Orthopedic Surgery
William Lohrer, MD

Physiatry
Wei Xu, MD

Radiology
Yvette Bailey, MD

Neurology
Shutish Patel, MD
Robert Berland, MD

Chiropractic
Dr. Steven Shaw
Dr. Rocco Giordano
Dr. Monica Nowak
Dr. Joseph Giannattasio
Dr. Ken Demarest
Dr. Pawel Markowicz
Dr. Richard Cohen
Dr. David Miller

Nurse Practitioner
Kevin Dinsmore, APRN

Physical Therapy
Svetlana Gitelman, PT
Paul Knecht, PT
Jan Violette, PTA
Maria Mouser, PTA

Hartford
36 Grand Street
Hartford, CT 06106
(860)-522-2225
(860)-493-2509 (fax)

Hartford
43 Woodland Street
Hartford, CT 06105
(860) 801-6175
(860) 924-0934 (fax)

New Britain
136 West Main Street
New Britain, CT 06052
(860)-225-7429
(860)-826-4762 (fax)

East Hartford
290 Roberts Street
East Hartford, CT 06108
(860)-290-3788
(860)-290-3789 (fax)

Middletown
62 Washington Street
Middletown, CT 06457
860-788-3975
860-788-3631 (fax)

Waterbury
140 Grandview Avenue
Waterbury, CT 06708
203-405-8887
475-274-0657 (fax)

HOM
HARTFORD ORTHOPEDIC MEDICINE

860-249-4466 • 860-249-4469 {Fax}

WELCOME!

Hartford Orthopedic Medicine (HOM) integrates the very best of Central and Western Connecticut's outstanding history of providing the best, most comprehensive treatment to injured patients.

Over thirty years of experience in the medical-legal arena with specific medical specialties in the area of Orthopedics, Physiatry, Neurology, Diagnostic & Interventional Radiology, Chiropractic, and Physical Therapy; work to create a collaborative environment where your injuries are treated, and beneficial reporting and documentation are maintained.

We welcome you to our practice but need your help too. Our goal is to provide you with efficient and superior healthcare and if you're being represented in a legal action, to provide your representing attorney's office with all the forms, data, documentation, and expertise they need. We're on the same team on your journey and expect all our patients to be honest with us, be respectful, keep all their appointments, and take their treatment plan seriously.

Please complete the following paperwork to the best of your ability. If you need help, we'd be happy to assist you when you arrive in our office but getting through most of this before you come in does save time and ensure accuracy.

- **CONFIDENTIAL PATIENT INFORMATION** provides us with all the necessary information to effectively open a patient treatment file with our practice and adequately address all your areas of concern.
- **QUESTIONS ABOUT YOUR PAIN AND THE ACCIDENT** will help our office staff and doctors identify your problem areas and develop the best course of treatment.
- **INFORMED CONSENT** will help you understand some of the processes, diagnoses, treatments, orders, and other modalities that we may administer in association with your care. Always feel free to ask us questions about your treatment plan.
- **SECURITY AGREEMENT** explains your rights and responsibilities associated with our charges. HOM does not participate with insurance so we can treat you effectively, not just what the insurance company will pay for. We work with your representing attorney in your best interest, when it comes to managing our fee(s).
- **PRIVACY NOTIFICATION** explains your rights to privacy under federally-regulated HIPAA regulations and lets us know with whom we can share your information.
- **MEDICAL RELEASE AUTHORIZATION** gives us your permission to share your medical records with your attorney and co-treating doctors, and also gives us your permission to request your medical records from a hospital, urgent care, or other doctor who may have treated you for this same accident.

Together, we will work to help you manage your treatment and make this difficult journey a bit more bearable. We're here for you and care because you care!

Follow us on 𝕏 for updates and weather closings. - @HfdOrtho

HOM
HARTFORD ORTHOPEDIC MEDICINE

CONFIDENTIAL PATIENT INFORMATION

Completing these pages accurately will help us with your treatment, as well as provide the best documentation associated with your injury. You will be offered help and given an opportunity to ask questions at your first appointment. Please make every effort to complete this information completely and accurately.

