CBC
CONNECTICUT BACK CENTER
*Comprehensive Spinal Care*

Welcome to the Connecticut Back Center!

Your first visit is scheduled for an **EMG/NCS** with **Andrew Gregory, PA** on

**Due to the COVID-19 pandemic, we have made adjustments to the schedule to assure physical distancing. Face masks are now optional, however we do encourage unvaccinated patients or patients at high risk to wear a mask.**

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 Eisler, 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.

Name: DOB: Date:

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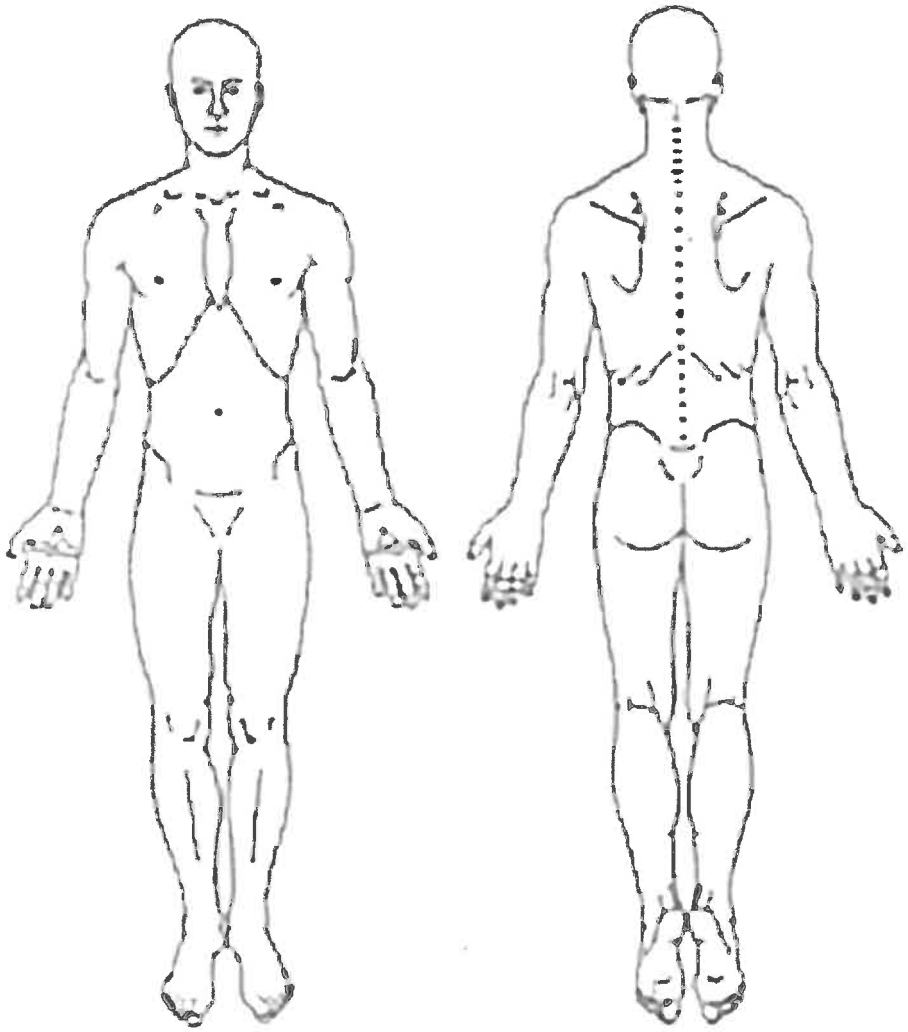
# EMG Intake Form

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

| *No Pain* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *Unbearable Pain* |
|---|---|---|---|---|---|---|---|---|---|---|---|

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

Over →

How long have your symptoms been present?

| Years: | Months | Weeks: |
|---|---|---|

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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www.ctbackcenter.com

# ELECTRODIAGNOSTIC TESTING

## THE ANATOMY:

Nerves and muscles in the human body generate electrical signals that act as a messaging system to and from the brain. There are two types of nerves that deliver these messages. Sensory nerves deliver information about your surroundings to the brain. Motor nerves deliver signals from the brain to activate your muscles. Damage to these nerves and muscles such as injury or disease can alter the movement of these electrical signals, and the productivity of the messaging system. You may experience symptoms such as pain, weakness, numbness or tingling in your back, neck, hands or legs. Electrodiagnostic testing is performed to measure the speed and degree of electrical activity in your muscles and nerves, assisting your doctor in making a proper diagnosis.

## WHAT ARE THE DIFFERENT TYPES OF TESTS?

### -ELECTROMYOGRAPHY (EMG):

An EMG test is performed to record and analyze the electrical activity in your muscles. When a normal muscle is at rest, it is electrically silent. During an EMG, small, thin, sterile needles are placed into the muscle recording its electrical activity. Insertion of the needles may cause some initial pain and discomfort. The doctor will then instruct you to relax the muscle and then to tense it slightly. When the needles are removed you may experience some soreness and bruising, but these effects will dissipate after a few days. There are no long-term side effects. The test is completed in less than an hour.

## NERVE CONDUCTION STUDY (NCS):

NCS are often done along with EMG's to determine if a nerve is functioning normally. This test is comprised of a series of electrodes being placed on the skin in various places along the nerve pathway. The technician will then stimulate the nerve with an electrical current. As the current travels along the nerve pathway, the electrodes pick up the signal and time how fast it is traveling. If the nerve is damaged the signal will be slower and weaker. The initial stimulation may be startling, though it is not painful and most people are comfortable during the testing.

