



Welcome to the Connecticut Back Center!

Due to the COVID-19 pandemic, we have made adjustments to the schedule to assure physical distancing. For the protection of all patients and staff, we require that anyone entering the office wear a face covering.

Please arrive 15 minutes prior to your scheduled appointment time, unless you have not completed your new patient paperwork ahead of time, then arrive 30 mins prior.

In addition to the forms requested, please keep in mind that it is your responsibility to provide our office with all of your insurance information prior to being seen by our providers. If your insurance requires a **referral for you to see a specialist**, you are responsible for obtaining that referral, and it must be received by our office prior to your appointment, otherwise we will have to reschedule with you. Referrals can be obtained by your Primary Care Provider.

If you have a **Worker's Compensation** claim, ALL information of the claim must be received by our office prior to your appointment (i.e., date of injury, claim #, etc.)

The following is a list of items you should have available when you come to your appointment:

- Insurance card
- Photo ID
- Co-Payment
- Insurance referral, if required by your health insurance - Please feel free to call our office ahead of time to make sure this has been received.
- Imaging CD's or hard copy: MRI or X-rays. It is imperative that we have access to the actual imaging you've done, not just the report of such imaging.
- Up to date medication list and past medical history

We are excited to see you here at CBC! We thank you for choosing our practice and look forward to working with you.

Sincerely,

Jesse Eister, MD, PhD



CONNECTICUT BACK CENTER

Comprehensive Spinal Care

OUR ADDRESS:

Connecticut Back Center
460 Hartford Turnpike, Suite B
Vernon, CT 06066
Tel: (860) 872-6229

FROM 84 EAST:

Take Exit 64/65. Stay to the right, follow signs for Route 30 North. Bear right at the light at the end of the exit (onto Hartford Turnpike). You will pass Kentucky Fried Chicken at the next light. Continue straight and you will see a Shell Gas Station on your right. Immediately after the Shell Gas Station, take a right into our parking lot. You will see the ECHN DaVita Dialysis building (brick building with blue roof). We are located at the far end of the building. Our entrance faces Hartford Turnpike.

FROM 84 WEST:

Take Exit 65. At the end of the exit, at the light, you will take a right. Continue straight until you see a Shell Gas Station on your right. Immediately after the Shell Gas Station, take a right into our parking lot. You will see the ECHN DaVita Dialysis building (brick building with blue roof). We are located at the far end of the building. Our entrance faces Hartford Turnpike.

CONNECTICUT BACK CENTER

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____

DOB: _____ Gender: _____ Marital Status: S M D W

Ethnicity: _____ Are you a Veteran? YES NO

Primary Care Physician: _____ Referring Physician: _____

How did you find out about us? _____

Primary Insurance:	Secondary Insurance:
ID#:	ID#:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Address:	Policy Holder Address:
Employer:	Employer:
Address:	Address:

Emergency Contact: _____ Relationship: _____ Phone #: _____

Is injury related to: MVA Work _____ If so, Date of Accident/Injury: _____

Do you have an Attorney? Yes No Name: _____ Phone #: _____

Patient Signature: _____ Date: _____



Welcome to CBC! Office Policies

Cancellation Policy:

If you cannot keep an appointment, please call the office to cancel at least 24 hours prior to that appointment. If you do not call the office and do not show up for the appointment, you will be charged \$50.00. This fee is NOT billable to your insurance company and will need to be paid prior to being seen for your next appointment. Of course, consideration is given to appointments canceled due to inclement weather, emergencies, illness, etc.

Payments:

Co-payments are required at the time of your visit (this is an agreement between you and your insurance company). Because of this agreement, we are mandated by your insurance company to **collect your copay at the time of service**. Those patients without health insurance (self-paying) are required to pay a \$350.00 deposit at the time of their visit, and to pay for each subsequent visit at the time of the appointment, unless other arrangements are made with the office prior to the appointment. These visits are to be paid in cash or with credit/debit card.

If a referral is required by your insurance company to see a specialist, you are responsible for obtaining that referral, and it must be sent to our office prior to your appointment by your Primary Care Physician. If it is not received, you will have to reschedule your appointment.

If you have a **worker's compensation claim**, ALL information regarding the claim must be received by our office prior to being seen. If you were involved in a **motor vehicle accident**, we MUST have a letter from your auto insurance company stating whether or not you have medical coverage (MEDPAY) with your policy, prior to being seen.