PERSONAL INFORMATION

Patient Full Name:		Date of Birth:	Today's Date:
Street Address:		City, State, Zip Code:	
Gender: ❑Male ❑Female	Social Security Number:	Driver's License or Other ID Number:	State:
Home Phone Number:	Cell Phone Number:	E-mail Address:	
Marital Status: ❑Single ❑Married ❑Divorced/Sep. ❑Widowed ❑Other		If Married, Name of Spouse:	
Employer Name and Location:		Employer Phone Number:	
Emergency Contact Name and Relationship:		Emergency Contact Phone Number:	

Auto Insurance

Name of Automobile Insurance Company:		Name of Insured:
Insurance Company Address:		City, State, Zip Code:
Accident Claim Number:	Name of Adjuster:	Adjuster's Phone Number with Extension:

Health Insurance

Name of Health Insurance Company:		Name of Insured:
Insurance Company Address:		City, State, Zip Code:
Group, Plan, or Patient ID Number:		Insurance Company Phone Number:

Attorney

Name of Attorney And Law Firm:		
Attorney Address:		City, State, Zip Code:
Attorney Phone Number:	Attorney Fax Number:	Attorney E-Mail Address:

1. Is your injury the result of an accident?	❑Yes ❑No
2. What date and time (if known) did the accident or injury occur?	
3. What is the Type of your accident?	❑Auto ❑Work-Related ❑Slip & Fall ❑Other
4. How long have you been experiencing the symptoms of your injury?	
5. Are your symptoms getting worse?	❑Yes ❑No ❑Constant ❑Comes/Goes
6. If your accident happened at work, briefly explain what happened?	

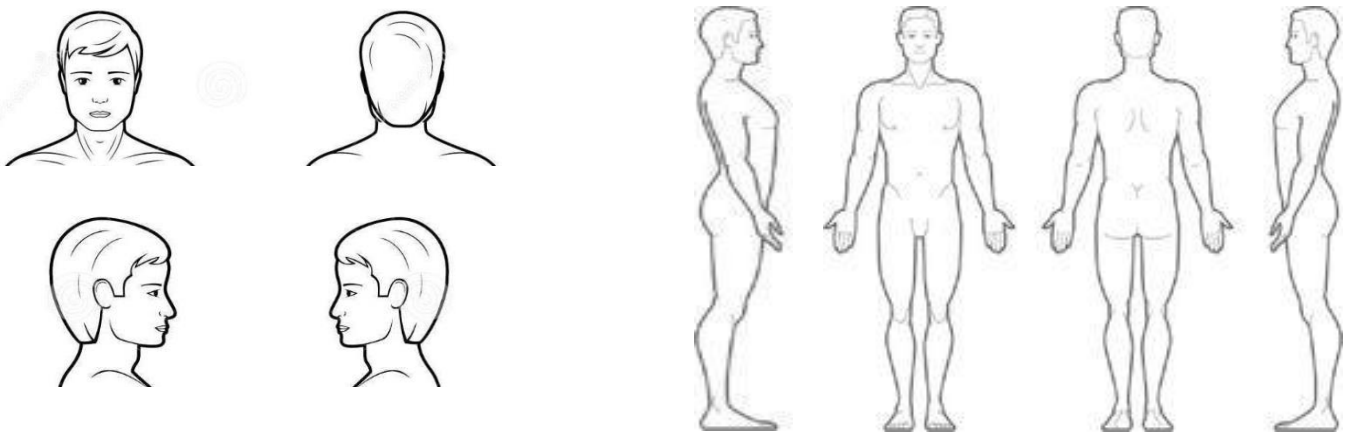
Please List Any Medications You are Currently Taking:

Please List Any Recurring Medical Problems You Have (Diabetes, High Blood Pressure, Cancer, Etc.):

Please List Any Prior Motor Vehicle Accidents, Slip & Falls, or Work Injuries You Might Have Had:

If Female, Are You Pregnant? ❑Yes ❑No ❑Maybe		If Yes, How Long? ❑0-3 Mos. ❑3-6 Mos. ❑6-9 Mos. ❑Unknown	
Do You Smoke? ❑Yes ❑No	If Yes, How Often?	Do You Drink Alcohol? ❑Yes ❑No	If Yes, How Often?

