regularly, and I agree to make and keep my appointments. I will inform my Provider/Nurse Practitioner of all other medications and treatments I am receiving or any changes in any other medication (i.e**. Xanax, Clonazepam** etc.) I am receiving from other Providers.

_____ 14. I understand that my Provider/Nurse Practitioner does not prescribe controlled substances to patients that are currently in a **Methadone treatment program or currently using Suboxone and the patient will not be prescribed any pain medication who are already prescribed these substances.**

_____ 15. I agree that I will not use my pain medication higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized by this practice to do so. I will inform my other Provider/Nurse Practitioner of my use of medication for chronic pain, and I will inform CT Go Green Medical if another Provider prescribes controlled substances for the acute problem. My Provider at CT Go Green Medical is my pain management Provider/Nurse Practitioner regarding my pain medications. If there is a medical emergency (fractures, surgery, dental procedures that may require post-op pain medication), another Provider may prescribe pain medication to me, however, **I must make an appointment to see my pain management Provider within TWO WEEKS (2 WEEKS) to discuss the temporary medication regimen. I also understand that if I have any problems taking or tapering the new medication or the schedule, it may be necessary to be referred to a counselor or another Provider who specializes in caring for patients with medication problems or dependence.**

_____ 16. I understand that should my pain mediation (s) needs to be adjusted for any reason, **I agree to return the unused portion of the medication Prior to receiving the new prescription and that there will be no exceptions.** Having been duly informed in advance, the medication will be destroyed in the presence of a witness in a safe manner that is safe for the environment. **The unused medication is not to be flushed or discarded outside of this office in any way.**

_____ 17. I acknowledge that CT Go Green Medical has a compliance and safety program that is to protect against diversion of medication in the community. **As a result, it is necessary for random urine (and if necessary, blood) toxicology testing of ALL PATIENTS at least twice per year, testing may be more frequently as deemed necessary. If the patient does not agree to participate in this program, the pain management Provider/Nurse Practitioner will not be able to prescribe or continue to prescribe your medication**. Patient agrees If I do not agree to participate in this government mandated program, I will not be able to continue receiving pain medications for the treatment of my pain. I understand my insurance will be billed for the urine test. And by signing this agreement I agree to personally pay the cost of this test if my insurance denies payment. I was informed that I may request a prescription to have the test performed at an outside laboratory. **If I do so, I agree to have the test performed within 2-4 hours of leaving the office** and I will be responsible for the outside laboratory fees if my insurance denies payment.

_____ 18. **I was informed that because of the risks of certain medications to unborn babies, I will inform ALL Providers, Obstetricians and Gynecologists immediately if I become pregnant or planning on becoming pregnant**. I am aware that should I carry a baby to delivery while taking these medications (opioids, benzodiazepines, Amphetamines), the baby will be physically dependent upon opioids or these medications. I am aware that the use of opioids is not generally associated with risk of birth defects, however birth defects can occur whether or not I (mother) am on medication and there is always the possibility that my baby will have a birth defect while I am taking an opioid.

_____ 19. **I am aware that chronic opioid use has been associated with low testosterone levels in males.** This may affect my mood, stamina, sexual desire and physical and sexual only performance. I understand that my doctor may order blood tests to check testosterone level (male).

_____ 20. I understand that my Provider can wean me off controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. **Stopping my opioids, antiseizure, or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizure or death).** I should follow the schedule provided to wean from my medications rather than just abruptly stopping them.

_____ 21. I understand that if the medication requires adjustment, an appointment must be made to see the Provider**. NO ADJUSTMENTS WILL BE MADE OVER THE PHONE**. I understand that medication and adjustments are done during office appointments except under very extreme circumstances**. If I am in need of a refill on any of my pain medication (s), I will call the office AT LEASE 72 HOURS PRIOR to the due date of an appointment and will not call after office hours or on the weekend for this purpose. I must stay with the prescribed dose so that I do not run out of medication early. The medication (s) is expected to last to my net scheduled appointment. I UNDERSTAND THAT THIS PRACTICE'S POLICY IS NOT TO PRESCRIBE EARLY, (i.e., before the due date). I agree that I will use my medication exactly as prescribed and that if I run out early may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms and/or hospitalization**.

