

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CIRCLE EITHER “Y” FOR YES OR “N” FOR NO REGARDING YOUR HEALTH:**

LOWER BACK PAIN Y N HIGH/LOW BLOOD PRESSURE Y N

LEG OR FOOT PAIN/NUMBESS Y N VASCULAR LEG PROBLEMS Y N

BOWEL/BLADDER Y N PACEMAKER Y N

SPINAL FRACTURES Y N STROKE Y N

SPINAL STENOSIS Y N HIGH CHOLESTEROL Y N

SPINAL ARTHRITIS Y N SHINGLES Y N

SCIATICA Y N RHEMATOID Y N

NECK PAIN Y N KIDNEY ISSUES OR DIALYSIS Y N

HERNIATED DISC Y N GOUT Y N

DIABETES (A1C: \_\_\_\_\_) Y N HIP SURGERY Y N

HAND PROBLEMS Y N LEG FRACTURES Y N

NEUROPATHY Y N HEADACHES Y N

HEART ATTACK Y N CVA Y N

HEART PROBLEMS Y N HTN Y N

OSTEOARTHRITIS Y N ALLERGIES Y N

WEIGHT LOSS/GAIN Y N ALLERGIC TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Conditions: (circle all that apply)**

Arthritis Cancer Diabetes Heart disease

Hypertension Psychiatric illness Skin disorder Stroke

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries: (circle all that apply)**

Appendectomy Cardiovascular procedure Cervical spine Hysterectomy

Joint replacement Prostate Lumbar spine Gall bladder

Brain Shoulder Thoracic spine Knee

Carpal Tunnel Gastro-intestinal Uro-genital Hernia

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies: (circle all that apply)**

Eggs Fish/shellfish Milk/lactose Peanuts

Soy Sulfites Wheat/glutens

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History: (circle all that apply)**

Caffeine use: occasional often never

Alcohol consumption: occasional often never

Exercise: occasional often never

Chew tobacco: occasional often never

Cigarettes: occasional often never

Wear seat belt: occasional often never

Recreational drug use: occasional often never

**Family History: (circle all that apply)**

Arthritis: parent sibling other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer: parent sibling other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: parent sibling other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease: parent sibling other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension: parent sibling other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke: parent sibling other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid: parent sibling other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupational Activities:**

Administration Business owner Clerical/secretary Computer user

Heavy equipment operator Daycare/childcare Construction Health care

Food service industry Medium manual labor Manufacturing Home services

Heavy manual labor Light manual labor Executive/legal Housekeeper

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **FREQUENCY** | **PURPOSE** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**PLEASE LIST ANY HISTORY OF CANCER AND THE DATE:**

|  |  |  |
| --- | --- | --- |
| **AREA** | **DATE** | **TREATMENT** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**PLEASE LIST ANY ORGAN TRANSPLANTS AND THE DATE:**

|  |  |
| --- | --- |
| **AREA** | **DATE** |
|  |  |
|  |  |
|  |  |

**PLEASE CIRCLE ON THE DIAGRAM BELOW WHERE YOU ARE CURRENTLY EXPERIENCING SYMPTOMS:**



**PAIN INTENSITY SCALE**

**BEST CASE:** 1 2 3 4 5 6 7 8 9 10

**GETS WORSE WITH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORST CASE:** 1 2 3 4 5 6 7 8 9 10

**GETS BETTER WITH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FREQUENCY OF SYMPTOMS:**  □CONSTANT (76%-100% of the day) □FREQUENT (51%-75% of the day)

 □OCCASIONAL (26%-50% of the day) □INFREQUENT (1%-25% of the day)

 □NO SYMPTOMS (0% of the day)

**PLEASE CIRCLE ANY OF THE FOLLOWING THAT DESCRIBE YOUR SYMPTOMS:**

STABBING SHARP ELECTRIC SHOCK COLD TINGLING PINS + NEEDLES

DEAD FEELING THROBBING BURNING STINGS ACHES NUMBNESS

SWELLING TIREDNESS CRAMPING OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MECHANISM OF INJURY:** □INSIDIOUS □GRADUAL ONSET

 □SUDDEN ONSET □TRAUMATIC

 DATE OF INJURY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGGRAVATING ACTIVITIES:** □SITTING □STANDING □WALKING

□STAIR CLIMBING □CARRYING >10 LBS □GETTING DRESSED

□DRIVING □DANCING □RECREATION

□WORKING □LAYING DOWN

**HEALTH STATUS:** □ MY HEALTH IS GOOD

 □ I HAVE SOME HEALTH ISSUES

 □ I HAVESEVERE HEALTH ISSUES

**ADL STATUS:** □ I AM ABLE TO PERFORM ADL’S WITHOUT MODIFICATION

(ACTIVITIES OF □ I NEED SOME ASSISTANT/MODIFICATION WITH ADL

DAILY LIVING) □ I AM IN A FACILITY TO ASSIST WITH ADL

**CURRENT WORK STATUS:** □FULL TIME □PART TIME □UNEMPLOYED

 □STUDENT □RETIRED

**TREATMENT HISTORY:** I have tried and failed a course of conservative therapy lasting 90 days or longer consisting of:

 □IBUPROFEN □TOPICAL ANALGESIC(S)

