Reno Regenerative Medicine

Regen Providers - 730 Sandhill Road, Suite 120 Reno, NV 89521

PATIENT DEMOGRAPHIC INFORMATION

[PATIENT]

Last Name: _____ First Name: _____ MI: _____

Preferred Name/Nickname: _____ Whom may we thank for referring you? _____

DOB: _____/ _____/ _____ SEX: ☐M ☐F SS #: _____ DL #: _____

Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Email Address: _____

Cell Phone #: (_____)_____-_____ Home Phone #: (_____)_____-_____ Carrier: _____

Street Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired

Employer: _____ Work Phone #: (_____)_____-_____

[SPOUSE/GUARDIAN]

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ ☐ Cell ☐ Home Phone #: (_____)_____-_____

Employer: _____ Work Phone #: (_____)_____-_____

[EMERGENCY CONTACT(S)] - ☐ Same as above ☐ In addition to above

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ ☐ Cell ☐ Home Phone #: (_____)_____-_____

Employer: _____ Work Phone #: (_____)_____-_____

Please initial and sign below to acknowledge that you have read and understand these authorizations.

_____ **I authorize you to leave a detailed message on my phone regarding appointments.**

_____ **I authorize you to leave a detailed message on my home or cell phone number regarding medical treatment, care, test results, or financial information.**

_____ **Messages may only be left with (select *all* that apply):**

☐ SELF ☐ Persons Listed Above ☐ Persons upon answer

☐ Other: _____

[RELEASE OF PROTECTED HEALTH INFORMATION]

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the results of tests, procedures, and financial information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic results, appointment information, and/or financial information released to any family members you must sign this form. Further release of medical information may require a signed authorization release of health information form depending on the information requested.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize the release of my protected health information to the persons listed below. (e.g., spouse, parent, etc):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Printed Name_____ **Date**_____

_____

Signature of Patient or Responsible Party

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PRIMARY INSURANCE INFORMATION

Subscriber Last Name: _____ First Name: _____ MI: _____

DOB: _____/ _____/ _____ SEX: ☐M ☐F Social Security #: _____

Relationship to Subscriber: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other: _____

Insurance Company: _____

POLICY ID #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Subscriber Last Name: _____ First Name: _____ MI: _____

DOB: _____/ _____/ _____ SEX: ☐M ☐F Social Security #: _____

Relationship to Subscriber: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other: _____

Insurance Company: _____

POLICY ID #: _____ Group #: _____

[RESPONSIBLE PARTY] (Complete if different than patient or if patient is a dependent) - ☐ SELF

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Phone #: (_____)_____-_____

Please initial and sign below to acknowledge that you have read and understand your responsibility as a patient.

_____ **To ensure a wonderful patient experience we want you to understand you are financially responsible for anything your insurance allows and does not pay. The deductible, co-insurance and co-pay are your financial responsibility. All copays are due and payable at each visit unless prepaid. The amount your insurance will allow and pay for, and your responsibility is determined by your agreement with your insurance company based on the policy you have chosen. Your claims will be processed according to the benefits of your insurance plan. It is your responsibility to know and understand your insurance plan, your deductible and your co-insurance. These fees may also apply:**

_____ **No Show Policy - Please call at least 24 hours before your appointment if you are unable to come in.**

_____ **$35 NSF charge - Any returned check from the bank.**

_____ **If you are a private pay patient without insurance, payment for all services is due at the visit.**

_____ _____

Patient Printed Name **Date**

_____

Signature of Patient or Responsible Party

Revised January 2024

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Health History

Last Name: _____ First Name: _____ MI: _____

DOB: _____/ _____/ _____ Today's Date: _____/ _____/ _____

Chief Complaint: _____

(Describe your symptoms including the location)

Rate your overall symptoms 0 being no pain 10 being the worst pain_____

How long have you had these symptoms? _____

How often do you experience these symptoms (circle)? **Constant, Frequent, Intermittent, Occasional, Rare, Unknown**

The symptoms were caused by (circle): **Chronic problems, Auto accident, work related accident, worsening of long-term issue**

Other causes: _____

Describe the symptom characteristics, circle all that apply: **aching, burning, dull, sharp, throbbing**

Does the pain radiate to other parts of the body, if so where?_____

Do you have numbness or tingling, if so where?_____

What makes your symptoms worse (circle)? Nothing, Bending, Lifting, Physical Activity, Walking, Other_____

What relieves your symptoms (circle)? Nothing, Cold, Heat, Massage, Medication, Rest, Other_____

What interventions have you tried (check)?

- ☐ No Treatment
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Heat/Ice
- ☐ Homeopathic Remedies
- ☐ Injection(s)
- ☐ Massage
- ☐ Over the counter medications
- ☐ Physical therapy
- ☐ Prescription medication
- ☐ Surgery
- ☐ Other_____

Select all previous tests performed to evaluate your symptoms:

Location and year of testing:

_____

_____

_____

- ☐ CT Scan
- ☐ MRI
- ☐ X-ray
- ☐ EMG nerve testing
- ☐ Peripheral vascular studies

Exposures:

At home or at work to:

☐ Chemotherapy ☐ Agent Orange ☐ Statin Medications ☐ Methotrexate
☐ Environmental toxins

Do any of these Medical Problems Apply to You? (Select as many as appropriate)

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Blood Pressure High
☐ Blood Pressure Low
☐ Cancer
☐ Chemotherapy
☐ Degenerative Disc Disease
☐ Diabetes
☐ Foot or ankle problems
☐ Other_____

☐ Gout
☐ Hepatitis
☐ Hip disorders
☐ History of Stroke
☐ Incontinence
☐ Kidney Disease
☐ Kidney Stones
☐ Knee Problems
☐ Metal in the Body
☐ Multiple Sclerosis
☐ Other_____
_

☐ Neck or Back Problems
☐ Neuropathy
☐ Non-healing wounds
☐ Spinal Surgery
☐ Sexually transmitted infections
☐ Seizures or Epilepsy
☐ Pain Stimulators
☐ Sexual Dysfunction
☐ Shoulder elbow, wrist or hand problems
☐ Vasectomy
☐ **None of the above apply**

Previous Surgeries? (Select as many as appropriate)

	Date of Surgery		Date of Surgery
☐ Joint Surgery	_____	☐ Pacemaker/Defibrillator	_____
☐ Artificial joint replacement	_____	☐ Pain Stimulator	_____
☐ Spinal surgery	_____		

List any other medical problems or surgeries not listed above.

