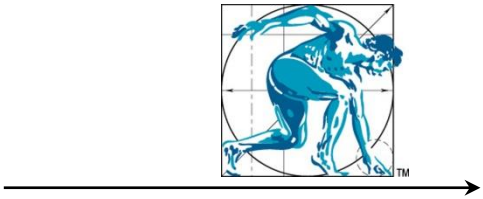


VALLEY SPORTS PHYSICIANS & ORTHOPEDIC MEDICINE

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.

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: _____ **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

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, MOTOR VEHICLE ACCIDENT, OR WORKER'S COMPENSATION CASES

I authorize the release of any medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original.
I further authorize Dr. Tortland and/or the staff of Valley Sports Physicians to apply for benefits on my behalf for covered services rendered by him or by his order. I request that any payments from my insurance company be made directly to Valley Sports Physicians or to Dr. Tortland. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either me or my insurance company at any time by written request.

I understand that, while insurance claims may be submitted as a courtesy by Dr. Tortland, Valley Sports Physicians on my behalf, I am ultimately responsible for all medical costs incurred as a result of my receiving treatment in this office.

PATIENT / GUARDIAN SIGNATURE: _____ **DATE**: _____

PATIENT MEDICAL HISTORY

Name _____ Age: ____ Date of Birth: _____

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 _____

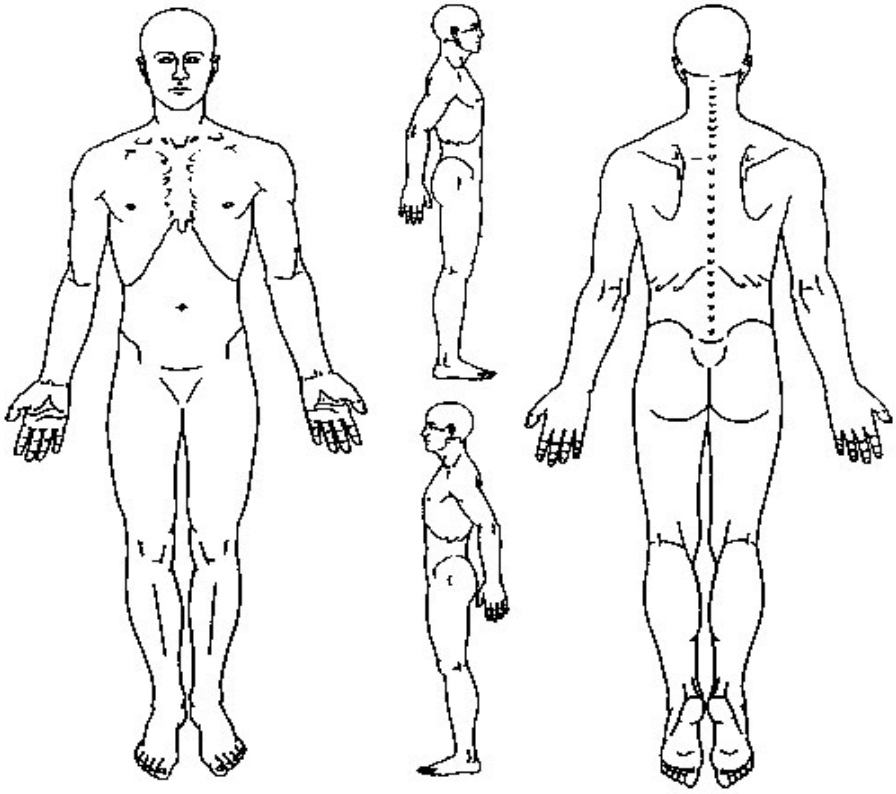
packs/day x _____ years _____

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:

_____

Rev. 03/07/2021

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 ARE OUT OF NETWORK WITH ALL MEDICARE & MEDICARE ADVANTAGE PLANS. Our fees and charges are based on the cost of doing business. While most physicians and rehabilitation services are covered to some degree by insurance, **you are ultimately responsible for your bill**. Our office will assist you by filing insurance forms when appropriate. If we do not participate with your insurance, there may be a balance that you are responsible for after your insurance pays their portion. **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.** If your insurance requires a referral or an authorization to be seen, it is your responsibility to obtain that referral or authorization. Unless prior arrangements are made otherwise, payment is expected at the time service is rendered. Supplies such as braces, orthotics, and nutritional supplements typically are not covered by insurance. Regenerative medicine procedures billed under New England Stem Cell Institute such as, but not limited to, PRP (Platelet-Rich-Plasma), Prolotherapy, Prolozone, Stem Cell and PLA are not covered by any insurance. We will be happy to arrange 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, Thursday: 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 Valley Sports Physicians, 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, Valley Sports Physicians 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: _____

ULTRASOUND GUIDANCE WAIVER

I fully understand that the ultrasound guidance code (code: 76942) is **no longer being covered by insurance companies** when performed with certain facet and tendon / ligament injections: (code: 20550 / 20551).

I understand that, in the interest of both patient safety and injection accuracy, Dr. Tortland will **NOT** perform injections unless ultrasound guidance is used. On this basis, **is fully responsible for the cost of the ultrasound guidance at the time of the injection.** that I will be responsible for payment of the ultrasound guidance should I desire to have the nerve block performed.

The cost of the ultrasound guidance is $200.00, due in full at the time of service.

I understand that the charge for the nerve block itself will be submitted to my insurance for payment, but that I will be responsible for any co-payment or deductible that applies. I also understand that payment for any service that is not covered by insurance is due at the time that service is rendered unless other arrangements have been made.

Printed Patient Name (and Guardian Name if applicable):_____

Patient or Guardian Signature: _____

Date: _____

VSP Witness: _____

NERVE BLOCK INJECTION WAIVER (AETNA ONLY)

I fully understand that my insurance company, **Aetna**, is no longer paying for ultrasound guidance when some nerve block injections are performed, on the basis that they deem the ultrasound guidance "experimental."

I understand that, in the interest of both patient safety and injection accuracy, Dr. Tortland will **NOT** perform a nerve block unless ultrasound guidance is used. On this basis, I agree that I will be responsible for payment of the ultrasound guidance should I desire to have the nerve block performed.

I understand that the charge for the nerve block itself will be submitted to my insurance for payment, but that I will be responsible for any co-payment or deductible that applies. I also understand that payment for any service that is not covered by insurance is due at the time that service is rendered unless other arrangements have been made.

Printed Patient Name (and Guardian Name if applicable): _____

Patient or Guardian Signature: _____

Date: _____

VSP Witness: _____

PATIENT RESPONSIBILITY

I understand that **Valley Sports Physicians** will submit my procedure to my insurance company. Valley Sports Physicians will do everything in their power to get my procedure paid. If they exhaust 3 appeals and the insurance will not pay the procedure, I understand and agree that I am responsible for this charge; this includes any injections, office visits for evaluation, diagnostic ultrasound or ultrasound guided injections.

I understand and agree that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balances.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand and agree that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. I understand I must keep a credit card on file, for if an account balance has been unpaid for at least 60 days after the date of service, the credit card will be charged to pay off the current account balance.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. **Valley Sports Physicians** provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Patient Name (and Guardian Name if applicable): _____

Patient or Guardian Signature: _____

Date: _____

(FOR OFFICE STAFF ONLY)

VSP Witness: _____

CREDIT CARD AUTHORIZATION

I authorize Valley Sports Physicians & Orthopedic Medicine 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.

Valley Sports Physicians & Orthopedic Medicine 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

Valley Sports Physicians & Orthopedic Medicine, Inc.
59 Sycamore Street Glastonbury
Phone: 860-430-9690 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.

Signature: _____ **Date:** _____

Print Name: _____ **Date:** _____

Preferred number of contact: _____

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
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
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

Valley Sports Physicians

59 Sycamore Street, Suite 301

Glastonbury CT 06033

860-430-9690

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.