NEW ENGLAND STEM CELL INSTITUTE

59 SYCAMORE ST. STE 301
GLASTONBURY, CT 06033

Directions to Glastonbury Office

From Points North:
Take **I-91 South** toward Hartford
Take **Exit 30** on the left to merge onto **I-84 East** toward **CT-2**/East Hartford/New London
Take **Exit 55** to merge onto **CT-2 East** toward **Norwich/New London**
Take **Exit 8** for **CT-94/Hebron Avenue**
At the end of the ramp go across Hebron Avenue onto Sycamore Street and #59 is on your left.

From Points South:
Take **I-91 North**
Take **Exit 25** to merge onto **CT-3 North** toward Glastonbury
Take the exit onto **CT-2** East toward Norwich
Take **Exit 8** for **CT-94/Hebron Avenue**
At the end of the ramp go across Hebron Avenue onto Sycamore Street and #59 is 0.1 miles on your left..

From Points West:
Take **I-84 East** towards Hartford.
Take **Exit 55** to merge onto **CT-2 East** toward **Norwich/New London**
Take the exit onto **CT-2 East** toward Norwich.
Take **Exit 8** for **CT-94/Hebron Avenue**
At the end of the ramp, go across Hebron Avenue onto Sycamore Street and #59 is 0.1miles on your left.

From Points East:
Take **Route CT-2 West**
Take **Exit 8** for **CT-94/Hebron Avenue.** Take a right off exit on to Oak street then take your next left at traffic light onto CT-94/Hebron Ave. Follow Hebron Ave for 0.5 miles and then at the next traffic light/intersection take a left on to Sycamore street. #59 will be 0.1miles down on the left.

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Non-Participating Waiver

I _____, fully understand that New England Stem Cell Institute is completely out of network and / or have opted out of network with all insurance companies, including Medicare and Medicare Advantage plans.*

My claim will not be submitted to my insurance company. Payment is due in full on the date of service.

Patient Signature: _____

Date: _____

Witness Signature: _____

*Our services are not covered by Medicare, and no Medicare payment will be made to either the practitioner or to the patient for our services, as the practitioner has opted out of Medicare.

- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c06.pdf

NEW ENGLAND STEM CELL INSTITUTE

NEW PATIENT REGISTRATION - PLEASE COMPLETE ALL INFORMATION

Patient Name _____ Date _____

Date of Birth _____ Age _____ Marital Status (circle): S M D W Sep

Race: ___American Indian/Alaska Native ___Asian ___Hawaiian/Pacific Islander ___Black or African American ___Hispanic ____White ____Other ___Declined to Answer

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Declined to Answer

Preferred Language: ____English ____Spanish ____Other_____

Mailing Address _____ City _____ State _____ Zip _____

Street Address (if different) _____ City _____ State _____ Zip _____

Telephone: Cell: _____ Home:_____ Work: _____ **E-mail:** _____

Primary Care Doctor: Name _____ City _____ Phone _____

Spouse's Name _____ Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Who referred you to our practice? (so we may thank them!): _____

PATIENT EMPLOYER INFORMATION

Employer Name _____ Phone_____ Occupation _____

Employer Address _____ City_____ State_____ Zip _____

INSURANCE INFORMATION (for outside imaging / labs only)

PRIMARY INSURANCE _____ ID # _____ Group # _____ Eff Date _____

Policy Holder Name _____ Relationship _____ D.O.B._____

Policy Holder Place of Employment _____ City_____ State_____ Zip _____

SECONDARY INSURANCE _____ ID # _____ Group # _____ Eff Date _____

Policy Holder Name _____ Relationship _____ D.O.B_____

Policy Holder Place of Employment _____ City_____ State_____ Zip _____

PLEASE NOTE WE DO NOT TAKE PERSONAL INJURY, CAR ACCIDENT, OR WORK INJURY

If your injury is related to a personal injury, work injury or car accident we will need documentation that the case is closed.