_____ 22. I acknowledge that I have read the above agreement, have had my questions answered understand the agreement and I agree to abide by the terms of this Agreement if I am placed on pain medication and/or controlled substances (including, but not limited to narcotic analgesics)

By signing this form voluntarily, I give my consent for the treatment of my pain with narcotic/opioid pain medication (s) and agree to follow this contract's requirements.

Patient Name _____

Patient Signature _____

Date _____ Pharmacy Name _____

Pharmacy Location _____

Provider Signature_____ Date _____

A copy of this document will be part of your medical record, will be kept in your medical file, and will be released as part of the record when records are requested. Upon request, you will be given a signed copy of this agreement on the date signed.

CT Medical Green

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Pain Management
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Phone: 203-874-7001|Fax: 203-874-7002

Patient Registration Form

Date ____/____/____

Patient Name_____ Nickname_____

Date of Birth_____ Social Security Number_____

Marital Status_____ Previous Name_____

Sex ☐ M ☐ F ☐ Other Language_____ Ethnicity _____

Home Phone_____ Is it OK to leave a detailed message? ☐ Yes ☐ No

Work Phone_____ Cell phone_____ Email address_____

Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Home Address_____

Employers name_____

Occupation_____ Former occupation (if retired) _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____

Pharmacy Name_____

Pharmacy Address and Tele #_____

INSURANCE INFORMATION

Primary Insurance _____ Date of Birth ___/___/___ Policy Holder Name_____

Secondary Insurance_____ Date of Birth ___/___/___ Policy Holder Name_____

PROVIDERS

Primary Care provider_____ Phone_____

Referring Physician_____ Phone_____

Patient Name_____ Date of Birth_____

REASON (S) FOR VISIT_____

PAST MEDICAL HISTORY

☐Allergies
☐Anxiety
☐ Anemia

☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Benign prostatic hyperplasia
☐ Bipolar disorder
☐ Cancer
☐ Cerebrovascular accident
☐ COPD
☐ Chronic pain
☐ Coronary arteriosclerosis
☐ Deep vein thrombosis
☐ Depressive disorder
☐ Diabetes mellitus
☐ End-stage renal disease
☐ Epilepsy
☐ Essential hypertension
☐Gastroesophageal reflux disease
☐HIV/AIDS
☐ High Cholesterol
☐Hyperlipidemia
☐Hyperthyroidism
☐Hypothyroidism
☐ Insomnia
☐Inflammatory disease of liver
☐ischemic heart disease
☐ Leukemia
☐Osteoporosis
☐Obesity
☐Obstructive sleep apnea
☐ Sickle cell anemia
☐Substance abuse disorder
☐Thyroid disease
☐Tuberculosis
☐Other_____
☐None

PAST SURGICAL HISTORY

☐Abdominal surgery
☐Cesarean section
☐Coronary artery bypass graft
☐Decompression of the spine
☐Hip surgery
☐Other_____
☐None_____
☐Hysterectomy
☐Knee surgery
☐Lumbar spine surgery
☐Neck surgery
☐Shoulder surgery

MEDICATIONS (include dosage and frequency)

1._____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES: Please list all known allergies and the side effects _____
_____
_____
_____

PAIN HISTORY

How long has the pain been present? _____

Cause of the pain? _____

Location of the pain _____

Type of pain (i.e. sharp, stabbing, shooting, burning, electric dull aching)_____

Time of occurrence (day/night/all the time) _____

Pain is worsened by (i.e. walking, standing etc.) _____

Pain improved with (i.e. sleep, stretching, massages etc.) _____

INTERVENTIONAL PAIN HISTORY

☐None
☐Epidural injection-Cervical
☐Epidural injection-Thoracic
☐Epidural injection-Lumbar
☐Facet Injection-Cervical
☐Facet injection(s) Thoracic
☐ Facet injection (s) Lumbar
☐ Medial Branch Block-Cervical
☐ Medial Branch Block-Lumbar
☐Other_____
☐Medial Branch Block-Thoracic
☐RFA-Cervical
☐RFA-Thoracic
☐RFA Lumbar

SOCIAL HISTORY

What is your smoking status?
☐Current everyday smoker
☐Current some day smoker
☐Former smoker
☐Vape
☐Never smoker
☐Cigar smoker

Do you consume alcohol?
☐None
☐Less than one per day
☐1-2 drinks per day
☐Every day
☐Weekend/special occasion

Do you exercise?
☐Daily
☐1-3 times per week
☐Occasionally
☐Never
☐Other_____

FAMILY HISTORY (If ALIVE write medical condition, DECEASED cause and age at time of death)

