

REGENERATION, P.C.

PATIENT INFORMATION

Date _____

Patient Name

_____/_____/_____
Date of Birth

Street Address

City

State

Phone Number

Alternate Phone Number

Email Address

Insurance Carrier: _____ Policy number: _____

Emergency Contact: _____ Phone number: _____
Relationship: _____

How did you hear about Regeneration PC?

MEDICAL INFORMATION

Are you currently under the care of a physician? YES NO

Please list current providers involved in your care:

PLEASE LIST ANY CURRENT MEDICAL CONDITIONS:

PLEASE LIST ANY ALLERGIES:

PLEASE LIST CURRENT MEDICATIONS AND SUPPLEMENTS:

PLEASE LIST PREVIOUS SURGERIES:

Do YOU have any of the following medical conditions?

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problem |
| <input type="checkbox"/> Lung Problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chemotherapy(active) |

Do you have a FAMILY HISTORY of any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Stroke Cancer | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Thyroid disease |

WOMEN ONLY:

Are you currently Pregnant or Breastfeeding?

YES

NO

Last Menstrual Period _____

Last Pap Smear: _____

Last Mammogram: _____

CONSENT TO FILE INSURANCE/FINANCIAL RESPONSIBILITY

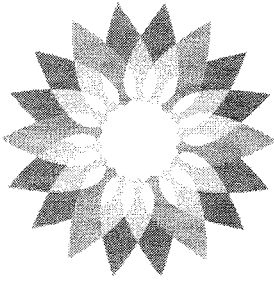
Your medical health coverage is a contract between you and your insurance company. Regeneration, P.C. will file in-network medical insurance claims. In-network insurance company co-payments and deductibles are due at the time of service.

Patients with out of network insurance, Medicare and Medicaid are responsible for payment in full at the time of service. A billing statement will be prepared for you to file with your insurance company.

By my signature below, I give my consent to Regeneration, P.C. to file a medical claim to my carrier. I understand that all unpaid charges are my responsibility.

Printed name: _____ **Date:** _____

Patient or legal guardian signature: _____



REGENERATION, P.C.

HIPPA INFORMATION AND CONSENT FORM

What this is all about: The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with the office services. HIPAA provides certain rights and protections to you as a patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

Regeneration, P.C. has adopted the following practices:

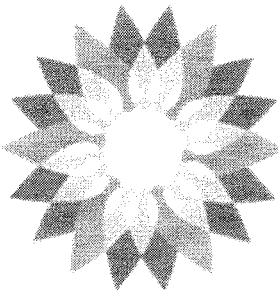
1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to person other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records. PHI and other documents or other information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilized a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA
4. You understand and agree to inspections of the office and review the documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office of Regeneration, P.C.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better service the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations.
2. The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
3. The practice reserves the right to change the notice of privacy practices.
4. The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

(Date)



REGENERATION, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and /or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting the owners.

By signing this form, you acknowledge receipt of the notice of Privacy Practice for Regeneration, P.C.

Patient name printed

Patient signature

Date

Witness name printed

Witness signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

_____ The patient refused to sign

_____ Due to an emergency situation it was not possible to obtain an acknowledgement

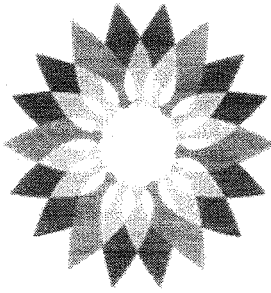
_____ We weren't able to communicate with the patient

_____ Other: _____

Employee Signature

Date

This form does not constitute legal advice and covers only Federal not state law



REGENERATION, P.C.

We recently made the decision to move our billing in house at Regeneration, PC. We are hoping to expedite the billing process and eliminate errors in our billing. We are updating our records with your most recent insurance information. If you are not the carrier of your medical insurance we need the following information. Thank you for your patience during this time of transition.

INSURANCE BILLING INFORMATION:

Your name: _____

I am the policy holder Yes _____ No _____

If no, please complete the following information:

Subscriber Name: _____

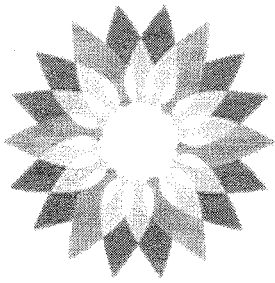
DOB: _____ SSN: _____

Address (if different than patients)

Phone : _____

Employer: _____

Relationship to the patient: _____



REGENERATION, P.C.

CANCELLATION/NO SHOW POLICY

Regeneration P.C. has currently developed a policy of charging a fee for missing appointments or cancelling within a 24 hour notice. The fees must be paid at the time of cancellation or you will receive a bill. The fees are as follows:

Aesthetic Service \$50 fee

Groupon, Today's Deal, and Bid and Buy Service will be counted as used

Medical Patients will get 3 chances but then will be charged a \$50 fee and possible termination from office

The purpose of this fee is to encourage patients to take their appointments as seriously as we do. The reserved time is for you, and we would like to see you keep your scheduled appointment.

We remain available to discuss this policy in general or individual circumstances. Thank you for your understanding.

Print and Sign _____

Date: _____

Regeneration P.C.

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Lincoln, NE 68516

402.483.0431