Comprehensive Neurology and Pain Center of CT, L.L.C.
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue Suite 2400
Wallingford, CT 06492
Phone: (203) 626-9080
Fax: (203) 626-9074

999 Summer Street Suite 100
Stamford, CT 06905
Phone: (203) 724-9290
Fax: (203) 724-9288

Dear New Patient,

It is with great pleasure that we welcome you to Comprehensive Neurology and Pain Center of Connecticut! You scheduled an initial consultation with Dr. Igor Turok Neurologist and Pain Management Specialist. Please arrive to your appointment 15 minutes early to process your check in.

Upon arrival, you will be asked to provide us with a current up to date legal photo identification as well as all active insurance cards. This includes your primary, secondary, and tertiary insurances. If you are insured through a workers compensation, auto or department of labor you must provide prior to your visit the full insurers name, claim number and billing address or authorization for visit with all the information included.

Please note that your co-payments are due at the time of visit at the front desk. It is per contract with your insurance company that we collect your benefits mandated copayment in full. Co-payments must be paid using credit card or cash.

Dr. Turok is a specialist , if your insurance requires a referral It is your responsibility to obtain one from your primary care physician. To find out if your policy requires a referral, call the customer service number that is located on the back of your primary insurance card. Your PCP may be able to electronically send referral to your insurance company however we still require a copy.

If you have any recent radiological reports (MRI's, CT Scans, MRA's, etc.), please obtain a copy to bring with you to provide to the doctor.

Your care and treatment is a priority to us here at CNPC. To ensure that all of our patients are evaluated and treated in a timely manner, we require a 24 hour cancellation notice by phone. Failure to cancel an **INITIAL CONSULTATION, PROCEDURE, OR DIAGNOSTIC TEST** will result in a $75.00 fee. Failure to cancel a **FOLLOW UP VISIT OR MEDICATION VISIT** will result in a $50.00 fee. These fee's are patient responsibility and will not be covered by your insurance. If you are more than 15 minutes to your appointment, you may be asked to reschedule.

We are looking forward to providing you with comprehensive care. Please let us know how we can make you feel comfortable and quickly at home in our office. Thank you for choosing us, we are eager to meet you!

Sincerely,

Dr. Igor G. Turok M.D. and Staff

Comprehensive Neurology and Pain Center of CT, L.L.C.
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue Suite 2400
Wallingford, CT 06492
Phone: (203) 626-9080
Fax: (203) 626-9074

999 Summer Street Suite 100
Stamford, CT 06905
Phone: (203)724-9290
Fax: (203)724-9288

PERMISSION FOR OPERATION OR SPECIAL PROCEDURE

1. I hereby authorize Dr. Igor G. Turok and/or such associates by him/her, to examine, treat and perform any diagnostic testing or certain procedure(s) in the office deemed necessary to properly evaluate or/and treat my condition(s). I authorize any additional unanticipated procedures as are considered necessary by my physician on the basis of findings during the course of said procedure(s). This authority extends to remedying conditions that are not known to the physician at the time the above procedure(s) is commenced.

2. I have been informed to my satisfaction and understanding by the physician of the following: 1) The general nature of the ailment; 2) The general nature of the contemplated procedures to correct or to diagnosis the ailment; 3) The recognized risks and consequences; 4) The prospects of success; 5) The reasonably anticipated consequences if the procedure is not performed; and 6) The alternative methods of treatment or diagnosis if any, and the reasonably anticipated consequences involved in each.

3. I am aware that in the practice of medicine and surgery, unexpected complications may occur. I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

4. I consent to the administration of such anesthetics as are deemed necessary by the above physician and/or his/her designated assistants in order to perform the above procedure(s). I also consent to intravenous solutions and contrast (dye) agents as maybe considered necessary or advisable by the physician responsible for this service without exceptions. Any tissues or parts surgically removed are disposed of in accordance with accustomed practice.

5. I consent to the photographing of the operation and procedures to be performed for medical, scientific or educational purposes.

I hereby warrant that I have been legally adjudged as competent. I further certify that I am fully able to understand and weigh the benefits versus the risks of the above listed procedure(s). I understand that it is my right to determine the extent of my medical care, and that I may revoke this consent at any time. I warrant that I willfully consent to the procedure and am under no duress by the above named physician, his/her assistants or staff to consent to the above listed procedure.