AUTHORIZATION TO RELEASE INFORMATION

I understand that I am ultimately responsible for all medical costs incurred as a result of my receiving treatment in this office. I understand my bill will not be submitted to my insurance, as New England Stem Cell Institute is out of network with all insurance carriers. I agree to pay the bill in full on the date of service unless prior arrangements have been made with the billing office prior to the appointment. I understand and agree that my credit card on file will be charged for any account balance past due 60 days from the date of service.

Signature _____ Date _____

Patient (or Parent/Guardian)

PATIENT MEDICAL HISTORY

Name _____ Age: ____ Date of Birth: _____ Date:_____

Who referred you?_____

What is the main problem for which you are seeking medical attention?

_____

_____

When did this problem begin? _____ Is this problem a result of (circle one): Sports MVA Work Other

Please give details of how your pain/injury occurred:

_____

_____

_____

What types of treatment have you tried for THIS problem?

	Dates	Please Describe
Surgery		
Injections		
Medication		
Chiropractic		
Physical Therapy		
Acupuncture		
Massage		
Other		

What diagnostic studies have been done for THIS problem?

	Dates	Results		Dates	Results
X-rays			**MRI**		
CT can			**Bone Scan**		
Other					

On a scale of 1-10 (10 = worst) how would you rate your pain? (Circle one)

At Best: 1 2 3 4 5 6 7 8 9 10

At Worst: 1 2 3 4 5 6 7 8 9 10

At Present: 1 2 3 4 5 6 7 8 9 10

Is your pain getting (circle one): Getting Better Getting Worse Staying the Same

What makes your pain worse?

_____

What makes your pain better?

_____

How would you describe the nature or character of your pain?

_____

Where is the majority of your pain located?

_____

Does your pain or symptoms travel or radiate to other areas? If yes, describe:

_____

_____

Have you had the same or similar injuries/problems in the past (circle)? No Yes If "Yes", please describe:

_____

How much do you:

smoke: never _____

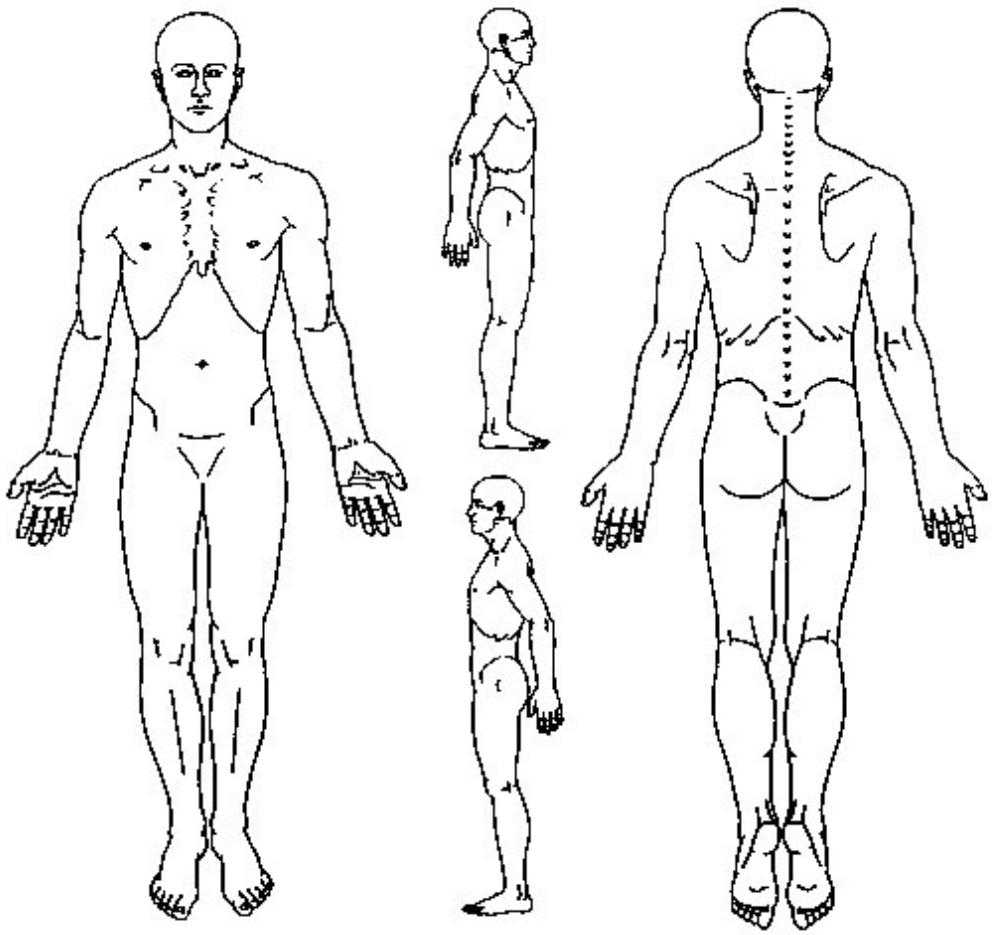
packs/day x _____ years _____

drink alcohol: never____

type _____ amount_____

CURRENT MEDICATIONS (including vitamins)	ALLERGIES (describe reaction)

PLEASE INDICATE BOTH THE LOCATION AND NATURE OF YOUR PAIN ON THE DIAGRAM BELOW:



Numbness	Pins & Needles	Burning	Ache	Stabbing
= = =	O O O	x x x	Λ Λ Λ	/ / /

FAMILY HISTORY

	If Living		If Deceased	
	Age	**Health Problems**	**Age**	**Cause of Death / Health Problems**
Father				
Mother				
Brother(s)				
Sister(s)				

CURRENT MEDICAL PROBLEMS (FOR WHICH YOU ARE UNDER TREATMENT)

HOSPITALIZATIONS AND SURGERIES

Date	Reason	Date	Reason

MEDICAL HISTORY -- please check all past and current conditions

HEENT		**ENDOCRINE**		**MUSCULOSKELETAL**	
Headaches (other than migraine)		Diabetes (insulin-dependent)		Herniated Disc	
Migraines		Diabetes (non-insulin depend)		Location:	
Concussion		Hypothyroid (underactive)		Degenerative Disc	
Head injury		Hyperthyroid (overactive)		Location:	
Glaucoma		Gout		Spinal stenosis, cervical	
Use hearing aids		**GASTROINTESTINAL**		Spinal stenosis, lumbar	
CARDIOVASCULAR		Heartburn / indigestion		Scoliosis	
High blood pressure		Ulcers		Rheumatoid arthritis	
High cholesterol		Diarrhea		Osteoporosis	
Heart murmur		Constipation		Arthritis – location:	
Coronary Artery Disease		Gall bladder problems			
Have a pacemaker		Irritable bowel		Ehlers-Danlos Syndrome	
Congestive Heart Failure		Colitis / Crohn's disease		Fibromyalgia	
Stroke		Diverticulosis/Diverticulitis		Other:	
Varicose Veins		**GENITOURINARY**			
History of Blood Clots		Kidney stones		**PSYCHIATRIC**	
RESPIRATORY		Prostate trouble (men only)		Anxiety	
Asthma		**NEUROLOGICAL**		Depression	
Bronchitis		Stroke		Panic attacks	
COPD		Multiple sclerosis		**CANCER**	
Emphysema		Seizure disorder		Breast	
SKIN		Alzheimer's		Uterine	
Eczema		Parkinson's		Prostate	
Psoriasis		Chronic Lyme		Skin (specify):	
		Chronic Fatigue Syndrome		Lung	
		Nerve injury (specify):		Other cancer:	

Other conditions not noted above:

_____

Office Policies

Office Hours, Appointments

Office visits are by appointment only. Every effort will be made to give you an appointment at the earliest convenience. If you have an urgent problem, we will attempt to see you as soon as possible during normal business hours, although we are not an emergency-based practice.

Cancellations and Missed Appointments

We have a 48 hours' cancellation / confirmation policy: all patients must respond with confirmation or cancellation at least 48 hours in advance to avoid a disruption fee. Dr. Tortland is committed to spending enough time with you to listen to your history and perform a thorough physical exam. We schedule new patients for 60+ minutes and follow-up visits for 30+ minutes. Because of our commitment to patients of quality care and the increasing trend of the general public to skip appointments without giving notice, it has become necessary for us to charge for MISSED VISITS (NO SHOWS).

