REGENEMED BIO HEALTH®

** PLEASE NOTE ALL REGENERATIVE TREATMENTS ARE NOT COVERED BY INSURANCE AND IT IS A SELFPAY SERVICE

REGENERATIVE MEDICINE NEW PATIENT PACKET

PATIENT NAME: _____ DOB: _____

HOME ADDRESS: _____

PHONE#: _____ EMAIL: _____

SS#:_____ DRIVER LICENSE#:_____

GENDER (CHECKMARK) MALE___ FEMALE___ MARITAL STATUS:_____

PRIMARY RACE: (CHECK ALL THAT APPLY)

WHITE___ AFRICAN AMERICAN___ AMERICAN INDIAN___ HISPANIC___ DECLINE TO SPECIFY

ETHNICITY: ___ HISPANIC OR LATINO ___ NOT HISPANIC OR LATINO ___DECLINE TO SPECIFY

EMERGENCY CONTACT:_____ PHONE#: _____

EMPLOYER NAME:_____ OCCUPATION: _____

PRIMARY CARE DR: _____ PHONE#:_____

HOW DID YOU HEAR ABOUT THE OFFICE?: _____

REASON FOR THE VISIT? _____

I CERTIFY THAT THE INFORMATION I HAVE REPORTED IS CORRECT

SIGNATURE: _____ DATE: _____

REGENEMED BIO HEALTH®

NAME : _____

DATE : _____

PCP : _____

REFERRAL SOURCE :_____

PRIMARY INS : _____

PHARMACY :

_____

PHARMACY PHONE# :

_____

PHARMACY LOCATION :

_____

Allergies (Please list *or* write "NONE" if applicable)

1)_____ **2)**_____ **3)**_____

Current Medications (Attach additional paper, as needed)

drug name_____**dose**_____**freq**_____
drug name_____**dose**_____**freq**_____
drug name_____**dose**_____**freq**_____
drug name_____**dose**_____**freq**_____
drug name_____**dose**_____**freq**_____

Medical History (If you have had these conditions, check ones that apply)

	ALCOHOLISM		BLEEDING DISORDER		HEART ATTACK		KIDNEY DISEASE		SEIZURES
	ARTHRITIS/RA/OA		DIABETES I OR II		HEART DISEASE		DRUG ABUSE		STROKE
	ASTHMA		EMPHYSEMA		HIGH BLOOD PRESSURE		DEPRESSION		TB
	GOUT		HIV/AIDS		THYROID DISEASE		REFLEX (GERD)		SHINGLES
	SPINAL STENOSIS		CANCER:				OTHER:		

Surgical History (If you have had surgery, circle, and list all that apply. Include the year of surgery.)

	HEART	BYPASS	ANGIOPLASTY	STENTS		FRACTURE	WHERE:	WHEN:	OTHER? LIST BELOW
	SPINE	CERVICAL	THORACIC	LUMBAR		CANCER	WHERE:	WHEN:	

Social History (Circle all that apply) Smoking Alcohol Drugs Do you live alone? YES or NO

Occupation? _____ **Number of children**?_____ **Retired? From:** _____

Family History (circle all that apply. Please specify relationship, Mother, Father, etc...)

	ALCOHOLISM		BLEEDING DISORDER		HEART ATTACK		KIDNEY DISEASE		SEIZURES
	ARTHRITIS/RA/OA		DIABETES I OR II		HEART DISEASE		DRUG ABUSE		STROKE
	ASTHMA		EMPHYSEMA		HIGH BLOOD PRESSURE		DEPRESSION		TB
	GOUT		HIV/AIDS		THYROID DISEASE		REFLEX (GERD)		SHINGLES
	SPINAL STENOSIS		CANCER:				OTHER:		

