



PLEASE ARRIVE AT LEAST 30 MINUTES PRIOR TO YOUR APPOINTMENT.

PATIENT INFORMATION

How did you hear about Regenexx?: _____

General Information

Patient Name: _____ Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ May we leave a message at this #? [] Yes [] No Work
Work Phone #: _____ May we leave a message at this #? [] Yes [] No Cell
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 #: _____

Preferred Pharmacy Information

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone #: _____ Pharmacy Fax #: _____

Insurance

Carrier: _____ Address: _____
Policy #: _____ Account #: _____
Benefit Code: _____ Effective Date: _____
Precertification Required? [] Yes [] No Contact: _____
Telephone #: _____
Policy Holder (if different than patient): _____ Date of Birth: _____
Insured through Employment? [] Yes [] No If so, Employer: _____

Secondary Insurance

Carrier: _____ Address: _____
Policy #: _____ Account #: _____
Benefit Code: _____ Effective Date: _____
Precertification Required? [] Yes [] No Contact: _____
Telephone #: _____
Policy Holder (if different than patient): _____ Date of Birth: _____
Insured through Employment? [] Yes [] No If so, Employer: _____



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.**

This notice was published, and becomes effective on/or before **April 14, 2003.**

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.



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.

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, Medigap 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 Medigap 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. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. 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: _____

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

I accept

I decline

Signature: _____ Date: _____

PLEASE ARRIVE AT LEAST 30 MINUTES PRIOR TO YOUR APPOINTMENT.

Patient Name _____ Age: _____ DOB: _____ Hand Dominance: Right Left

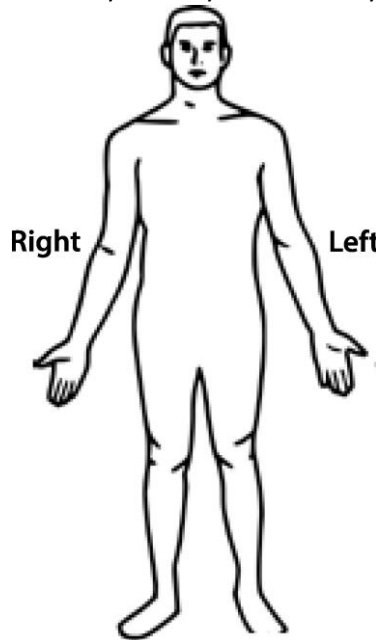
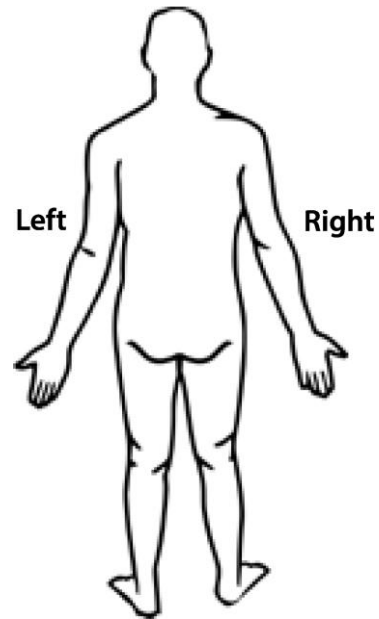
Chief Complaint: _____

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
^^^	ache
000	pins and needles
///	stabbing
XXX	burning
---	shooting
***	tingling


FRONT

BACK
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										WORST PAIN I CAN POSSIBLY IMAGINE
Back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg Pain	0	1	2	3	4	5	6	7	8	9	10
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Arm Pain	0	1	2	3	4	5	6	7	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? CT Scan MRI EMG X-Rays Injections Surgeries

Review of Systems: Circle any of the symptoms below that you've experienced recently

Constitutional: weight change, weakness, fatigue, fever, nausea

ENMT: hearing problems, dizziness, sinus trouble, sore throat, ringing ears

Eyes: vision problems, double vision

Respiratory: cough, coughing up blood, wheezing, asthma

Cardiovascular: shortness of breath, chest pain, leg swelling, increased blood pressure

Gastrointestinal: trouble swallowing, heartburn, vomiting, diarrhea, blood 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: List all medication/food/chemical allergies No Allergies

Prescription Medications: None

Over The Counter Medications/Supplements/Vitamins/Creams/Eye Drops/Oils/Etc. None

Medical Illnesses: Check those you have been diagnosed with None

Diabetes Asthma High Blood Pressure Heart Attack Sleep Disorders Stroke Stomach Ulcers Cancer

Heart Murmur HIV/AIDS Hepatitis Anemia Seizures Hyper/Hypo Thyroid Osteoporosis Deep Vein

Thrombosis Broken Bones Bowel or Bladder Incontinence Gout Osteoarthritis or Rheumatoid Arthritis

Other: _____

Injuries: Please include broken bones, concussion, motor vehicle accidents, falls, etc. No Injuries

Surgeries: Please include dates No Surgeries

Family History: Check those that apply No family history of medical problems

Arthritis Back Problems Heart Problems Diabetes Cancer Other: _____

Social History:

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

Occupation: _____

Hobbies/Interests: _____

Do you use tobacco? Yes No If yes, how often? _____

Do you use alcohol? Yes No If yes, how often? _____

Do you use drugs? Yes No If yes, how often? _____