Patient: ____ **Date:** _______________

Witness: ____ **Date:** _______________

Certification of Physician: I discussed the procedure with the patient, guardian, or representative of the patient and fully informed him/her about the potential risk, benefits, alternatives, etc.; and he/she consented to having the procedure performed and to signing this form.

____ **Date:** _______________
Physician's Signature

Comprehensive Neurology and Pain Center of CT, L.L.C.
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue Suite 2400
Wallingford, CT 06492
Phone: (203) 626-9080
Fax: (203) 626-9074

999 Summer Street Suite 100
Stamford, CT 06905
Phone: (203)724-9290
Fax: (203)724-9288

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Igor G. Turok, M.D. or any employee of Comprehensive Neurology and Pain Center of Connecticut, L.L.C. to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me at any time.

I also authorize Comprehensive Neurology and Pain Center of Connecticut, L.L.C. to release any and all medical records concerning my care to any physician, hospital, or other health care professional providing care to me at any time. Additionally, I authorize Comprehensive Neurology and Pain Center of Connecticut, L.L.C. to release any and all medical records concerning my care to Medicare, Medicaid, Insurance Company, third party administrators, or Managed Care Company.

Printed Name: ______________________________________

Patient Signature: ______________________________ Date: _________

Comprehensive Neurology and Pain Center of CT, L.L.C.
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue Suite 2400
Wallingford, CT 06492
Phone: (203) 626-9080
Fax: (203) 626-9074

999 Summer Street Suite 100
Stamford, CT 06905
Phone: (203)724-9290
Fax: (203)724-9288

Authorization to Discuss Medical Information

I, ____ , date of birth ________________ give permission to Comprehensive Neurology and Pain Center of CT, L.L.C. and Dr. Igor Turok, to discuss my personal health information with the following authorized person(s):

Name : ____
Relationship : ________________________________
Contact Number : _______________________________

Name : ____
Relationship : ________________________________
Contact Number : _______________________________

Patient Signature : ________________________________ Date : ______________

Comprehensive Neurology and Pain Center of CT, L.L.C.
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue Suite 2400
Wallingford, CT 06492
Phone: (203) 626-9080
Fax: (203) 626-9074

999 Summer Street Suite 100
Stamford, CT 06905
Phone: (203)724-9290
Fax: (203)724-9288

Patient Information

Date: ________________________ Email:________________________________

Last Name:____________________ First Name:____________________ SSN:____________________

Address:______________________ City:__________________________ ST:_______ Zip:_________

DOB:__________ Gender: ( )M ( )F Marital Status: ( )S ( )M ( )D ( )W Language:_____________

Race (please circle): American Indian or Alaska Native Asian Native American or Other Pacific Islander
Black or African American White Hispanic Other Race Refuse to Report
Ethnicity (please circle): Hispanic or Latino Not Hispanic or Latino Refuse to Report

Home Phone:__________________ Cell Phone:__________________ Work Phone:_________________

Employer:________________________________ Occupation:____________________________________

PCP:_____________________________________ Phone Number:_________________________________

Emergency Contact:___________________________ Relationship:____________ Phone:_____________

Insurance Information

Primary Insurance Carrier: _____________________________________ Co-Pay: $__________________

Name of Insured(if other than self): ______________________________ Relationship:_______________

I.D. #: ____ Group #: _______________________

Secondary Insurance Carrier: __________________________________ Co-Pay: $ __________________

I.D. #: ____ Group #:_______________________

*If required by your Insurance Carrier: Referring Physician:_______________________________________

Worker's Compensation / Auto Claims - Insurance Name: _____________________________________
Billing Address:____
Claim Number: ________________________________ Date of Injury (DOI)______________________
Adjuster: ______________________________________ Phone: _________________________________
Fax:___________________________________
Attorney: ______________________________________ Phone: _________________________________

** I hereby authorize payment directly to Igor G. Turok, M.D. of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependent's. I authorize the above providers to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

****Patient Signature**: Date:

Comprehensive Neurology and Pain Center of CT, L.L.C.
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue Suite 2400
Wallingford, CT 06492
Phone: (203) 626-9080
Fax: (203) 626-9074

999 Summer Street Suite 100
Stamford, CT 06905
Phone: (203)724-9290
Fax: (203)724-9288

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: **DOB**:

Maiden or Other name (if applicable):

I acknowledge that I have received a copy of the Notice of Privacy Practices of Comprehensive Neurology & Pain Center of Connecticut, L.L.C.