Father: _____ Mother _____

Sister (s) _____ Brother (s)_____

Maternal Grandfather _____ Maternal Grandmother_____

Paternal Grandfather _____ Paternal Grandmother _____

MEDICAL CONDITION

☐Cancer_____
☐Heart disease _____
☐Diabetes _____
☐Hypertension _____
☐Stroke/TIA _____
☐Alcohol abuse _____
☐Drug abuse _____
☐Psychiatric illness_____
☐ Seizures _____
☐Depression/suicide _____
☐Osteoarthritis_____
☐Osteoporosis _____
☐Scoliosis _____
☐Other _____

NAMES OF OTHER PROVIDERS/SPECIALISTS you are currently seeing (**include phone number**)

OB-Gynecology _____

Cardiology _____

Pulmonology _____

Endocrinology _____

Neurology _____

Hematology/Oncology_____

Nephrology _____

Orthopedist _____

Podiatrist _____

Geriatrician _____

Other _____

CT Medical Green

ACKNOWLEDGEMENT OF HIPPA PRIVACY PRACTICES

I acknowledge that I have received a copy of a separate document, of a Notice of Privacy Practices which was handed to me by Connecticut Go Green Medical PLLC and my rights regarding privacy of my protected health information. This includes a notice of Privacy Practice-Pharmacy.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

AUDIO/VISUAL ACKNOWLEDGEMENT

In order to better enable us to strictly comply with HIPPA privacy and security laws and regulations, while recognizing the legitimate privacy concerns of our patients and staff, the use of any video or audio recording devices in this office by patients or visitors such as cell phones including but not limited to cameras, audio recorders is strictly prohibited.

We reserve the right to terminate any patient as permitted under the State laws of Connecticut if the patient or anyone accompanying the patient is found to be in violation of this policy.

Patient Signature: _____ Date: _____

Print Name: _____

CT Medical Green

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE- PHARMACY

Patient Name: _____ Date: _____

Date of Birth: _____

I acknowledge that I have received a written copy of a document informing me that Connecticut Go Green Medical will be using an electronic pharmacy system that will permit the viewing of my medication history from external sources such as but not limited to the Pharmacist and pharmacy staff at the pharmacy of my choosing.

Patient Signature: _____ Date: _____

Print Name: _____

TO BE COMPLETED BY THE COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On_____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, however I was unable to:

☐ Patient declined to sign the Written Acknowledgement.
☐ Patient/Caregiver unable to sign the Acknowledgement.
☐ Other _____

Name and Title _____

Employee signature _____

Date_____

CT Medical Green

Patient Name_____ Date of Birth _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please list the name (s) below of anyone who may need to speak to us regarding your appointments, care and medication (s). Please include attorneys, care givers and conservators and anyone who may pick up prescriptions on your behalf.

Connecticut Go Green Medical may release information to the following people

Name_____ Relationship_____

Name_____Relationship_____

The following person (s) are NOT authorized to receive or discuss my health information:

Name _____ Relationship _____

Name _____ Relationship _____

ADVANCED DIRECTIVE

We are dedicated to providing comprehensive care to patients and in following federal guidelines regarding important public health issues.

Please answer the following question.

Are you able to name a primary care giver or surrogate decision maker in the event you are unable, unwilling, or incapacitated?
If yes, please indicate below the name of the individual and their relationship to you.

Name _____ Relationship _____

Phone number_____

If no, please check the box below.

☐I do now wish or am unable to name a primary caregiver or a surrogate decision maker.

Patient Signature _____ Date _____

Print Name _____

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confusion, or other changes in mental state and thinking abilities**. I understand that my decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else if I am in any way sedated, feel drowsy, mentally foggy or not thinking clearly.** These activities may include but are not limited to driving or operating heavy or dangerous machinery, being responsible for another individual who is unable to care for **himself/herself or working in unprotected heights.**

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PATIENTS at least twice per year, testing may be more frequently as deemed necessary. If the patient does not agree to participate in this program, the pain management Provider/Nurse Practitioner will not be able to prescribe or continue to prescribe your medication. Patient agrees If I do not agree to participate in this government mandated program, I will not be able to continue receiving pain medications for the treatment of my pain. I understand my insurance will be billed for the urine test. And by signing this agreement I agree to personally pay the cost of this test if my insurance denies payment. I was informed that I may request a prescription to have the test performed at an outside laboratory. **If I do so, I agree to have the test performed within 2-4 hours of leaving the office** and I will be responsible for the outside laboratory fees if my insurance denies payment.