Paperwork:

If you have paperwork that requires the doctor's completion and signature, please fill out your portion of the form and either mail or bring it to the office. We do our best to have the forms ready for pickup, mailing or faxing within 7-10 business days. **Please note there is a one time fee in the amount of \$30.00 for completion of paperwork.**

Discharge Policy:

It is the policy of this practice to maintain a cooperative and trusting physician-patient relationship with its patients. When such a physician-patient relationship has not been formed or a physician-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of this practice to terminate the physician-patient relationship within the bounds of applicable state and federal laws, rules, and regulations; the American Medical Association guidelines, and this policy so that the patient can develop the type of trusting relationship with another physician that is essential to successful continued care and treatment.

Signature: _____

Date: _____



HIPAA Privacy Restrictions Questionnaire

Patient Name: _____ DOB: _____

May we send statements to your home? Yes No

May we leave messages (including test results) on your answering machine/voicemail? Yes No

May we send you a fax? Fax #: _____ Yes No

May we contact you via email? Email Address: _____ Yes No

Please list names and relationships of persons who we may release information or talk to about your care/appointments

Consent for Treatment/Release of Medical Information

I consent to treatment necessary for the care of the patient listed above. I hereby authorize the release of all medical records to the referring and family physicians.

Signature: _____ Date _____

For restrictions to your protected health information (PHI) other than noted above, please submit in writing to the compliance/privacy officer utilizing our "restriction of use or disclosure of protected health information" (PHI) form.

Financial Responsibility - Insurance Agreement

I acknowledge full responsibility for services rendered and agree to make definite financial arrangements for payment. I understand that the charges for professional services may not be covered fully by my insurance company and therefore, I am solely responsible for payment of all services. I authorize the release of any information necessary to determine liability or payment and to obtain reimbursement on any claims. I authorize that payment of medical benefits be made to Jesse G. Eisler, M.D. I assign the benefits payable to which I am entitled including government, private insurance and other health plans, to Jesse G. Eisler, M.D. This assignment will remain in effect until revoked by me in writing

Signature: _____ Date: _____



Medication Agreement

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of a medication increases certain risks, which include but are not limited to

- Addiction/Dependence
- Allergic reactions
- Overdose
- Drowsiness, dizziness or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting and/or constipation

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from the physician.
2. I understand that due to the high potential of abuse of these medications the following rules apply:
 - I will not be able to obtain early refills or receive replacement of lost or stolen medication.
 - Refills will only be provided during normal business hours and I understand that Connecticut Back Center requests 72 hour notice to refill a medication.
3. I will obtain prescriptions for my spine related issues through Connecticut Back Center, and will fill these prescriptions at my designated pharmacy. In an acute emergency, another provider may prescribe medications for me. If this occurs, I will notify the Connecticut Back Center as soon as possible.
4. I will submit urine or blood tests and pill counts, if requested by my provider, in order to assess my compliance.
5. I agree to keep my regularly scheduled appointments as long as I am taking the medication.
6. If I do not follow these guidelines, I understand that my treatment may be terminated.

Patient Signature:

Date:

Provider Signature:

Date:

PAST MEDICAL HISTORY (Please check all that apply):

CARDIAC: Heart Attack Murmur Abnormal Rhythm Other: _____
PULMONARY: Asthma COPD Emphysema Other: _____
ENDOCRINE: Diabetes Hypothyroid Pituitary Tumor Other: _____
CIRCULATORY: Hypertension Stroke Aneurysm Other: _____

PAST SURGICAL HISTORY (Please list type, date, surgeon/hospital):

MEDICATIONS (If more space is needed, please use back of form or attach list)

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>	<u>DURATION TAKEN</u>
_____	_____	_____	_____
_____	_____	_____	_____

DRUG ALLERGIES: _____

FAMILY HISTORY: (Please check and indicate which parent/sibling and year of illness/death):

CARDIAC:	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Hypertension	_____
PULMONARY:	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Emphysema
ENDOCRINE:	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypothyroid	_____
NEUROLOGIC:	<input type="checkbox"/> Stroke	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Tumor
CANCER:	<input type="checkbox"/> Lung	<input type="checkbox"/> Breast	<input type="checkbox"/> Intestinal
OTHER:	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