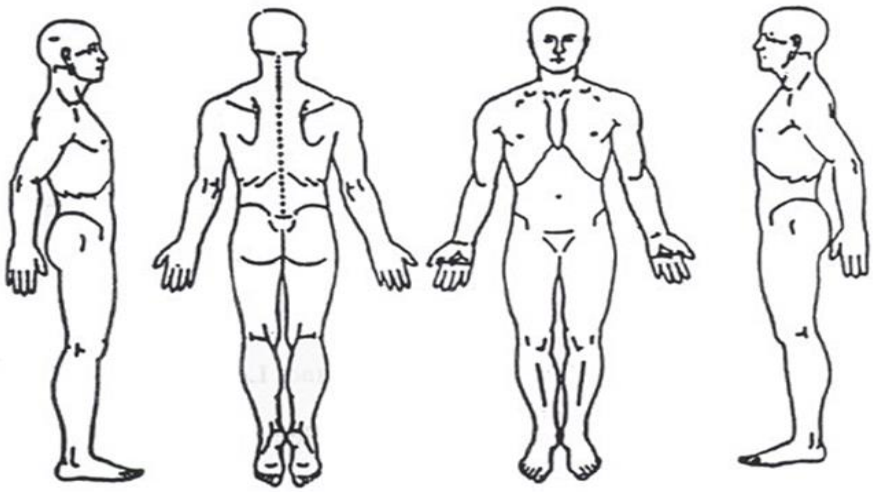
Review of Systems (How are you feeling? Check off all that currently apply)

	HEADACHES		FAINTING
	SHORTNESS OF BREATH		NEURO ISSUES
	BLOOD IN URINE		HEARTBURN
	KIDNEY DISORDER		KIDNEY STONES
	SHINGLES		CONSTIPATION
	BLADDER/BOWEL		BLACK OUTS
	DENTURES		COPD/LUNG ISSUES
	CHEST PAIN		VERTIGO
	PALPITATIONS		DIARRHEA
	WHEEZING		NAUSEOUS
	SKIN DISORDER		VOMITING
	CARDIAC DISORDER		OTHER LIST BELOW
	HEARING LOSS		
	VISION CHANGES		
	TROUBLE URINATING		

PAIN TYPE AND LOCATION:

SHARP STABBING DULL ACHING BURNING NUMBNESS/TINGLING

^^^^ XXXX :::: NNNN



REGENEMED BIO HEALTH®

PATIENT CONSENT TO RECEIVE MAIL OR PHONE CALLS

Do we have your permission to:		YES	NO
1	Mail appointment reminders to your home?		
2	Call you at home?		
3	Call you at work?		
4	Leave a message on your home phone?		
5	Leave a message on your work phone?		
6	Share appt info with the person that answers your phone?		
7	Share appt info with the person that answers your work phone?		

☐ ☐ ☐

Preferred method for appt reminders: TEXT EMAIL PHONE

Phone#: _____ Email: _____

****

AUTHORIZATION FOR FAMILY OR FRIENDS TO RECEIVE INFOR1'1ATION ABOUT YOUR MEDICAL CONDITION OR BILL

I authorize the following individual(s) to receive written and/or oral communications about my medical condition, care, appointments, and the status of my bill. I understand that they need to provide the last four digits of my social security number for oral communication. If they should come to pick up a prescription or to discuss my care or thestatus of my bill, they will need to bring a photo ID.

_____ _____

Name/Relationship Name/Relationship

_____ _____

Name/Relationship Name/Relationship

_____

PATIENT SIGNATURE

REGENEMED BIO HEALTH®

MEDICAL RECORD RELEASE

DATE .....

PATIENT NAME .....

RECORDS REQUESTED FROM .....
NAME

SPECIFIC RECORDS _____

☐ ALL MEDICAL RECORDS

I hereby authorize and request you to release the medical records requested above to OrthoMed Pain & Sports Medicine. I understand that they may contain information regarding my illness and/or treatments. They may also contain psychiatric, alcohol, HIV, or drug abuse information.

DATES FROM ..... TO .....

_____ _____

PATIENT SIGNATURE **DOB**

Requested by Dr. William J Cole Jr. D.O.

OrthoMed Pain & Sports Medicine, LLC

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (941) 371-7171.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. OrthoMed Pain & Sports Medicine provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The participant understands that:

· Protected health information may be disclosed or used for treatment, payment or health care operations.
· OrthoMed Pain & Sports Medicine has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
· OrthoMed Pain & Sports Medicine reserves the right to change the Notice of Privacy Practices.
· The participant has the right to request restrictions to the uses of their information but OrthoMed Pain & Sports Medicine does not have to agree to those restrictions.
· The participant may revoke this Consent in writing at any time and full disclosures will then cease.
· OrthoMed Pain & Sports Medicine may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

_____

NAME (PRINT)

_____ _____

SIGNATURE **DATE**

_____ _____

SIGNATURE OF REPRESENTATIVE DATE

NO SHOW POLICY & PROCEDURES

I. Purpose

A. To assure that patients have access to care when needed by maximizing the utilization of available appointments.
B. To provide a mechanism for appropriately managing the patient that fails to utilization of available appointments.