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By signing this form voluntarily, I give my consent for the treatment of my pain with narcotic/opioid pain medication (s) and agree to follow this contract's requirements.

Patient Name _____

Patient Signature _____

Date _____ Pharmacy Name _____

Pharmacy Location _____

Provider Signature_____ Date _____

CT Medical Green

Connecticut Go Green Medical

Pain Management
31 Cherry St Ste 1
Milford, CT 06460
Phone: 203-874-7001|Fax: 203-874-7002

Patient Registration Form

Date ____/____/____

Patient Name_____ Nickname_____

Date of Birth_____ Social Security Number_____

Marital Status_____ Previous Name_____

Sex ☐ M ☐ F ☐ Other Language_____ Ethnicity _____

Home Phone_____ Is it OK to leave a detailed message? ☐ Yes ☐ No

Work Phone_____ Cell phone_____ Email address_____

Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Home Address_____

Employers name_____

Occupation_____ Former occupation (if retired) _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____

Pharmacy Name_____

Pharmacy Address and Tele #_____

INSURANCE INFORMATION

Primary Insurance _____ Date of Birth ___/___/___ Policy Holder Name_____

Secondary Insurance_____ Date of Birth ___/___/___ Policy Holder Name_____

PROVIDERS

Primary Care provider_____ Phone_____

Referring Physician_____ Phone_____

Patient Name_____ Date of Birth_____

REASON (S) FOR VISIT_____

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PAST MEDICAL HISTORY

☐Allergies
☐Anxiety
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Benign prostatic hyperplasia
☐ Bipolar disorder
☐ Cancer
☐ Cerebrovascular accident
☐ COPD
☐ Chronic pain
☐ Coronary arteriosclerosis
☐ Deep vein thrombosis
☐ Depressive disorder
☐ Diabetes mellitus
☐ End-stage renal disease
☐ Epilepsy
☐ Essential hypertension
☐Gastroesophageal reflux disease
☐HIV/AIDS
☐ High Cholesterol
☐Hyperthyroidism
☐Hypothyroidism
☐ Insomnia
☐Inflammatory disease of liver
☐ischemic heart disease
☐ Leukemia
☐Osteoporosis
☐Obesity
☐Obstructive sleep apnea
☐ Sickle cell anemia
☐Substance abuse disorder
☐Thyroid disease
☐Tuberculosis
☐Other_____
☐None_____

PAST SURGICAL HISTORY

☐Abdominal surgery
☐ Cesarean section
☐Coronary artery bypass graft
☐Decompression of the spine
☐Hip surgery
☐Other_____
☐None_____
☐Hysterectomy
☐Knee surgery
☐Lumbar spine surgery
☐Neck surgery
☐Shoulder surgery

MEDICATIONS (include dosage and frequency)

1._____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES: Please list all known allergies and the side effects _____
_____
_____
_____

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PAIN HISTORY

How long has the pain been present? _____
Cause of the pain? _____
Location of the pain _____
Type of pain (i.e. sharp, stabbing, shooting, burning, electric dull aching) _____
Time of occurrence (day/night/all the time) _____
Pain is worsened by (i.e. walking, standing etc.) _____
Pain improved with (i.e. sleep, stretching, massages etc.) _____

INTERVENTIONAL PAIN HISTORY

☐None
☐Epidural injection-Cervical
☐Epidural injection-Thoracic
☐Epidural injection-Lumbar
☐Facet Injection-Cervical
☐Facet injection(s) Thoracic
☐ Facet injection (s) Lumbar
☐ Medial Branch Block-Cervical
☐ Medial Branch Block-Lumbar
☐Other_____
☐Medial Branch Block-Thoracic
☐RFA-Cervical
☐RFA-Thoracic
☐RFA Lumbar

SOCIAL HISTORY

What is your smoking status?
☐Current everyday smoker
☐Current some day smoker
☐Former smoker
☐Vape
☐Never smoker
☐Cigar smoker

Do you consume alcohol?
☐None
☐Less than one per day
☐1-2 drinks per day
☐Every day
☐Weekend/special occasion