SOCIAL HISTORY:

Occupation: _____ How long? _____ Date Unemployed: _____
 Substance Use (Amount/Frequency): Tobacco: _____ Alcohol: _____ Other: _____

REVIEW OF SYSTEMS (Please check all that apply):

Neurologic:	<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory	<input type="checkbox"/> Numbness	Other: _____
Eyes:	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contacts	<input type="checkbox"/> Blurriness	<input type="checkbox"/> Double Vision	Other: _____
Ears/Throat:	<input type="checkbox"/> Deafness	<input type="checkbox"/> Ringing	<input type="checkbox"/> Swallowing	<input type="checkbox"/> Hoarseness	Other: _____
Cardiac:	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Skip Beats	<input type="checkbox"/> Rapid Beat	<input type="checkbox"/> Edema	Other: _____
Pulmonary:	<input type="checkbox"/> Cough	<input type="checkbox"/> Cough Blood	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Short Breath	Other: _____
Intestinal:	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Bleeding	Other: _____
Urinary:	<input type="checkbox"/> Frequency	<input type="checkbox"/> Burning	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Bleeding	Other: _____
Musculoskel:	<input type="checkbox"/> Pain	<input type="checkbox"/> Weakness	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cane/Walker	Other: _____
Endocrine:	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss			Other: _____
Skin:	<input type="checkbox"/> Bruising	<input type="checkbox"/> Lesions	<input type="checkbox"/> Birthmarks		Other: _____
Hematology:	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Transfusion	<input type="checkbox"/> Hepatitis		Other: _____
Psychiatric:	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Fatiguability		Other: _____

Signature: _____

Date: _____

Name:

DOB:

Date:



