PATIENT DEMOGRAPHIC FORM

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Preferred Phone: _____ ❑ Home ❑ Cell ❑ Work May we leave a message? ❑ Yes ❑ No

Secondary Phone (if applicable): _____ May we leave a message? ❑ Yes ❑ No

Email: _____ Ethnicity: ❑ Decline ❑ Hispanic or Latino ❑ Not Hispanic Latino

Race: ❑ Decline ❑ African American or Black ❑ American Indian or Alaskan Native ❑ Asian

❑ Native Hawaiian or Other Pacific Islander ❑ White ❑Other

Primary Doctor: _____ Primary Doctor Phone: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Pharmacy Phone: _____

Primary Insurance: _____ Subscriber/Policy ID Number: _____

Group Number: _____ Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

If Different Than Patient; Policy Holder's Name: _____ DOB: _____

Do You Have a Secondary Insurance? ❑ Yes ❑ No (If yes, please provide primary and secondary insurance cards at the time of your appointment)

Emergency Contact: _____ Relationship: _____

Phone: _____ ❑ Home ❑ Cell ❑ Work

Alternate Phone: _____ ❑ Home ❑ Cell ❑ Work

Do you have Advanced Directives? ❑ Yes ❑ No

Do you have a Durable Power of Attorney for Medical Care? ❑ Yes ❑ No

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT

PATIENT RECORD OF DISCLOSURES & COORDINATION OF CARE

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.

It is company policy to not have recorded evaluations. We encourage the patient to take notes. Upon request, the company can provide a copy of the Doctor's evaluation.

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?
❑ Yes ❑ No If Yes, person's name: _____ Relationship: _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- Telephone Communication
  - ❑ Home telephone
    - ❑ Okay to leave a message
  - ❑Work telephone
    - ❑ Okay to leave a message
- Written Communication
  - ❑ Okay to mail home address
  - ❑ Okay to mail work address

❑Okay to leave information with specified people. (Primary care physician, spouse, attorney, friend, etc)

Please include name, relationship, and phone number:

_____

_____

_____

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

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.

____Regenexx Des Moines is committed to providing excellent, personalized patient care. To do so, we understand that you may need to email and/or text your provider during your treatment. Communication through email and/or text is not encrypted and may pose a HIPAA risk if sensitive information is communicated, and a breech were to occur. By initialing, you agree that if you use electronic communication with your provider, you are assuming this unlikely risk.

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT

FINANCIAL POLICY

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral or prior approval, I must obtain it prior to my visit.
- If, in the event that, my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Regenexx Des Moines on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Regenexx Des Moines to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Regenexx Des Moines. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

5. NON-PAYMENT ON ACCOUNT

Payment is due the day of treatment or within 10 days of receipt of your billing statement. Any balance over 90 days will be referred to a collection agency and the balance not paid will begin to accrue interest at the rate of 1.5%/month or the maximum allowed by law, whichever is lower. In addition, you agree you will be responsible for all costs of collection – late fees, charges, interest, court costs, collection fees, legal and other costs of collection.

I have read the *Financial Policy*. I understand and agree to the *Financial Policy*. I acknowledge that a copy of Regenexx Des Moines' *HIPAA Notice of Privacy Practices was made available*.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

A copy of this signed, dated document shall be effective as the original.