 □PRESCRIPTION PAIN MEDICATION(S) □PHYSICAL THERAPY

 □WEIGHT LOSS ATTEMPTED □CORTICOSTEROID INJECTIONS

 □INFORMAL PHYSICAL THERAPY (EXERCISE) □APPLICATION OF ICE

 □APPLICATION OF HEAT □REST

 □OTHER NSAIDS

 □OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WESTERN ONTARIO AND MCMASTER OSTEOARTHRITIS INDEX (WOMAC)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RATE YOUR PAIN WHEN…** |  | NONE | SLIGHT | MODERATE | SEVERE | EXTREME |  | **ARC USE ONLY** |
| Walking |  | 0 | 1 | 2 | 3 | 4 |  |
| Climbing stairs |  | 0 | 1 | 2 | 3 | 4 |  | TOTAL: |
| Sleeping at night |  | 0 | 1 | 2 | 3 | 4 |  |
| Resting  |  | 0 | 1 | 2 | 3 | 4 |  |
| Standing  |  | 0 | 1 | 2 | 3 | 4 |  |
|  |  |  |  |  |  |  |  |  |
| **RATE YOUR STIFFNESS IN THE…** |  | NONE | SLIGHT | MODERATE | SEVERE | EXTREME |  | **ARC USE ONLY** |
| Morning |  | 0 | 1 | 2 | 3 | 4 |  |
| Evening |  | 0 | 1 | 2 | 3 | 4 |  | TOTAL: |
|  |  |  |  |  |  |  |  |  |
| **RATE YOUR DIFFICULTY WHEN...** |  | NONE | SLIGHT | MODERATE | SEVERE | EXTREME |  | **ARC USE ONLY** |
| Descending stairs |  | 0 | 1 | 2 | 3 | 4 |  |
| Ascending stairs |  | 0 | 1 | 2 | 3 | 4 |  | TOTAL: |
| Rising from sitting |  | 0 | 1 | 2 | 3 | 4 |  |
| Standing  |  | 0 | 1 | 2 | 3 | 4 |  |
| Bending to floor |  | 0 | 1 | 2 | 3 | 4 |  |
| Walking on even floor |  | 0 | 1 | 2 | 3 | 4 |  |
| Getting in/out of car |  | 0 | 1 | 2 | 3 | 4 |  |
| Going shopping |  | 0 | 1 | 2 | 3 | 4 |  |
| Putting on socks  |  | 0 | 1 | 2 | 3 | 4 |  |
| Rising from bed  |  | 0 | 1 | 2 | 3 | 4 |  |
| Taking off socks |  | 0 | 1 | 2 | 3 | 4 |  |
| Lying in bed |  | 0 | 1 | 2 | 3 | 4 |  |
| Getting in/out of bath |  | 0 | 1 | 2 | 3 | 4 |  |
| Sitting  |  | 0 | 1 | 2 | 3 | 4 |  |
| Getting on/off toilet |  | 0 | 1 | 2 | 3 | 4 |  |
| Light domestic duties (cooking, dusting) |  | 0 | 1 | 2 | 3 | 4 |  |
| Doing heavy domestic duties (moving furniture) |  | 0 | 1 | 2 | 3 | 4 |  |
|  |  |  |  |  |  |  |  | **WOMAC TOTAL SCORE**/96 |
|  | PATIENT SIGNATURE: | DATE: |  |
|  | REVIEWED BY: | DATE: |  |
|  |  |  |  |  |

**PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS BY CIRCLING ONE ANSWER PER QUESTION:**

1. Do you experience knee pain? RIGHT / LEFT / BOTH
2. Do you experience knee pain at rest? YES / NO
3. Do you have knee osteoarthritis confirmed by imaging (x-ray/MRI)? YES / NO / UNSURE
4. Has your knee pain interfered with activities (such as walking, going up/down stairs and/or standing) for at least 6 months? YES / NO
5. Do you have morning knee stiffness lasting 30 minutes or less? YES / NO
6. Do you experience a grinding sensation with knee movement? YES / NO
7. Have you tried pain and/or anti-inflammatory medications (such as Tylenol, Aspirin, Advil or capsaicin cream) for at least 3 months without gaining long-term relief? YES / NO
8. Have you attempted physical therapy to the affected knee or participated in a personal exercise program without long-term relief? YES / NO
9. Have you attempted to lose weight to help with your knee pain? YES / NO
10. Have you used a knee brace without long-term relief? YES / NO
11. Has your doctor ever drained excess fluid from the affected knee(s)? YES / NO
12. Have you tried steroid/cortisone injection(s) to the knee without long-term relief?
13. Has your doctor injected FDA-approved Hyalgan, Orthovisc, Supartz, Synvisc-One or the like greater than 6 months ago? YES / NO

