REGEN ORTHO SPINE & PAIN
Affiliated with
Regenexx®

60 Business Park Dr Ste A Troy MO 63379
54 The Legends pkwy Ste 153 Eureka MO 63025

How did you hear about Regenexx:

_____

PATIENT INFORMATION

General Information

Patient Name:_____ Social Security#: _____
Address:_____
City:_____ State:_____ Zip: _____
Home phone#:_____ May we leave a message at this #? ☐ Ye s ☐ No
Work phone#:_____ May we leave a message at this #? ☐ Yes ☐ No Cell
phone#:_____ May we leave a message at this #? ☐ Yes ☐ No
Email:_____
Date of Birth:_____ Age: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Specify
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race: _____
☐ Decline to Specify

Primary Care Physician (PCP) Information

PCP name: _____
PCP address: _____
PCP phone#: _____
PCP fax#: _____

Insurance

Carrier:_____ Policy#:
ID#:_____ Effective Date: _____
Policy Holder (if different than patient):_____ Date of Birth: _____
Insured through Employment? ☐ Yes ☐ No If so, Employer: _____

Secondary Insurance

Carrier:_____ Policy#:
Effective Date: _____

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EMERGENCY INFORMATION AND SERVICE AGREEMENTS

Emergency Contact

Name:_____Relationship: _____
Address:_____
City:_____State:_____Zip: _____
Telephone#: ☐ Home _____
☐ Cell Phone _____
☐ Work _____

Payment is expected at the time services are rendered.

*I understand that by missing appointments or cancelling/rescheduling with less than 72 hours advance notice may result in the provider determining that I am unwilling or unable to comply with the treatment plan determined to be the best option for my care. Fee will be charged of $50.00 for no show fee for consultation appointments and $100.00 for missed procedures, no exceptions.

Please read carefully before signing: I hereby authorize Regenexx to release information acquired during the course of my examination and treatment to Centers for Medicare/Medicaid Services (CMS) and its agents or any other third party carrier, as necessary, to secure payment of any benefits due. I hereby assign payment of said benefits to include Medicare and commercial insurance directly to Regenexx for any medical procedures performed. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Patient name: _____

Signature:_____Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home phone ☐ Cell phone ☐ Work phone

☐ Written communication: ☐ Okay to mail to home address
☐ Okay to email me at this email address
☐ Okay to fax to this number

☐ Okay to leave information with specified people (i.e. attorney, spouse, friend, Primary Care Physician). ***Please include name, relationship, and phone number:***

_____

_____

_____

Patient Signature:_____ Date: _____

Print Name: _____

Date of Birth: _____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

MUSCULOSKELETAL
NEW PATIENT HISTORY

Patient Name______________________________Age:_ DOB:____________

Hand Dominance: **D** Right **D** Left

Chief complaint: -

Date of injury: -

When and how did this problem occur: -

Use the symbols below to mark areas on the body where you feel that type of sensation:

KEY:

numbness

A A A **ache**

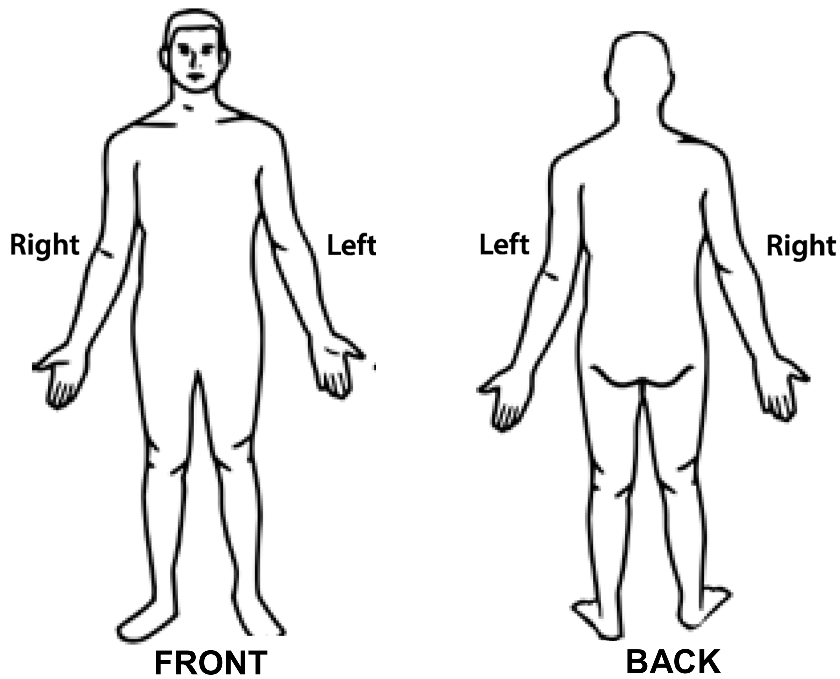
000 **pins and needles**

/ / / stabbing

XXX burning

shooting

*** * * tingling**



Pain Rating Scale

Please make an "X" on the line below that corresponds to the area of your body that you feel pain and its severity. Rate how much your pain hurts on an average day by placing the "X" along the line from "NO PAIN" on the left to "WORST PAIN I CAN POSSIBLY IMAGINE" on the right.

	NO PAIN 0									WORST PAIN I CAN POSSIBLY IMAGINE 0
Back Pain	1	2	3	4	5	6	7	8	9	10
Leg Pain	1	2	3	4	5	6	7	8	9	10
Neck Pain	1	2	3	4	5	6	7	8	9	10
Arm Pain	1	2	3	4	5	6	1	8	9	10

When do you experience pain? _____

_____

What makes your pain worse? _____

_____

What makes your pain better? _____

_____

What daily activities does this problem affect? _____

Have you received any of the following for this problem? **D** CT Scan **D** MRI **D** EMG DX-Rays D Injections D Surgeries

MUSCULOSKELETAL

New Patient History

Patient name: _____

Review of Systems: CIRCLE any symptoms or findings below that you have experienced recently:

Constitutional: Weight change, Weakness, Fatigue, Fever, Nausea

Eyes: Vision problems, Double Vision

ENMT: Hearing problem, dizziness, Sinus trouble, Sore throat, Ringing Ears

Cardiovascular: Shortness of breath, Chest pain, leg swelling, Increased blood pressure

Respiratory: Cough, Coughing up blood, Wheezing, Asthma

Gastrointestinal: Trouble Swallowing, Heartburn, Vomiting, Diarrhea, Bloody or Black Tar Stools

Genitourinary: Pain with urination, Blood in urine, Urgency, Incontinence

Musculoskeletal: Joint pain/stiffness, Cramps, Weakness, Loss of motion

Skin: Rash, Lumps, Itching, Dryness, Hair changes, Nail changes

Neurological: Fainting, Blackouts, Seizures, Paralysis, Weakness, Numbness, Memory loss, Headaches

Psychological: Nervousness, tension, mood changes, depression, anxiety

Endocrine: Heat or cold intolerance, sweating, thirst, changes with hunger

Hematology: Bruising, bleeding, transfusion reactions

Past Medical History

Allergies to medications/foods/chemicals?_____

Check those that you have been diagnosed with:

- ☐ Diabetes
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Sleep Disorders
- ☐ Stomach Ulcers
- ☐ Cancer
- ☐ Heart Murmur
- ☐ HIV/AIDS Hepatitis
- ☐ Osteoarthritis or Rheumatoid Arthritis
- ☐ Stroke
- ☐ Anemia
- ☐ Seizures
- ☐ Hyper/Hypo Thyroid
- ☐ Osteoporosis
- ☐ Deep Vein Thrombosis
- ☐ Broken Bones
- ☐ Bowel or Bladder Incontinence
- ☐ Gout
- ☐ Other

Medications
Please include dosage and amount, if known:_____

_____

Surgeries
Please include dates:_____

_____

Injuries
Please include broken bones, concussion, motor vehicle accidents, falls, etc.:_____

_____

_____

Family History of Medical Problems

CHECK those that apply:

- ☐ Arthritis
- ☐ Back Problems
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Cancer
- ☐ Other:_____

Social History
Do you exercise? ☐ Yes ☐ No
If yes, what type of exercise?_____

_____

Do you use tobacco, alcohol, or street drugs? ☐ Yes ☐ No

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☐ Written communication: ☐ Okay to mail to home address
☐ Okay to email me at this email address
☐ Okay to fax to this number

☐ Okay to leave information with specified people (i.e. attorney, spouse, friend, Primary Care Physician). ***Please include name, relationship, and phone number:***

_____

_____

_____

Patient Signature:_____Date: _____
Print Name: _____
Date of Birth: _____

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