## WHY DO I NEED ELECTRODIAGNOSTIC (EDX) TESTING?

An EMG/NCS test is performed to measure and analyze the electrical activity in your muscles and nerves. It is specifically used to gain information about the functioning of the nerves in your arms and legs. The results of this test will help to accurately

**Jesse G. Eisler, MD, PhD**

460 Hartford Turnpike
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Vernon, CT 06066

diagnose the cause of your symptoms such as numbness, tingling pain, muscle weakness and cramping. These tests can also help to find the exact location of your problem and document the age, severity, and prognosis of your condition.

I HAVE ALREADY HAD AN MRI. WHY DO I NEED MORE TESTS?

MRI and CT scans are very good ways to see structure. Eletrodiagnostic tests measure function. Sometimes a person may have a normal looking MRI but still have a loss of function. MRI's often show changes in structure that may or may not be related to your condition (this is a false positive). EDX testing will help your doctor know if there is a change in the function of your muscles and nerves. Loss of function may or may not relate to changes in physical structure.

HOW LONG WILL THESE TESTS TAKE?

Depending on your particular situation, your entire appointment may take from 30 to 90 minutes. Proper testing requires us to be thorough and test times may vary from patient to patient.

ARE THRE ANY LIMITATIONS BEFORE OR AFTER TESTING?

You can do any of your normal activities before and after the test. There are no dietary restrictions. Pain medications and muscle relaxers will not affect the test.

- Avoid Tobacco and caffeine two hours before the test.
- If you have myasthenia gravis, call and ask if you should take any medications before the test.

PLEASE let us know beforehand if you:

- Have a pacemaker
- Have an indwelling catheter
- Have a clotting disorder
- Take blood thinners (Such as Coumadin, Plavix, Aspirin)
- Are pregnant

Clothing: The technician will need to test your arms/legs and/or back. Please wear loose fitting clothing. Do not wear jeans. You may be required to change into a medical gown.

Skin: **Please do not use any body lotion, bath oils or creams on the day of your test.** These lotions may interfere with the results.

HOW SOON WILL I KNOW THE TEST RESULTS?

After the examination, check with your referring doctor to find out what the next step in your case will be. Results are typically available within 24-48 hrs.

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Patient Name:_____ Date:_____

Your signature on this document indicates you understand the following and consent to electrodiagnostic (EDX) testing. The following information will help you understand the procedures to be performed and risks involved so you can be an informed patient.

The studies to be performed typically include a physical examination of the injured and related body parts. You may be required to wear a gown. If you feel uncomfortable during this portion of the test you may tell the examining doctor or ask questions at any time.

Part of your neurodiagnostic study may include a nerve conduction velocity study, NCV, which is a way to help determine the location and severity of various nerve problems. This test involves a small stimulation (similar to static electricity) applied to your arm and/or leg and may produce a tingling/buzzing sensation or brief muscle twitch.

Part of your neurodiagnostic study may include electromyographic studies, EMG. This test allows us to measure the health of involved muscles with a small electrode. This pin electrode is disposable and pre-packaged as sterile and never pre-used or re-used. The electrode is roughly as thin as an acupuncture needle. Some risks that may occur as a result of EMG testing include bruising, discomfort, bleeding, or possible infection or allergic reaction. While there may be a slight amount of discomfort involved during portions of EDX testing, it is typically well tolerated by the vast majority of patients. **Please tell the doctor if you take any blood thinning medications, have an implanted cardiac defibrillator or indwelling catheter or if you have an infectious disease that is transmittable.**

| | | |
|---|---|---|
| Do you have a history of diabetes, thyroid or small vessel disease? | ☐ Yes | ☐ No |
| Have you been diagnosed with HIV, Hepatitis or Tuberculosis? | ☐ Yes | ☐ No |
| Are you pregnant? | ☐ Yes | ☐ No |
| Do you have any implanted metallic devices? | ☐ Yes | ☐ No |
| Do you have an implanted cardiac defibrillating device or pacemaker? | ☐ Yes | ☐ No |
| Do you have an indwelling catheter? | ☐ Yes | ☐ No |
| Do you take blood-thinning medication or have a clotting disorder? | ☐ Yes | ☐ No |
| Do you have any other known diseases or impairments? | | ☐ No |

☐ If Yes, please inform the examining doctor _____

Patient Signature: _____ Date: _____

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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:**

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# 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 $200.00 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 with a 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 fee in the amount of $30.00 for completion of paperwork that is good for 1 year from the date of payment. If you are requesting Medical records, there is a fee of $0.65/page unless being directly sent to another provider.***

**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.

**Patient Signature:** _____ **Date:** _____

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# 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:** _____

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# 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:** _____

## 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)

| MEDICATION | DOSAGE | FREQUENCY | DURATION TAKEN |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**DRUG ALLERGIES:** _____

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

| | | | | |
|---|---|---|---|---|
| **CARDIAC:** | [ ] Heart Attack | [ ] Hypertension | | _____ |
| **PULMONARY:** | [ ] Asthma | [ ] COPD | [ ] Emphysema | _____ |
| **ENDOCRINE:** | [ ] Diabetes | [ ] Hypothyroid | | _____ |
| **NEUROLOGIC:** | [ ] Stroke | [ ] Aneurysm | [ ] Tumor | _____ |
| **CANCER:** | [ ] Lung | [ ] Breast | [ ] Intestinal | _____ |
| **OTHER:** | [ ] _____ | [ ] _____ | [ ] _____ | _____ |

## SOCIAL HISTORY:

Occupation: _____ How long? _____ Date Unemployed: _____

Substance Use (Amount/Frequency: Tobacco: _____ Alcohol: _____ Other: _____

## REVIEW OF SYSTEMS (Please check all that apply):

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

Signature: _____ Date: _____ rev 7/2014