-IF YOU DID have the previously mentioned injection(s), did you receive significant improvement in pain and functional ability (easier to walk and/or stand)? YES / NO

-IF YOU DID have the previously mentioned injection(s), were you able to use fewer pain relieving medications for six months afterwards? YES / NO

**ADVANCED REGENERATIVE CARE**

**AUTHORIZATION OF ASSIGNMENT/INFORMED CONSENT TO CARE**

***(PLEASE READ EACH SECTION, 1-5, AND SIGN AFTER READING ALL SECTIONS)***

1. A patient coming to a health care provider gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The health care provider, of course, will not provide specific health care, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full-skin evaluations. These examinations should be performed by your family physician, OB/GYN or dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or various other contraindications. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol, etc.) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber, and any new prescriptions should be issued by your primary care provider. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines or allergies. I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request
2. Functional medicine, functional neurology, and joint injection experiences like all forms of health care, while offering considerable benefit, may also provide some level of risk. The level of risk is most often very minimal, yet in rare cases, injury has been associated with the health care forms listed above. Prior to receiving care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition and your overall health. These procedures will assist us in determining if proper care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. At Advanced Regenerative Care, I understand and accept that there are risks associated with care and give consent to the examinations that the health care provider deems necessary as reported following my assessment. This notice if effective as of the date it is signed and will expire seven years after the date on which you last received services from our company.
3. According to the Federal Food, Drug and Cosmetic Act as amended, Section 201 (g) (1), the term, “drug” is defined to mean: “articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease”. A vitamin is not a drug, NEITHER is a mineral, trace element, amino acid, herb or homeopathic remedy. Although a vitamin, mineral, trace element, amino acid, or herb, may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.
4. I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO Advanced Regenerative Care, AND INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the health care provider to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize use of this signature on all insurance claims, including electronic submissions.

**I HAVE READ AND UNDERSTAND LINES 1-5 ABOVE:**

NAME (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**ADVANCED REGENERATIVE CARE**

**HIPAA NOTICE**

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object the use of my health information for directory purposes
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

**PLEASE INITIAL ONE OPTION BELOW:**

\_\_\_\_\_\_\_\_\_\_ I do not wish to request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time, and the Privacy Notice is posted in the office.

\_\_\_\_\_\_\_\_\_\_ I wish to receive a paper copy of the Privacy Notice.

**APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION**

Your provider and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health-related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. **By signing this form, you are giving us authorization to contact you with these reminders and information.**

* I acknowledge that it is the policy of Advanced Regenerative Care to leave a reminder message on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.
* I acknowledge that if I should have a problem or question regarding my rights, I may speak with Advanced Regenerative Care management about my concerns.

PATIENT NAME (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE RELATIONSHIP BY CHECKING AN OPTION BELOW:**

* + Parent or guardian of minor patient
	+ Guardian or conservator of an incompetent patient
	+ Beneficiary or person representative of deceased patient
	+ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



1. NOTIFIER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. IDENTIFICATION NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NON-INSURANCE COVERED PROCEDURES**

|  |  |  |
| --- | --- | --- |
| **D.** | **E. REASON MEDICARE MAY NOT PAY** | **F. ESTIMATED COST** |
| Wharton’s Jelly Regenerative Tissue MatrixBone Marrow Regenerative Tissue MatrixPRP (Platelet Rich Plasma)PEMFDecompression ChairKnee on TracOTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | These services are not covered by insurance in our setting. | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**NOTE:** The procedures listed in box D are non-covered by any major medical or Medicare insurance companies. Box E states the reason of non-coverage. Box F contains the estimated cost of all non-covered procedures listed in box D.

**WHAT YOU NEED TO DO NOW:**

* Read this notice, so you can make an informed decision about your care.
* Ask us any questions that you may have after you finish reading.
* Choose an option below about whether to receive the services circled under letter D listed above.

NOTE: If you choose option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

|  |
| --- |
| **G. OPTIONS: Check only one box. We cannot choose a box for you.** |
| □**OPTION 1**. I want the option D. circled items listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.□**OPTION 2.** I do not want the option D. circled items listed above. I understand with this choice, I am not responsible for payment, and I cannot appeal to see if Medicare would pay.  |
| **H. ADDITIONAL INFORMATION:**This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, call your insurance company to verify. |

Signing below means that you have received and understand this notice. You also receive a copy.

|  |  |
| --- | --- |
| 1. **SIGNATURE:**
 | **J. DATE:** |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



**X RAY QUESTIONNAIRE: FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you are NOT pregnant at this time. **Please check all that apply.**

* + There is a possibility that I may be pregnant at this time.
	+ Yes, I am definitely pregnant.
	+ No, I am definitely not pregnant.
	+ I request that x-ray films not be taken because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF LAST MENSTRUAL PERIOD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_