CONNECTICUT BACK CENTER

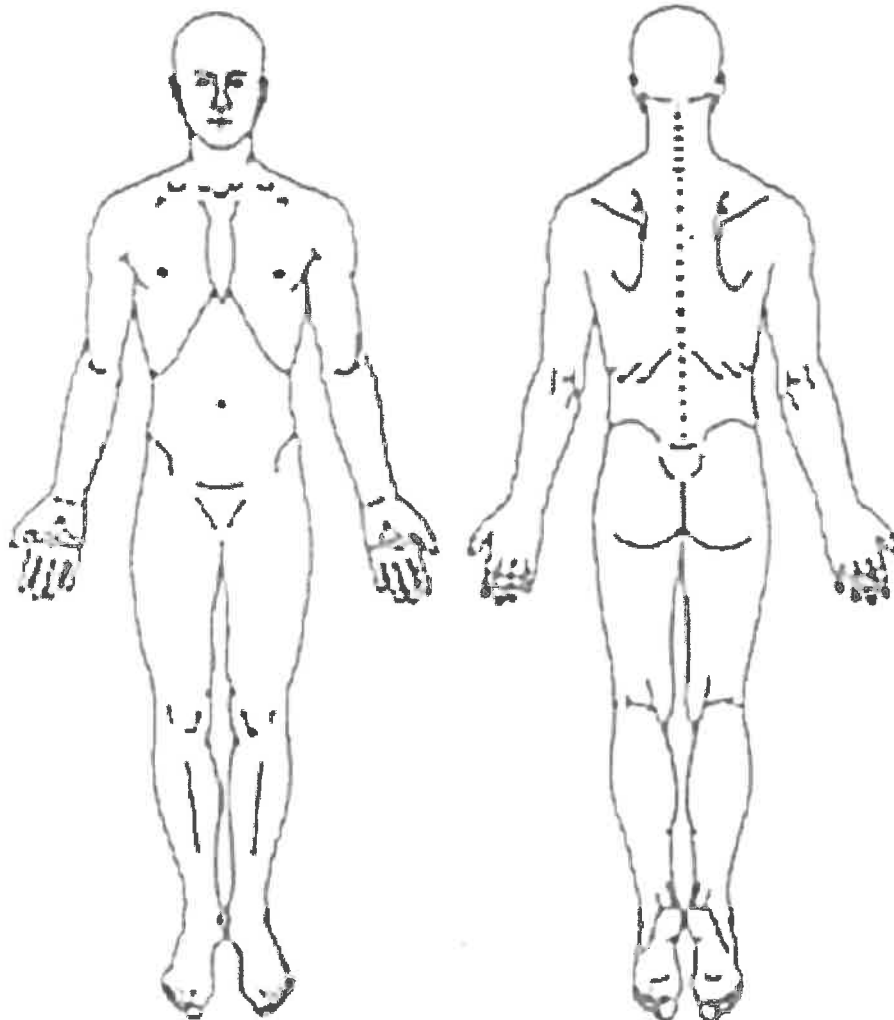
Comprehensive Spinal Care

Spine Intake Form

Please rate the severity of your pain by circling a number below

<i>No Pain</i>	1	2	3	4	5	6	7	8	9	10	<i>Unbearable Pain</i>
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On the diagram below please indicate where you are experiencing your symptoms



A = Ache

B = Burning

N = Numbness

P = Pins and Needles

S = Stabbing

O = Other

How long have your symptoms been present?

Years:	Months	Weeks:
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What makes symptoms worse?

What relieves your symptoms?

Is your pain getting better, worse, or staying the same?

Pain Intensity: Mild Moderate Severe Is it: Constant or Intermittent

What are your main goals for this visit?

Have you fallen in the last year? Yes NO

Are you unsteady on your feet? Yes No

Are you afraid of falling? Yes No

Which of the following treatments have you tried?

Physical Therapy:	Dates:
Aquatic Physical Therapy:	Dates:
Chiropractic:	Dates:
Cortisone Injection:	Dates:
Massage:	Dates:
Other:	Dates:

Height	Weight:
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Oswestry Upper/Lower Back Disability Index

Please answer by circling **ONE** number for each section

Section 1 - Pain Intensity

0. I have no pain at the moment
1. The pain is mild at the moment
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment
4. The pain is very severe at the moment
5. The pain is worst imaginable at the moment

Section 2 - Personal Care (washing, dressing, etc.)

0. I can look after myself normally without causing extra pain
1. I can look after myself normally but it causes extra pain
2. It is painful to look after myself and I am slow and careful
3. I need some help but manage most of my personal care
4. I need help every day in most aspects of self care
5. I do not get dressed, I wash with difficulty and stay in bed

Section 3 - Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives me extra pain
2. Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed
3. Pain prevents me from lifting heavy weights but I manage light/medium weights if conveniently positioned
4. I can lift very light weights
5. I cannot lift or carry anything at all

Section 4 - Sitting

0. I can sit in any chair as long as I like
1. I can sit only in my favorite chair as long as I like
2. Pain prevents me from sitting more than 1 hour
3. Pain prevents me from sitting more than 30 minutes
4. Pain prevents me from sitting more than 10 minutes
5. Pain prevents me from sitting at all

Section 5 - Walking

0. Pain does not prevent me walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ½ mile
3. Pain prevents me from walking more than 100 yards
4. I can only walk using a stick or crutches
5. I am in bed most of the time

Section 6 - Standing

0. I can stand as long as I want without pain
1. I can stand as long as I want but it gives me extra pain
2. Pain prevents me from standing more than 1 hour
3. Pain prevents me from standing more than 30 min
4. Pain prevents me from standing for more than 10 min
5. Pain prevents me from standing at all

Section 7 - Sleeping

0. My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain I have less than 6 hours sleep
3. Because of pain I have less than 4 hours sleep
4. Because of pain I have less than 2 hours sleep
5. Pain prevents me from sleeping at all.

Section 8. - Sex life

0. My sex life is normal and causes no extra pain
1. My sex life is normal but causes some extra pain
2. My sex life is nearly normal but very painful
3. My sex life is severely restricted by pain
4. My sex life is nearly absent because of pain
5. Pain prevents any sex life at all

Section 9 - Social Life

0. My social life is normal and give me no extra pain
1. My social life is normal but increases the degree of pain
2. Pain has no significant effect on my social life apart from limiting my more energetic interests
3. Pain has restricted my social life and I do not go out as often
4. Pain has restricted my social life to my home
5. I have no social life because of pain

Section 10 - Traveling

0. I can travel without pain
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but I manage journeys over 2 hours
3. Pain restricts me to journeys of less than 1 hour
4. Pain restricts me to short necessary journeys under 30 min
5. Pain prevents me from traveling except to receive treatment