Dynamic Regenerative Care

INFORMED PATIENT CONSENT

Dear Patient,

A technician will be with you shortly. The technician will ask various questions about your medical background and perform basic tests. This information is intended to help our physician/physician assistant gain a better understanding of your medical history before your evaluation.
I, _____, acknowledge that I have been previously cleared by my treating Physician to have moderate exercise. I agree to pay any fees associated with services and any additional tests upon completion of my visit, these fees are final and non-refundable. I consent to treatment by the Dynamic Regenerative Care physician indicated below. I acknowledge that these services may be considered to be elective treatments, and that they may not be covered by Medicare. I understand I have the right to refuse any procedure or treatment and I have the right to discuss all medical treatments with my clinician.

Signed this _____ day of _____, _____

Patient's Signature:_____

Doctor's Signature:_____

Patient Profile Sheet

PLEASE PRINT CLEARLY

Name:_____ **Date:**_____

Address:_____

Phone: Cell_____ **Home:**_____

Email_____ **Age:**_____ **DOB:**_____

Occupation:_____ **Employer:**_____

SSN:_____ **Driver License:State**_____ **#**_____

EMERGENCY Contact _____ **Phone** _____

Preferred Pharmacy:_____ **(Name and Location)**

HIPAA PRIVACY NOTICE

This form is intended for the use and/or disclosure of Protected Health Information (PH) when providing or seeking treatment, payment, and healthcare operations

1. This privacy notice contains a thorough and complete description of the uses and/or disclosures of my protected health information ("PH") which are necessary to provide me with treatment, and which are also necessary for the Practice to obtain payment for that treatment and to perform other healthcare operations. I have been informed that, upon my request, the privacy notice will be made available to me. Prior to signing this Agreement, the Practice advised me of my right to obtain a copy of the Privacy Notice and has encouraged me to read it in its entirety, in accordance with applicable law.
2. To protect your privacy and to remain in compliance with applicable law, the Practice reserves the right to change the practices depicted in its Privacy Notice.
3. I am aware that the Practice's "Notice of Privacy Practices" is displayed in the waiting area and that I am free to request a copy of the same at any time.
4. The Notice of Privacy Practices contains my rights, as well as the duties and obligations of this office as it relates to my protected health information.

I have read and understand this notice in its entirety, and agree that any questions I may have had have been answered to my full and complete satisfaction and understanding.

_____ _____

Name of Individual (Printed) Signature of Individual

Cancelation Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call Dynamic Regenerative Care as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 48 hours in advance. Appointments are in high demand. Your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at 253-509-0424 between the hours of 9:00 am - 5:00 pm Tuesday-Saturday. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is canceled less than 48 hours before the appointed time. A no-show is when a patient misses an appointment without canceling. In either case, we will charge the patient a $75 missed appointment fee.

For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee.

I understand the "no-show" policy of Dynamic Regenerative Care and agree to provide a credit card number, which may be charged $75 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 48 hours in advance in order to avoid a potential no-show charge to the credit card provided.

Print Name:_____

Signature Name: _____ Date:_____

CONSENT TO LEAVE VOICE OR TEXT MESSAGES

Completion of this document authorizes the disclosure and/or use of health information about you. The purpose is to give permission to leave certain health information on your voice or text messaging service. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____
(Please print)

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: Dynamic Regenerative Care to call or text the following telephone numbers:

Mobile:_____
Home: _____
Work: _____

and leave detailed voice or text messages with the following information:

☐ Details about my next appointment (provider name, date/time, and callback number).
☐ Test and other exam results.
☐ Account payments, balances, or cost estimates.
☐ Only the following types of health information (including any dates):_____
_____
☐ I DECLINE. Please do NOT leave any voice or text messages.

EXPIRATION

This authorization expires: _____
(Insert date)

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment.
If the health information is being disclosed or used, I may inspect or obtain a copy of this health information.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Dynamic Regenerative Care 7901 Skansie Ave #105 Gig Harbor, WA 98335

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

_____

Patient or Legal Representative Signature/Date/Time

_____

Print Patient's or Legal Representative's Name

_____

Legal Representative's Relationship to Patient

_____

Witness Signature/Date/Time

_____

Print Witness's Name

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____
Date of Birth: _____, 20____
Social Security Number: _____-____-_____

II. **AUTHORIZATION**. I authorize Dynamic Regenerative Care ("Authorized Party") to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____.
☐ - My medical-related information from _____, 20____ to _____, 20____.
☐ - Other: _____.