Do you exercise?
☐Daily
☐1-3 times per week
☐Occasionally
☐Never
☐Other_____

FAMILY HISTORY (If ALIVE write medical condition, DECEASED cause and age at time of death)

Father: _____ Mother _____
Sister (s) _____ Brother (s)_____
Maternal Grandfather _____ Maternal Grandmother_____
Paternal Grandfather _____ Paternal Grandmother _____

MEDICAL CONDITION

☐Cancer_____
☐Heart disease _____
☐Diabetes _____
☐Hypertension _____
☐Stroke/TIA _____
☐Alcohol abuse _____
☐Drug abuse _____
☐Psychiatric illness_____
☐ Seizures _____
☐Depression/suicide _____
☐Osteoarthritis_____
☐Osteoporosis _____
☐Scoliosis _____
☐Other _____

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NAMES OF OTHER PROVIDERS/SPECIALISTS you are currently seeing (**include phone number**)

OB-Gynecology _____

Cardiology _____

Pulmonology _____

Endocrinology _____

Neurology _____

Hematology/Oncology_____

Nephrology _____

Orthopedist _____

Podiatrist _____

Geriatrician _____

Other _____

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ACKNOWLEDGEMENT OF HIPPA PRIVACY PRACTICES

I acknowledge that I have received a copy of a separate document, of a Notice of Privacy Practices which was handed to me by Connecticut Go Green Medical PLLC and my rights regarding privacy of my protected health information. This includes a notice of Privacy Practice-Pharmacy.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

AUDIO/VISUAL ACKNOWLEDGEMENT

In order to better enable us to strictly comply with HIPPA privacy and security laws and regulations, while recognizing the legitimate privacy concerns of our patients and staff, the use of any video or audio recording devices in this office by patients or visitors such as cell phones including but not limited to cameras, audio recorders is strictly prohibited.

We reserve the right to terminate any patient as permitted under the State laws of Connecticut if the patient or anyone accompanying the patient is found to be in violation of this policy.

Patient Signature: _____ Date: _____

Print Name: _____

CT Medical Green

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE- PHARMACY

Patient Name: _____ Date: _____

Date of Birth: _____

I acknowledge that I have received a written copy of a document informing me that Connecticut Go Green Medical will be using an electronic pharmacy system that will permit the viewing of my medication history from external sources such as but not limited to the Pharmacist and pharmacy staff at the pharmacy of my choosing.

Patient Signature: _____ Date: _____

Print Name: _____

TO BE COMPLETED BY THE COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On_____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, however I was unable to:

☐ Patient declined to sign the Written Acknowledgement.
☐ Patient/Caregiver unable to sign the Acknowledgement.
☐ Other _____

Name and Title _____

Employee signature _____

Date_____

Patient Name_____ Date of Birth _____

CT Medical Green

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please list the name (s) below of anyone who may need to speak to us regarding your appointments, care and medication (s). Please include attorneys, care givers and conservators and anyone who may pick up prescriptions on your behalf.

Connecticut Go Green Medical may release information to the following people

Name_____ Relationship_____

Name_____Relationship_____

The following person (s) are NOT authorized to receive or discuss my health information:

Name _____ Relationship _____

Name _____ Relationship _____

ADVANCED DIRECTIVE

We are dedicated to providing comprehensive care to patients and in following federal guidelines regarding important public health issues.

Please answer the following question.

Are you able to name a primary care giver or surrogate decision maker in the event you are unable, unwilling or incapacitated?
If yes, please indicate below the name of the individual and their relationship to you.

Name _____ Relationship _____

Phone number_____

If no, please check the box below.

☐I do now wish or am unable to name a primary caregiver or a surrogate decision maker.

Patient Signature _____ Date _____

Print Name _____

CT Medical Green

AUTHORIZATION TO ACCESS/RELEASE MEDICAL INFORMATION

Patient Name _____ Date of Birth _____

Home address _____

Home phone _____ Cell phone _____

I hereby authorize Connecticut Go Green Medical to make uses and disclosures of my protected health information (information about me in my medical records and/or financial records indicated below:

☐ Release information from my record to: _____

☐ Obtain information from: _____

Provider/Facility Name: _____

Address: _____

Description of information to be disclosed/released/accessed and from Dates of Service: _____ to _____

Copy of standard report (please check all that apply):

☐ Most recent visit note ☐ Entire chart ☐Test results/lab test ☐ Consult report

☐Imaging reports of X-ray/MRI and EKG ☐Procedure notes ☐Other_____

I understand that HIV/AIDS related, Substance abuse and mental health information contained within the parts of the records indicated above shall not be transmitted to anyone without written consent or authorization unless otherwise indicated.