II. Cancellation/ No Show Policy for New patient consultation, Office Visits, Med. Refill, OMT, Procedures, TPI.

A. If a patient is unable to keep their appointment, they are required to cancel their appointment with appropriate prior notice (72 hours).
B. Failure to the patient to cancel their appointment without a 72-hour notice is considered a "No Show" for purpose of this policy.

III. Cancellation/ No Show Policy for Radio Frequency Ablation (RFA)

Due to the large block of time needed for Radio Frequency Ablation (RFA), last minute cancellations can cause problems and added expenses for the office.
If Radio Frequency Ablation (RFA) is not cancelled at least five (5) business days in advance you will be charged a two hundred dollars ($200) fee; this is will not be covered by your insurance company.

IV. *Same Day/ Acute "NO SHOWS"

The patient who fails to keep a same day or an acute appointment, and does not cancel appointment with appropriate notice, is counted and managed as other "No Show".

APPOINTMENT	NO SHOW FEE
New Patient Consultation	$100
Office Visit	$100
Medication Refill	$100
OMT	$100
Procedures/PRP	$150
RFA	$200
TPI	$100

_____ _____

PATIENT SIGNATURE **DATE**

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC &/OR VIDEO IMAGES

AUTHORIZATION:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy regulations.

PURPOSE:

The photographic/video images, and/or testimonial will be used for: *social media and/or advertising.*

REVOCABILITY:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

If desired, copy provided.

☐ "YES, I would like a copy of this form." form given to patient by _____ (initial)

☐ NO I DO NOT CONSENT FOR DISCLOSURE OF IMAGES/VIDEO

_____ _____

PATIENT SIGNATURE **DATE**

IF PERSONAL REPRESENTATIVE/GUARDIAN:

_____ _____

PRINTED NAME RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE DATE

REGENEMED BIO HEALTH®

OPIOID RISK TOOL

NAME: _____ DATE: _____

AGE: _____ SEX: M F

FAMILY HISTORY OF SUBSTANCE ABUSE

(CHECK ONLY BOXES THAT APPLY)	YES	NO
FAMILY HISTORY OF ALCOHOL?		
FAMILY HISTORY OF ILLEGAL DRUGS?		
FAMILY HISTORY OF RX DRUGS?		

PERSONAL HISTORY OF SUBSTANCE ABUSE

(CHECK ONLY BOXES THAT APPLY)	YES	NO
PERSONAL HISTORY OF ALCOHOL?		
PERSONAL HISTORY OF ILLEGAL DRIGS?		
PERSONAL HISTORY OF RX DRUGS?		
AGE BETWEEN 16-45 YEARS?		
HISTORY OF PREADOLESCENT SEXUAL ABUSE?		

PSYCHOLOGIC DISEASE

(CHECK ONLY BOXES THAT APPLY)	YES	NO
ADD, OCD, BIPOLAR, SCHIZOPHRENIA?		
DEPRESSION?		

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

(USE "X" TO INDICATE YOUR ANSWER)

OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING QUESTIONS:	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
	0	1	2	3
LITTLE INTREST OR PLEASURE IN DOING THINGS				
FEELING DOWN, DEPRESSED OR HOPELESS				
TROUBLE FALLING OR STAYING ASLEEP, OR SLEEPING TOO MUCH				
FEELING TIRED OR HAVING LITTLE ENERGY				
POOR APPETITE OR OVEREATING				
FEELING BAD ABOUT YOURSELF OR THAT YOU ARE A FAILURE, OR HAVE LET YOURSELF OR FAMILY DOWN				
TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TV				
THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD OR HURTING YOURSELF IN SOME WAY				
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED; OR THE OPPOSITE, BEING SO FIGITEY OR RESTLESS THAT YOU HAVE BEEN MOVING AROUND MORE THAN USUAL				