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: 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

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 & TO ASSIGN BENEFITS

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, Dr. LaVallee 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 or Dr. LaVallee 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/Dr. LaVallee, 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.

Signature ____ Date ______________________________

Patient (or Parent/Guardian)

PATIENT MEDICAL HISTORY

Name ___________________________________ Age ______ Date of Birth ____________ Date ______________
School (students only) ____________________________ Who referred you? _________________________________
Personal Physician _________________________________ Address ____

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): MVA Sports 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		
Chiropractic		
Physical Therapy		
Medication		
Other		

What diagnostic studies have been done for THIS problem?

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

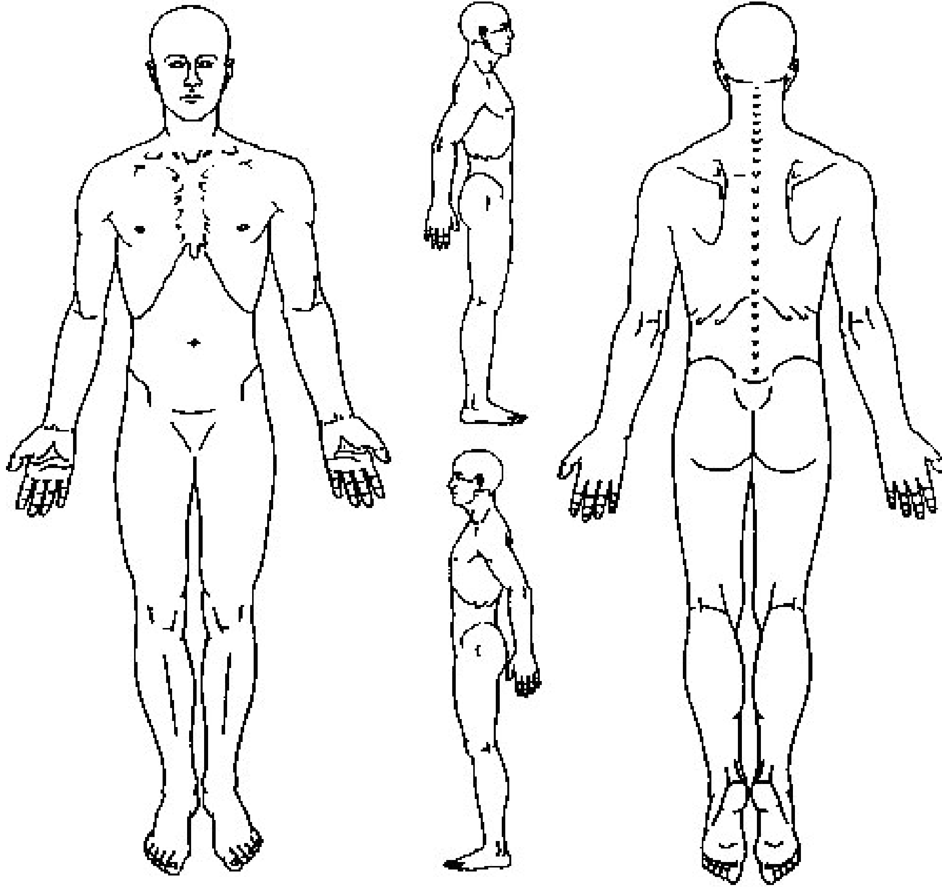
On a scale of 1-10 (10=worst) how would you rate your pain? (Circle one) 1 2 3 4 5 6 7 8 9 10
Is your pain getting (circle one): Getting Better Getting Worse Staying the Same
What makes your pain worse? ____
What makes your pain better?____
How would you describe the nature or character of your pain? ____
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? No Yes → If "Yes", please describe: _____________
____

CURRENT MEDICATIONS (including vitamins)	ALLERGIES (describe reaction)

How much do you: smoke: _____ packs/day drink caffeine: _____ cups/day drink alcohol: type_________
_____ Years Amount ____________

Athletic / Sporting Activities		
	Amounts/Times per week	Previous Injuries
Sport 1:		
Sport 2:		
Sport 3:		

Please indicate both the location and nature of your pain on the diagram below:



Numbness	Pins & Needles	Burning	Ache	Stabbing
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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 PRESENT conditions – "X" all PAST conditions):

HEENT		**RESPIRATORY**		**MUSCULOSKELETAL**	
Headaches		Asthma		Herniated Disc	
Migraines		Bronchitis		Location:	
Concussion		Pneumonia		Broken bones	
Head injury		Shortness of breath w/exercise		(specify)	
Eye problems		Coughing during / after exercise		Chronic back pain	
Wear glasses / contacts		Use an inhaler		Chronic neck pain	
- last eye exam:		**GASTRO-INTESTINAL**		Joint pain	
Hearing problems		Heartburn / indigestion		(specify):	
Sinus problems		Ulcers		Whiplash injury	
Frequent colds		Diarrhea		Shoulder injury	
CARDIOVASCULAR		Constipation		Knee injury	
High blood pressure		Gall bladder problems		Sprained ankle	
Angina		Use antacids		Wear orthotics in shoes	
Chest pain with exertion		Hemorrhoids		Scoliosis	
Palpations		Irritable bowel		Tendonitis	
Irregular heart beat		Colitis / Crohn's disease		Bursitis	
Heart failure		Blood in stool/black tarry stool		Rheumatoid arthritis	
Get lightheaded / faint w/exercise		Diverticulosis / Diverticulitis		Degenerative arthritis	
Heart murmur		Excess gas / bloating		Short leg	
High cholesterol		**GENITOURINARY**		Osteoporosis	
Stroke		Frequent urinary infections		**ENDOCRINE**	
Aneurysm		Kidney stones		Diabetes (insulin-dependent)	
Phlebitis / blood clots in legs		Prostate trouble (men only)		Diabetes (non-insulin depend)	
Varicose veins		Burning while urinating		Hypothyroid (underactive)	
NEUROLOGICAL/PSYCHIATRIC		**FEMALE ONLY**		Hyperthyroid (overactive)	
Nerve injury (specify)		Age first menstrual period:		Gout	
		Age menopause:		Easily fatigued	
Anxiety		Frequency of periods:		**OTHER**	
Depression		Irregular menstrual cycles		Cancer	
Panic attacks		Irregular bleeding / spotting		Type:	
Dizziness		Frequent yeast infections		Anemia	
Convulsions / seizures		# of pregnancies			
Anorexia / Bulimia		# of deliveries			

PHYSICIANS NOTES:

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.

Cancellations and Missed Appointments

If you cannot make your appointment, please give us the courtesy of at least 24 hours notice so that another patient may have the opportunity to see the doctor. **If you are late for your scheduled appointment the practitioner may require that you be rescheduled. **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.**

Dr. Tortland and Dr. LaVallee are committed to spending enough time with you to listen to your history and perform a thorough physical exam. We scheduled NEW patients for 40-60 minutes and follow-up visits for 20-30 minutes and this limits the number of patients we can see per day. 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 24hrs notice of your inability to make a scheduled appointment. Existing Patients missing an office visit will be charged $75, New patients missing an office visit will be charged $100**

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 24 hours in advance EACH TIME, will be DISMISSED from the practice.

We are out of Network with Medicare as of Jan1, 2017. All medicare advantage plans are also considered out of network

Fees, Payments, and Insurance

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**. **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 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. 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.

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 Valley Sports Physician, 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** ____________________

Printed Name

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

Name of Patient: ____

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: ______________________________

What is your preferred number of contact ____

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 Glastonbury

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.