Signature (patient or authorized representative):

____ Date: ____________________
Patient

____ Date: ____________________
Representative

Relationship/Authority (if signed by authorized representative):

For Office Use Only

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented me from obtaining acknowledgement
Other (specify)

____

Current Medication List

Please list all tablets, patches, drops, ointments, injections, etc. Include prescription, over the counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, Albuterol, Nitroglycerin). Please notify CNPC of all changes in medications list. Thank you.

Medication (Brand and Generic Name)	Dose	How and how often you take the medication	Reason for taking	Date Started	Prescriber

Patient Name:________________________ DOB:______________ Date Updated:________________

Comprehensive Neurology and Pain Center of CT, L.L.C.
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue Suite 2400
Wallingford, CT 06492
Phone: (203) 626-9080
Fax: (203) 626-9074

999 Summer Street Suite 100
Stamford, CT 06905
Phone: (203)724-9290
Fax: (203)724-9288

INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE AND DIRECT CNPC TO RELEASE TO GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE, ALL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH HOSPITALIZATION AND MEDICAL CARE AND PERMIT REPRESENTATIVES THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATED TO SUCH CARE AND TREATMENT.

ASSIGNMENT OF BENEFITS

I ALSO HEREBY ASSIGN, TRANSFER, AND SET OVER TO CNPC SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN THE PRACTICE.

FINANCIAL AGREEMENT

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE. IF I AM NOT COVERED UNDER ANY INSURANCE POLICY OR PLAN, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED DURING MY MEDICAL CARE AT CNPC.

PATIENTS ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME, IN APPLYING FOR PAYMENT UNDER THE TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO THE PHYSICIAN OR ORGANIZATION PROVIDING THE SERVICES.

Signature (of patient or authorized representative):

\- Date:

Patient

____ Date: ______________

Representative

Comprehensive Neurology and Pain Center of CT, L.L.C.
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue Suite 2400
Wallingford, CT 06492
Phone: (203) 626-9080
Fax: (203) 626-9074

999 Summer Street Suite 100
Stamford, CT 06905
Phone: (203)724-9290
Fax: (203)724-9288

**** IMPORTANT! THIS AGREEMENT IS TO BE SIGNED IN THE EVENT YOUR PHYSICIAN PRESCRIBES ANY CONTROLLED SUBSTANCES DURING THE COURSE OF YOUR TREATMENT AT CNPC.**

Controlled Substance Agreement and Informed Consent Form

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids," to treat chronic pain. I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small, there is a chance of developing an addiction to controlled substances if I am placed on them to control my pain.

2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy or am not thinking clearly.

3. I will not use any illegal controlled substances including, but not limited to marijuana and cocaine. I will not drive while intoxicated with alcohol.

4. The CNPC policy regarding the dispensing of controlled substances requires that I will be seen regularly and I agree to make and keep my appointments. I will advise my doctor of all other medicines and treatments that I am receiving.

5. If the medication requires adjustment, an appointment must be made to see the doctor. No adjustments will be made over the telephone. My careful planning is required. I understand that medication refills and adjustments are done during office appointments except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. I understand that the CNPC policy is not to prescribe early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

6. I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, accidentally destroyed), I may not receive a replacement from my physician. CNPC expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.

7. My physician will prescribe whatever medication he/she is comfortable with and thinks is best; he/she is not under any obligation to prescribe any specific medication.

8. I am aware of the possible risks and benefits of other types of treatments that does not involve the use of opioids. The other treatments discussed included: Injections, therapy, and surgery (if indicated).

9. I agree to come to the CNPC with my medication on the same day that I am called and submit to a pill count, and/or urine or blood screening to detect illegal substances or confirm proper use of prescribed medicine. The call to come to the CNPC can be made either randomly, or if a concern arises. I may be required to bring my unused medication routinely to each office visit. If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

10. I give permission to the CNPC staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.

11. I will not use my pain medication in higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized to do so. I will inform my other doctor(s) of my use of medication for chronic pain, and I will inform the CNPC staff if another physician prescribes controlled substances for the acute problem. My doctor at CNPCC is my primary doctor with regard to my pain medications. If there is a medical emergency (e.g., broken leg, surgery requiring post-op pain medication, dental procedures, etc.), another doctor may prescribe pain medication to me, but I will advise the prescribing doctor of my care at CNPCC, authorize the doctor to disclose information to CNPC, and I will also notify my doctor at CNPCC of the medication and dosage.

