PATIENT INFORMATION

General Information

Patient Name:_____ Social Security#:_____
Address:_____
City:_____ State:_____ Zip:_____
Home phone#:_____ May we leave a message at this #? ☐ Yes ☐ 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:_____ 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:_____

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 I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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

Signature:_____ Date:_____

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

☐ I accept
☐ I decline

Signature:_____ Date:_____

Regenexx®

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.