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.
☐ - ONLY the following party:
Name: _____
Address: _____
Phone: (____) ____-_____ Fax: (____) ____-_____
E-Mail: _____

IV. **PURPOSE**. The reason for this authorization is: (check one)

☐ - **General Purpose**. At my request (general).

☐ - **To Receive Payment**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ - **To Sell Medical Records**. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.

☐ - **Other**: _____.

V. **TERMINATION**. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.
☐ - On the following date: _____, 20____.
☐ - Other: _____.

VI. **ACKNOWLEDGMENT OF RIGHTS**.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - **Being a Minor**. Patient is ____ years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____.

☐ - **Other**: _____.

Signature of Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. **SENSITIVE INFORMATION**. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ - **I consent** to have the above information released.

☐ - I **do not consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

II. **HIV/AIDS**. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - **I consent** to have the above information released.

☐ - I **do not consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

Please circle your answer

MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

ARTHRITIS	YES	NO	HEADACHES	YES	NO
DIABETES	YES	NO	HIGH CHOLESTEROL	YES	NO
HIGH BLOOD PRESSURE	YES	NO	BLOCKED ARTERY	YES	NO
HEART ATTACK	YES	NO	STROKE	YES	NO
HEART DISEASE	YES	NO	GASTROINTESTINAL	YES	NO
MULTIPLE SCLEROSIS	YES	NO	LIVER DISEASE	YES	NO
EPILEPSY	YES	NO	KIDNEY DISEASE	YES	NO
HEPATITIS	YES	NO	PROSTATE PROBLEMS	YES	NO
BOWEL PROBLEMS	YES	NO	ACUTE PAIN OR SWELLING	YES	NO
CANCER	YES	NO	HIV INFECTION / AIDS	YES	NO
BLOOD TRANSFUSION	YES	NO	MAJOR DEPRESSION	YES	NO
TUBERCULOSIS	YES	NO	BLEEDING DISORDER	YES	NO
URO-GENITAL PROBLEMS	YES	NO	SLEEP APNEA	YES	NO
SICKLE CELL(ANEMIA)	YES	NO	SEXUALLY TRANSMITTED	YES	NO
SICKLE CELL TRAIT ONLY	YES	NO	HERPES	YES	NO
PEYRONIE'S DISEASE	YES	NO	MALARIA	YES	NO
THYROID PROBLEMS	YES	NO	LEUKEMIA	YES	NO

OTHER_____

SURGERY

HEART	YES	NO	BLOCKED ARTERY	YES	NO
PROSTATE	YES	NO	URO-GENITAL	YES	NO
BOWEL	YES	NO	BLADDER	YES	NO
HERNIA	YES	NO	HEAD	YES	NO
ORTHOPEDIC	YES	NO	SPINE	YES	NO

OTHER_____

INJURIES

HEAD	YES	NO	BACK	YES	NO
PELVIS	YES	NO	EXTREMITIES	YES	NO

FAMILY HISTORY

DIABETES	YES	NO	HEART DISEASE	YES	NO
CANCER	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTHRITIS	YES	NO	EXCESSIVE WEIGHT	YES	NO
MIGRAINES	YES	NO	HAIR LOSS / BALDNESS	YES	NO

OTHER SIGNIFICANT AILMENTS

_____

ALLERGIES

HAVE YOU HAD AN ALLERGIC REACTION TO ANY MEDICATION YES NO

IF YES PLEASE PROVIDE
DETAILS_____

_____

PLEASE DESCRIBE YOUR MAIN CONCERN

_____

_____

_____

WHEN DID THIS START?

_____

DO YOU HAVE A FAMILY PHYSICIAN?

_____

WHEN WAS YOUR LAST PHYSICAL?

_____

CURRENT MEDICATIONS (pills, injections, ect.)

_____

_____

PLEASE DESCRIBE ANY TREATMENTS YOU HAVE TRIED IN THE PAST AND YOUR RESULTS

_____

_____

_____

_____

SOCIAL HISTORY

COCAINE USE	YES	NO	ALCOHOL	YES	NO
MARIJUANA	YES	NO	CIGARETTES/CIGAR	YES	NO
COFFEE USE	YES	NO			

REVIEWED BY PHYSICIAN:_____

DATE:_____