12. (Females only) Because of the risks of certain medications to unborn children, I will inform all physicians, obstetrician/ gynecologist and CNPC, immediately if I become pregnant or decide to try to become pregnant. I am aware that should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware the use of opioids is not generally associated with risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

13. (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

14. My physician can wean me off of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. If I am weaned off, the CNPC staff may inform my other health care providers as the reasons for the weaning.

15. Abstinence Syndrome (Withdrawal Syndrome): Stopping opioid, antiseizure or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizures or death). I should wean from my medications rather than stopping them abruptly. If I find myself without medication, I will use the emergency line to notify my doctor.

16. I understand that in general I may be weaned off of my medication or my drug therapy may be terminated at the discretion of my physician if any of the following occur:

- a) It is the opinion of my physician that controlled substances are not very effective for my pain and/or my functional activity is not improved.
- b) I misuse the medication.
- c) I develop rapid tolerance or loss of effect from this treatment.
- d) I develop side effects that are significant and detrimental to me.
- e) I obtain controlled substances from other sources other than my physician without informing him or her.
- f) Pill counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and/or I fail to submit to such counts/tests on the day that I am called.
- g) I am arrested and/or, convicted for a controlled or illicit drug violation including drunk driving.
- h) Any violation of this agreement.

17. I further understand that my drug therapy will be terminated or detoxification in a controlled environment will be required if I give away, sell, distribute and/or transport with the intent to sell or dispense my medication.

18. I choose to use ______________________________ Pharmacy, located at, ______________________________, for all of my pain medication prescriptions. I will not fill partial prescriptions if my pharmacy does not stock the full quantity of medication, if I change my pharmacy for any reason, I agree to notify my pain physician.

****I have read the above Agreement and understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this Agreement, if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement by signing this form voluntarily; I give my consent for the treatment of my pain with narcotic/opioid pain medicines.****

____

Patient **Date** ____________________

____

Physician **Date** ____________________

Comprehensive Neurology and Pain Center of CT
Igor G. Turok, M.D.
Diplomat of American Board of Neurology
Anesthesia, Interventional Pain Management

67 Masonic Avenue, Ste. 2400
Wallingford, CT 06492
203-626-9080/Fax: 203-626-9074

999 Summer Street, Ste. 100
Stamford, CT 06905
203-724-9290/Fax: 203-724-9288

Late and Missed Appointments

At Comprehensive Neurology & Pain Center of CT we put our faith in you to keep your appointment. When we set up an appointment, specific amount of time is reserved especially for you based on your treatment plan.

If for any reason you must cancel or change your appointment, it is important that you give our office **at least 24 hours notice** to offer that spot to someone else.

- **1st missed appointment:** If an appointment is missed or canceled within the 24 hour window, a call or letter will be sent to your home reminding you of our policy and the effects of your missed appointment. We also reserve the right to charge you missed appointment rates stated below.
- **2nd missed appointment:** After your second missed appointment, a letter will be sent to your home notifying you of a change in status of your account. In order for you to schedule a future appointment with our doctors, a deposit must be made. The deposit is 50% of the cost of that appointment, or $100.00 whichever is greater. Upon arrival, this fee is credited toward the cost of the patient's treatment. If the patient does not show up to the appointment the deposit is non-refundable. If you choose to not pay the deposit you have the option of being placed on a short notice list and will be notified of last minute scheduling opportunities.
- **After 2 missed appointment,** the patient will be placed on a short notice list and will be notified when there is a cancellation or opening in the schedule. No appointments can be scheduled ahead of time until the patient's account is placed back in good standing. The decision to place the patient's account back in good standing lies at the sole discretion of the practice manager.

We understand that true emergencies happen. If this is the case, please provide us with a doctor's note or other adequate proof and the missed appointment will be removed from your accounts record.

Late arrival: When we reserve time for you, we require all of that time to provide you with the best quality care possible. When you are late it decreases our ability to accomplish this. If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

Missed Appointment Rates: Consultation - $50 / Follow up - $50.00 / Procedures - $100.00

I have read the policy above. I understand and agree to abide by the listed terms.

____ ____________________
Patient Name Date