On The Figures Below, Please Mark Your Areas of Pain and/or Discomfort:



Please Indicate Further, any Symptoms or Complaints You've Experienced After This Accident:

Head and Sensory	Upper Muscle Pain	Back and Extremity Pain	Lower Extremity Pain
❑Concussion with or without Loss of Consciousness	❑Face or Jaw Pain	❑Elbow Pain – Left or Right	❑Hip Pain – Left or Right
❑Blurred Vision	❑Neck Pain – General	❑Wrist Pain – Left or Right	❑Knee Pain – Left or Right
❑Cognitive Impairment (Confusion)	❑Neck Pain – Left or Right	❑Hand Pain – Left or Right	❑Ankle Pain – Left or Right
❑Dizziness / Vertigo	❑Trap Pain – Left or Right	❑Upper Back Pain	❑Foot Pain – Left or Right
❑Nausea / Upset Stomach	❑Shoulder Pain – Left or Right	❑Rib, Side, or Chest Pain	❑Numbness in Leg(s)
❑Headaches / Migraines	❑Numbness in Arm(s)	❑Lower Back Pain	❑Pain Radiating into Leg(s)
❑Ringing in the Ear(s)	❑Pain Radiating into Arm(s)	❑Other:	❑Other:

INFORMED CONSENT AND TREATMENT AGREEMENT

Read this information carefully. You will be given an opportunity to ask questions of your provider during your first encounter, prior to any treatment being ordered, prescribed or administered.

As a patient of Hartford Orthopedic Medicine (HOM), your care team may determine your course of treatment will involve the use of **orthopedic, pharmacologic, diagnostic/interventional radiology, neurologic, physiatric, chiropractic, physical therapy treatment(s)** or any combination of those specialties. the risks involved with your care is considered to be minimal due to the nature of the examinations and applied methods of treatment. However, it is HOM's policy that all patients are fully informed of the nature of care, purposes of examination/treatment, risks involved, as well as alternatives available to them prior to beginning their care. The nature of your examination may be inclusive to evaluative and treatment procedures involving participation on the part of the patient. Movement on the patient's part to identify and diagnosis injury and/or illness may result in momentary and/or heightened discomfort. Additionally, in rare occurrences injuries may be further agitated by the evaluation process and result in pain or discomfort being protracted or exacerbated. Other diagnostic tests may include certain sensory, cognitive, vestibular (balance), nerve conductivity, pain assessment, oculomotor, or similar tests and assessments.

Treatment for injuries may include the use of exercises, manipulation, injections, or pharmaceuticals. Although these procedures may involve a short period of discomfort at the point of injection, it is important to note that all precautionary measure have been taken and are observed during such procedures to minimize discomfort and combat risks of infection. I understand a member of my clinical care team may recommend the use of injections (TrP, ESI, etc.) as part of my care and treatment. I give my consent to the use of such procedure should it be called for as part of my treatment.

I understand prescribed medications may also be included with my treatment plan and produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance, self-discipline in not abusing the medication. The use of controlled medications such as opioids, stimulants, anxiolytics and benzodiazepines are effective to maximize treatment outcomes, but prescribed with utmost care and only under the judicious supervision of my HOM prescriber, in conjunction with strict patient compliance, to which compliance I agree and pledge to adhere.

Alternative methods of treatment can include self-administered exercise/therapy, over-the-counter analgesics, rest, hospitalization and surgery. I understand the risk associated with overuse of over-the-counter medications, risks associated with surgery, and the risk associated with not adhering to my treatment plan.