By signing this form, I authorize the release of information relating to:

☐Drug and Alcohol ☐HIV/AIDS ☐Mental Health information

Do **NOT** release the following: ☐ Drug and Alcohol ☐ HIV/AIDS ☐Mental Health information

Reason for requested use or disclosure: _____

Who are we sending the record to? ☐Patient ☐Physician/Provider ☐Other

Please indicate how you would like the records sent: ☐ Fax ☐ Email ☐ Mail

Please provide the information: Fax #_____ Attention _____

Email address _____

Address _____

CT Medical Green

AUTHORIZATION TO ACCESS/RELEASE MEDICAL INFORMATION

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- This authorization to release information is effective for a period of one year from the date of signature, unless otherwise specified here. This authorization is effective until _____.
- My decision to revoke this authorization does not apply to any release of my records that may have taken place prior to the date of the revocation if the practice has already taken action.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- I understand that I am not required to sign this form and the practice will not condition treatment, payment, enrollment or eligibility based on my signing of this authorization.
- I understand that I am entitled to a copy of this authorization.
- I understand that there may be a fee for a copy of my medical records.

Patient or patient representative signature Date

Printed name of patient or patient representative Relationship to patient Date

CT Medical Green

FINANCIAL POLICY AND RESPONSIBILITY

The Providers and staff of Connecticut Go Green Medical are dedicated to providing you with the best possible care and service (s). We consider your understanding of our financial policy as an essential element of your care and treatment. Please read the financial policy as it pertains to your responsibility and sign.

INSURANCE: You, the responsible party, are responsible for providing up to date insurance information. We will keep a copy of your insurance card (s) on file. Kindly report any changes to your insurance coverage immediately by telephone or upon arrival to your appointment. If your insurance changes and you do not inform our office, you may be responsible in full for any charges incurred.

REFERRALS: If your insurance plan requires referrals from your PCP to come to our office, YOU are responsible for obtaining the referral. If you do not obtain a referral, you may not be seen or you may be billed for the full amount for services rendered. Please check with your insurance company if you are not sure.

COPAYS: Copays must be paid at the time of service. Please come prepared to pay the specialist copay at each visit or you may not be seen.

DEDUCTIBLES AND COINSURANCES: We will submit your bills to your insurance carrier (s) for processing. All balances will be billed to you and payment is expected upon receipt. If you fail to pay any balance within 90 days, you may not be seen in the office until the balance is settled. Please inquire us if you need a payment plan.

MEDICARE: Medicare patients are responsible for their annual deductible, coinsurance and any non-covered services in which you agree to pay (Advanced beneficiary notice). We will bill your secondary insurance as appropriate to be processed in accordance with your plan. Any balances due after insurance processing will be your responsibility and will be due upon receipt. If you fail to pay any balance within 90 days, you may not be seen in the office util the balance is settled.

MOTOR VEHICLE ACCIDENT: If your charges are related to a MVA and you have Med pay or PIP coverage. We will bill your auto insurance carrier. Any balances not covered by your carrier are your responsibility. We will not suspend collection of your balance until a third-party claim is settled.

PATIENTS WITHOUT INSURANCE: If you do not have insurance, you may be offered a discount rate. Payments are due upon arrival to your appointment, there are no exceptions.

LATE CANCELLATION/NO SHOW FEES: We require 24 hours for cancelling an appointment. If you DO NOT give advance notice or fail to show for your appointment, We reserve the right to charge a $25 fee for a missed appointment and $50 for a missed procedure. The fee must be paid prior to rescheduling the next appointment.

RETURNED CHECKS: All returned checks are subject to a $35.00 service fee.

CT Medical Green

PAST DUE ACCOUNTS: We expect that you will pay your account balance in a timely manner. Any account with a balance over 90 days past due will be referred to an outside collection agency and you will be responsible for any related collection costs.

I have read, understand, and agree to the financial policies of Connecticut Go Green Medical

Patient signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Patient Name_____DOB_____

Patient Signature_____Date_____

SOAPP-R FORM

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 feel free to discuss with your provider or add any relative notes to the bottom of this form. Thank you.

	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
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

Comments:_____

SCORE:

_____