REGENERATION, P.C.

HEALTH INFORMATION QUESTIONNAIRE

PATIENT NAME _____ AGE _____ DOB _____/_____/_____

INSURANCE CARRIER _____ SSN # _____---_____---_____

ADDRESS _____ CITY/ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

EMAIL _____

CAN WE CONTACT YOU VIA (CIRCLE) MAIL PHONE EMAIL TEXT

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

HOW DID YOU HEAR ABOUT REGENERATION? _____

Have you ever had any of the following conditions? (check all that apply)

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Auto Immune Deficiency
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Chemotherapy (active)
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Infection
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Melanoma
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other – Please Explain

_____

Have you ever had

- ☐ Atopic Dermatitis
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Seborrheic Dermatitis
- ☐ Viitiligo
- ☐ Other skin conditions

Please explain

_____

Previous Cosmetic Facial treatments?
(check all that apply)

- ☐ Botox — Date _____
- ☐ Collagen Fillers — Date _____
- ☐ Chemical Peel — Date _____
- ☐ Waxing — Date _____
- ☐ Facial Surgery — Date _____
- ☐ Laser Surgery — Date _____
- ☐ Microdermabrasion — Date _____
- ☐ Other – Please Explain — Date _____

_____

Have you ever had

☐ Cold Sores or Fever Blisters

Frequency: <1 per year
1 – 3 per year
4+ per year

Other

Are you Pregnant? ☐ Yes ☐ No

Due Date: _____

Are you Lactating? ☐ Yes ☐ No

Do you Tan? ☐ Yes ☐ No

Last Tanning Session _____

Do you scar abnormally? ☐ Yes ☐ No

Are you currently using:

- ☐ Retin-A, Renova, Retinoic Acid Products
- ☐ Prescription Acne Medication
- ☐ Birth Controls Pills / Patch
- ☐ Hormone Replacement
- ☐ Accutane
- ☐ Past Accutane Use _____

Do you have allergies to:

- ☐ Medications
- ☐ Cosmetics
- ☐ Latex/Other

List current medications/supplements that you are taking

_____

_____

_____

List any questions that you have

_____

_____

_____

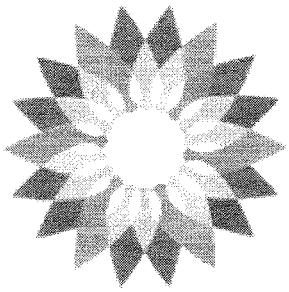
***Please complete the following if you are being seen for a service billable to your insurance company.**

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 time of service. Patients with out of Network insurance are responsible for payment in full at 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. If you have any questions please feel free to ask.

Signature of patient or legal guardian:_____

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.

HIPAA INFORMATION AND CONSENT FORM

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 office services. HIPAA provides certain rights and protections to you as a patient. We balance these needs with out goal of providing you with quality professional service and care. Additional information is available from the U. S. Department of Health and Human Services. www.hhs.gov

Regeneration PC 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 handling of charts, patient records, PHI and other documents or 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 owners of Apex Aesthetics, LLC.
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 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.

By signing this form 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.

_____ _____

Patient name Date

_____ _____

Witness Date

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.

6030 Village Dr., Suite 100

Lincoln, NE 68516

402.483.0431