- **A Missed Visit or No Show is defined as failing to give us 48 hours' notice of your inability to make a scheduled appointment. New patients missing an office visit will be charged $200.00. Existing patients missing an office visit will be charged $150.00.**
- **New patients who miss two consecutive initial office visits, or established patients who miss three scheduled appointments, without the favor of notifying our office at least 48 hours in advance each time, will be dismissed from the practice.**
- **Please note, since we do not like to turn our patients away, if you arrive later than 10 minutes past your scheduled time we can still see you that day, however a late charge of $20 will apply. Please try to arrive 5 to 10 minutes early.**

Fees, Payments, and Insurance

WE DO NOT ACCEPT ANY INSURANCE, INCLUDING MEDICARE.

Our fees and charges are based on the cost of doing business. Unless prior arrangements are made otherwise, payment is expected at the time service is rendered. **A credit card is required to be on file for all patients. If an account balance has been unpaid for at least 60 days after date of service, the credit card will be charged to pay off the current account balance.** In addition, supplies such as braces, orthotics, and nutritional supplements typically are not covered by insurance. We will be happy to arrange prior payment options for you, if needed.

Prescriptions and Refills

We will be happy to refill any prescriptions that have been originally provided by our office. We can phone prescription refills directly to your pharmacy during normal business hours. **Prescriptions will not be refilled during nights or weekends --** please anticipate your medication needs and make arrangements for refills according to the following schedule:

M, T, W, Th 8:00 am – 3:00 pm
Friday 8:00 am – 12:00 pm**.**

Daytime and After-Hours Phone Calls

During business hours, the Doctor's assistants will attempt to return patient phone calls either during the lunch hour or at the end of the day. After hours, emergency phone calls will be returned by the doctor on call that week, usually within 15 minutes.

Additional Policies (Children/Consent Waiver)

Children are welcome at New England Stem Cell Institute, but for safety's sake we ask that when brought to the office they must be supervised. Parents/Guardians are responsible for the safety and supervision of their children.

With my consent, New England Stem Cell Institute may call my home or other designated location and leave a message on voice mail or in person, or may mail or email to my home or other designated location any items that assist in carrying out treatment, payment and health care operations, such as appointments reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I, the undersigned, understand, have read and agree to the above Office Policies.

Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

I authorize New England Stem Cell to use my credit card on file as of ___/____/_____2023 for all charges past 60 days.

If payment plan is in place, we will use the credit card based on the agreement.

New England Stem Cell Institute will notify me by email with the receipt of payment.

Thank you for your understanding and cooperation.

Patient Signature: _____

Patient Print Name: _____

Date: _____

Rev 1; Jan 05, 2023

Acknowledgement of Receipt of Notice of Privacy Practices

New England Stem Cell Institute
59 Sycamore St. Ste 301
Glastonbury, CT 06033
Phone: 860-430-2821 Fax: 860-430-9693

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Date: _____

If not signed by the patient, indicate your relationship to the patient: _____

I GIVE PERMISSION TO COMMUNICATE MY PRIVATE HEALTHCARE INFORMATION TO:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused:

Efforts to obtain: _____

Reasons for refusal: _____

Summary of Notice of Privacy Practices

New England Stem Cell Institute

59 Sycamore St. Ste 301

Glastonbury, CT 06033

860-430-2821

The following is a brief summary of your rights and responsibilities as detailed in the attached Notice of Privacy Practices (the "Notice"). This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. Uses and Disclosures of Your Health Information. We may use the information we develop and collect for treatment by our practice or disclose the information to others whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes. [Add reference to research, fundraising or directories if included in the Notice.]

2. Other Uses and Disclosures. Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. Your Health Information Rights. You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:

a) You may request restrictions on certain uses and disclosures of your information
b) You may request that you receive your information from us in a certain way
c) You may inspect and copy your medical records
d) You may request an amendment to any record you believe is inaccurate
e) You may request an accounting of disclosures made of your records

4. Changes to the Notice. We reserve the right to change the Notice. If we do so, we will post it in our office, [and on our website] and provide a copy upon request.

5. Complaints. You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.