Blair Regenerative Medicine

1381 Plank Road Suite 102 Duncansville, Pa. 16635

Patient Name:_____Date:_____
DOB:_____Age:_____SS#/SIN:_____
Phone Number:_____Work:_____Email:_____
Check Appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated
Home Address: _____
City:_____State:_____Zip:_____
Gender: □ Male □Female
Employer Name: _____
Spouse or Patient's Guardian: _____
Whom may we thank for referring you? _____
Emergency Contact:_____Phone: _____

In an emergency and the patient is a minor, it is okay for us to treat in absence of parents;

_____ _____
Parent or Guardian Signature Date

Responsible Party (complete if different from above)
Name of The Person responsible for this account _____
Relationship to Patient _____
Address_____
Home Phone:_____Cell Phone _____
Driver's License # _____
Date of Birth: _____
Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, provide the card:
Name of the insured_____
Relationship to patient_____Birthdate_____
Name of Employer_____Work Phone _____
Address of Employer_____
City_____State_____
_____Zip_____ Insurance ID Number:
_____Group #_____Union or local # _____
Ins. Co. Address _____
City_____State_____
_____Zip _____

Updated 8/26/19

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Blair Regenerative Medicine, Jenna Rieg PA, Darryl Warner DC, Michael Lettieri MD,** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Providers") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Providers for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Providers as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Providers all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Providers can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Providers, myself, and/or my family members as a result of services rendered by Healthcare Providers, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Providers is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Providers can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Providers.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this_____day of_____, 20___. X_____
(patient signature)

X_____ _____
(Parent or Guardian Signature, if applicable) (Print name)

Health History

Chief Complaint: _____

History of Chief Complaint:

Location:_____ Quality: _____
(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity:_____ Duration: _____
(Scale of 1-10, 10 is worst pain) (When did it start? How long have you had pain?)

Timing:_____ Context: _____
(Does the pain/problem occur at specific times?) (What makes the pain/problem worse/better?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Anemia:	YES / NO	COPD:	YES / NO	Back Trouble:	YES / NO
Hepatitis:	YES / NO	Gout:	YES / NO	Bladder Infection:	YES / NO
COPD:	YES / NO	Anxiety:	YES / NO	Depression	YES / NO
High Blood Pressure:	YES / NO	Ulcers:	YES / NO	Bipolar:	YES / NO
Epilepsy:	YES / NO	A-Fib	YES / NO	Kidney Disease:	YES / NO
Fibromyalgia:	YES / NO	Migraines:	YES / NO	Hemorrhoids:	YES / NO
Thyroid Issues:	YES / NO	Tuberculosis:	YES / NO	Stroke:	YES / NO
Bleeding Tendency:	YES / NO	Incontinence:	YES / NO	Diabetes:	YES / NO
Asthma:	YES / NO	Cancer:	YES / NO	Hernia:	YES / NO
Hives or Eczema:	YES / NO	Pneumonia:	YES / NO	Mood Disorders:	YES / NO
AIDS/HIV:	YES / NO	Glaucoma:	YES / NO	Shingles:	YES / NO
Arthritis:	YES / NO	Bronchitis:	YES / NO		
Congestive Heart Failure:		YES / NO			
Deep Vein Thrombosis:		YES / NO			

Any Other Disease/Conditions: _____

_____

Previous Surgeries

What?	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (include nonprescription/supplements/vitamins)

_____

_____

Allergies (including medication allergies): _____

_____

Doctors:

Primary Care Physician: _____

Primary Care Physician's Phone #: _____

Specialist: _____

Specialist's Phone #: _____

Patient Social History (circle):

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Rarely	Moderate	Daily	
Use of Drugs:	Never	Type/Frequency: _____			

Family Medical History:

	Age	Disease	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____		
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Reviewing Provider:

_____ _____

Signature of Provider Date

_____

Printed Name of Provider

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is available through our front office.

What this is all about: 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 the 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. www.hhs.gov

We have adopted the following policies:

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 healthcare 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 persons 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 information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, text message, e-mail, 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 utilizes several 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 of 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 manager or a provider within the office.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
8. 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.

I, (name)_____(date)_____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.

Updated 8/26/19