If my treatment plan includes (or will include) the implementation of **chiropractic manipulation and treatment**, I understand and give consent to the following:

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT
The Chiropractor will use their hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "POP" or "CLICK" much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications Include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

THE PROBABILITY OF THOSE RISKS OCCURRING
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

ANCILLARY TREATMENT

In addition to chiropractic adjustments (manipulation) you may receive supportive treatments which will further assist in the management of your condition. While the risk of complication is low there is the possibility of side effects such as burns, soreness, skin irritation, etc. Some of the additional treatments which may be provided include hot moist heat, diathermy, ultrasound, TENS, electrical muscle stimulation, interferential therapy as well as multiple other modalities which have thermal, mechanical and chemical effects.

If my treatment plan includes (or will include) the implementation of **physical therapy or athletic training**, I understand and give consent to the following:

Physical Therapy is the treatment of physical dysfunction or injury by the use of therapeutic exercise and the application of modalities, intended to restore or facilitate normal function or development. Physical Therapy aids in the prevention or minimization of residual physical disability and assists patients in achieving their maximum potential health or level of recovery. This treatment is performed through evaluation, examination and employing rehabilitative procedures, manipulations, massage, exercise and physical agents including, but not limited to mechanical devices, heat, cold, electrical stimulus and sound vibration in the aid of diagnosis and/or treatment.

The inherent risk of Physical Therapy treatment exists due to the nature of the treatment which asks for exerted effort and the performing of physical activities with increasing degrees of resistance. Our physical therapist or physical therapist assistant(s) will take every precaution to ensure the safety of our patients during their treatments. Any risk is minimized with your and the therapist's control over procedures and ability to stop or decrease activities should they result in an increase of pain and/or discomfort beyond that of rehabilitative benefit.

THE RISKS AND DANGERS ASSOCIATED WITH REMAINING UNTREATED

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND ALL THE ABOVE

I have read or have had read to me the above explanations of treatment associated with the different specialties of HOM and the ones that apply to me and my treatment plan. I understand my care team has been carefully assembled, based upon my health concerns and complaints, to best address my unique issues and injuries. By signing below, I acknowledge that I have considered the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the diagnostic procedure(s) treatment(s) recommended. Having been informed of the risks and afforded ample opportunity to ask questions of my HOM provider(s), I hereby give consent to that treatment.

SIGNATURE OF PATIENT _____ DATE _____ PRINTED NAME _____

If patient is a minor:

I hereby request and authorize Hartford Orthopedic Medicine to perform Chiropractic treatment on the minor patient named above.

Under the terms and conditions of my divorce, separation or other legal authorization if applicable, the consent of a spouse/former spouse of other parent is not required. If my authorization to select and authorize this care is to be revoked or modified in any way, I will immediately notify this office.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____ PRINTED NAME _____

SECURITY AGREEMENT & ASSIGNMENT OF INTEREST IN PERSONAL INJURY CLAIM

Patient Name:_____ **Date of Injury:**_____

In exchange for good and valuable consideration, services provided by Hartford Orthopedic Medicine (Hereinafter "HOM") and the promise to provide services by HOM the receipt of which is acknowledged, I:

1. Grant a lien to HOM for its professional services, medical bills, and charges for any and all treatment whatsoever, and costs against any and all settlement or judgment arising from my personal injury claim as a result of my accident. Cost such as medical report fees and record copying fees, which are incurred by HOM in providing services to my attorney and me, will be deducted from any net recovery at the time of settlement or verdict in my personal injury case.

2. Understand that HOM does not contract with any managed care organizations and my health insurance may have policy limits that do not cover services provided by HOM, my basic reparation benefits or med-pay insurance may not be available to cover HOM expenses, I may have no collateral or third party source of payment, and the courtesy of credit from HOM will be extended only when payment is securely protected.

3. Understand that HOM does not participate with my managed care organization and that the services provided to me may not be included in my insurance plan's out of network benefits.

4. Assign an interest to HOM for its professional services, medical bills, and charges for any and all treatment whatsoever, and costs against any and all settlement or judgment arising from my personal injury claim as a result of my accident. Costs such as medical report fees and record copying fees, which are incurred by HOM in providing services to my attorney or me, will be deducted from any net recovery at the time of settlement or verdict in my personal injury case.