_____

_____

***Patient Social History*:**

Use of Alcohol weekly: ☐ Never ☐ less than 3 drinks ☐ 4-7 drinks ☐ 8-12 drinks ☐ 13 or more drinks

Use of Tobacco: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

If you quit smoking, how long ago?_____

Family Medical History (Check all that apply)

Arthritis	☐ No Family HX	☐ Parent	☐ Sibling	☐ Both Parent and Sibling
Cancer	☐ No Family HX	☐ Parent	☐ Sibling	☐ Both Parent and Sibling
Diabetes	☐ No Family HX	☐ Parent	☐ Sibling	☐ Both Parent and Sibling
Hypertension	☐ No Family HX	☐ Parent	☐ Sibling	☐ Both Parent and Sibling
Stroke	☐ No Family HX	☐ Parent	☐ Sibling	☐ Both Parent and Sibling
Thyroid Issues	☐ No Family HX	☐ Parent	☐ Sibling	☐ Both Parent and Sibling

Medication History

*If you already have a list with you, please let us make a copy and refrain from filling out this form.

* Please ensure to fill out the allergies portion on the next page and sign this document.

Medication Name	***Dosage***	***Frequency***

Allergies - ☐ I have no know allergies at this time

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Printed Name **Date**

Signature of Patient or Responsible Party

Reno Regenerative Medicine

CONSENT TO TREAT

Exam & X-Rays (if needed)

I hereby request and consent to the performance of a medical exam and diagnostic x-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the licensed medical provider (i.e.: doctor or chiropractic, medical doctor, nurse practitioner, or physician's assistant).

I will have an opportunity to discuss with the licensed medical provider (i.e.: Doctor of Chiropractic, medical doctor, nurse practitioner, or physician's assistant) the nature and purpose of the above named procedures.

I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in there are some risks to diagnostic services including but not limited to:

> *Radiographs:* ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I have read, or have had read to me, the above consent, and by signing below I agree to the above-named procedures.

_____ _____

Patient Printed Name Date

_____

Signature of Patient or Responsible Party

HIPAA Form

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Licensed Medical Provider" any licensed medical providers (i.e.: doctor of chiropractic, medical doctor, nurse practitioner, or physician's assistant) who now or in the future works at Reno Regenerative Medicine, LLC.

I consent to the use or disclosure of my protected health information by the Medical Provider for analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Medical Provider. I understand that analysis, diagnosis or treatment of me by the Medical Provider may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Medical Provider is not required to agree to the restrictions that I may request. However, if the Medical Provider agrees to a restriction that I request, the restriction is binding on the Medical Provider.

I have the right to revoke this consent, in writing, at any time, except that the Medical Provider has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have the right to request a copy of the Notice of Privacy Practices of the Medical Provider and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Medical Provider. This Notice of Privacy Practices also describes my rights and duties of the Medical Provider with respect to my protected health information.

The Medical Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Medical Provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Patient Printed Name Date

_____

Signature of Patient or Responsible Party

FINANCIAL POLICY

As a courtesy to you, our practice member, we will be happy to accept assignment of benefits for most insurance companies. However, it must be understood that the contract is between the practice member and the insurance company. The patient is fully responsible for any amount not paid by the insurance carrier. Our office policy regarding insurance claims is as follows:

- It is the practice member's responsibility to provide our office with correct and up to date insurance or billing information at the time of service, or the fees must be paid in full.

- For Out-of-Network patients, Regen Providers shall make every reasonable effort to collect on every claim from the patient or through negotiation with the insurance company, without putting undue hardship on the patient. When a patient is first seen at Reno Regenerative Medicine or Ascension Health the staff shall make reasonable efforts to collect some of the patient responsibility up front to cover some of the cost of services.

- Whenever a claim is fully and properly adjudicated and settled according to federal law and Regen Providers has a firm understanding of the patient's responsibility, Reno Regenerative Medicine or Regen Providers shall make reasonable efforts to collect the patient's true remaining balance. When a third-party billing company is used to submit an insurance claim, Regen Providers can only determine true responsibility once the third-party billing company notifies Regen Providers that the claim has been fully and finally adjudicated in accordance with law. Patient's true remaining balance will be due 30 days from receipt of billing unless other payment arrangements have been established.

- Our office accepts personal checks, debit cards, cash and credit cards.
    - A charge of $35.00 will be assessed for any returned checks. The practice member/guarantor will be held responsible for any collection charges on a delinquent account.

- Disclosure of Ownership Interest: Lloyd Decker, DC owns and has a financial relationship in Reno Regenerative Medicine LLC, Regen Providers LLC and Ascension Health LLC. You have the right to choose an alternative source of service provider. Should you desire to do so, please contact the office and ask for a list of alternate practices and/or providers.

If you understand and agree with all of the above office policies, please sign your name below and we will be happy to accept your insurance assignment authorizing payment to Reno Regenerative Medicine or Regen Providers.

_____ _____

Patient Printed Name Date

_____

Signature of Patient or Responsible Party