5. Assign my rights to receive health care payments from negligent parties or from insurance companies. Payments are made to: **Hartford Orthopedic Medicine, 136 West Main St., New Britain, CT 06052.**

6. Authorize and direct my attorney to pay from my personal injury proceeds such sums as may be due and owing for services rendered to me, by any reason, which are due to HOM, and to withhold such sums from any settlement, judgment, or verdict from disbursement to me as may be necessary to adequately protect and pay HOM

7. If the parties cannot agree upon the reasonableness of a bill or costs, or a dispute arises, I agree and understand that my attorney will be required under Professional Rule of Conduct 1.15(b) to hold the amount of money in dispute. If the parties cannot agree upon the reasonableness of a bill or costs, or a dispute arises, then the parties agree, and I, hereby, agree and stipulate to participate in binding arbitration within thirty days of receipt of personal injury proceeds by my attorney.

8. Understand that the bill for treatment and services are my responsibility and I am obligated to pay the bill regardless of the outcome of my case. My financial responsibility is not contingent upon a favorable settlement or judgment of a personal injury claim. I have been informed that, by acceptance of partial payment from a third party, HOM does not accept the partial payment as payment in full. When partial payment occurs, it has been explained to me that HOM will balance bill me for any outstanding balance. I have reviewed the fee schedule posted in the office and agree to receive services and be responsible for my bill. I acknowledge that this agreement is made for additional protection and in consideration of the courtesy of HOM awaiting payment.

I have read this document and fully understand it and agree to the content

_____ _____

Patient's Signature Date

PRIVACY INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of HOM, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of HOM. This includes sharing billing and health information with your representing attorney(s). These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical staff, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical personnel that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required By Law, Public Health issues as required by law: Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

Those with whom you authorize access to your health information including billing and financial information {Other than representing attorney(s) or co-treating healthcare facilities or provider(s)}:

Name	Relationship
Name	Relationship
Name	Relationship

Patient's Signature: _____ Date: _____

Witness Name: _____ Signature: _____

HOM
HARTFORD ORTHOPEDIC MEDICINE

136 West Main Street • New Britain, Connecticut 06052
(Phone) 860-249-4466 (FAX) 860-249-4469
www.Hartford-Ortho.com

MEDICAL RECORDS REQUEST/RELEASE AUTHORIZATION

By signing this form below, I authorize Hartford Orthopedic Medicine to use, receive, release or disclose the below indicated protected health information. The patient or their representative may revoke this authorization by notifying in writing HOM's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient. This Records Request/Release Form shall expire exactly one year from the signature date indicated below.

Person or Organization from whom records are being requested or to whom records should be released:

_____

Purpose for use, release or disclosure of protected health information:

_____

Protected Health Information to be sent to ***HOM, 136 W. Main St. New Britain, CT 06052 – 860-249-4469 {Fax}***

- ❑ Copies of all medical records for the period of _____to _____
- ❑ Copies of the information described below for the period of _____ to _____
- ❑ Examination Reports
- ❑ Lab, X-Ray, ED, Etc. Reports
- ❑ Reports and records from other physicians
- ❑ Other: _____

I understand that the following protected health information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions of a sensitive nature.

I authorize this information to be transmitted by way of ground parcel, fax, certified mail, electronic or direct delivery to, or pick up from ***Hartford Orthopedic Medicine.***

I am fully aware of my right under HIPAA regulations and have signed a copy of HOM's Notice of Privacy Practices. I have discussed any concerns I have with the release, use or disclosure of my protected health information with HOM's Privacy Compliance Officer and/or other appropriate office personnel.

I understand that HOM assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release HOM form all legal liability that may arise from the authorization.

Patient's Name:_____ Signature:_____ Date:_____

Patient's Date of Birth:_____ Social Security Number:_____

If Minor, Parent/Guardian Signature:_____ Date:_____