Patient Information

REGENERATIVE MEDICINE CLINIC
Naturally In Motion

Name: _____
First Last MIPreferred Name

❑ Male ❑ Female Date of Birth: _____ Age: _____ SS#: _____

Phone: (Mobile)_____ (H) _____ (W) _____

Email: _____ Would you like to receive our weekly Newsletter ❑YES ❑ NO

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Next of kin (spouse):_____ Phone: _____ Relation: _____

How did you hear about our practice? _____
❑ Star News ❑ State Port Pilot ❑ Internet

Health Insurance Information

Primary Insurance Company Name: _____

Policy Holder (if different from patient) Name: _____ SS# _____ DOB: _____

Primary Insurance ID#: _____ Group Plan # _____

Secondary Insurance Company Name: _____

Policy Holder (if different from patient) Name: _____ SS# _____ DOB: _____

Secondary Insurance ID#: _____ Group Plan # _____

Primary Care Physician_____

Are you currently being treated by other medical professionals? □Yes □No

If yes please list name and what you are being treated for:_____

_____

Have you seen a Physical Therapist in the Tri-County area? _____Would you like to see them again? _____

Name of Therapist or Clinic: _____

If NO please explain why: _____

Office use only

BP: _____ Pulse: _____ O2 Saturation: _____ MAP: _____

BMI: _____ BMI Percentile: _____

Health Information

Height:_____ **Weight:**_____ _____

Why are you seeing us today? _____

❑Right ❑Left ❑Both

How long have you had symptoms? _____ Days _____ Months _____ Years

Symptoms: ❑ Come & go ❑Are constant

❑Rapidly improving ❑ Slowly improving ❑ Gradually worsening
❑ Fluctuating ❑ Remains the same ❑ Rapidly worsening

What does it feel like? ❑ Sharp ❑ dull ❑ aching ❑ throbbing

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Please indicate treatments (other than surgery) you have tried for the condition:

❑ Bracing ❑ Prescription Drugs (please specify)_____

❑ Exercise Program ❑ Over-the-Counter Drugs (please specify)_____

❑ Physical Therapy ❑ Hyaluronic Acid Injections (date of last injection/ how many) _____

❑ Steroid Injections (date of last injection/ how many) _____

What makes it better? _____

What makes it worse? _____

What do you want to be able to do that you can't? _____

How has this problem affected your daily activities:_____

Your exercise habits: ❑ Never ❑ Daily ❑ Weekly ❑ Occasionally

Type of exercise: ❑ Walk ❑ Run ❑ Bike ❑ Swim ❑ Weight Train ❑ Other _____

Participate in sports? ❑ Yes ❑ No If yes, what sports? _____

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following?
Alcohol _____drinks/week Cigarettes _____packs/day Former Smoker_____

Have you ever been treated for any of the following medical conditions? Please check yes or no and **circle** all that apply. Explain further in the space provided if necessary.

□**Yes** □**No** Arthritis (rheumatoid, osteo-degenerative) _____ □ **Y e s**
□**No** Blood Diseases (anemia, leukemia, clotting problems) _____ □ **Y e s**
□**No** Ear, Nose, Throat (hearing loss, sinus disease) _____ □ **Y e s**
□**No** Diabetes (type, how controlled & when diagnosed) _____
□**Yes** □**No** Thyroid Disease (hypo, hyper, Graves disease) _____
□**Yes** □**No** Lung Disease (asthma, emphysema, COPD, chronic bronchitis) _____
□**Yes** □**No** Heart Disease (heart attack, arrhythmia, heart failure, heart valve disease)_____
□**Yes** □**No** High Blood Pressure _____
□**Yes** □**No** Gastrointestinal Disease (ulcers, esophageal reflux, intestinal or liver disease) _____
□**Yes** □**No** Genito-Urinary Disease (kidney disease, dialysis, kidney stones) _____
□**Yes** □**No** Neurological Problems (stroke, mini strokes, seizures, paralysis)_____
□**Yes** □**No** Skin Diseases (eczema, psoriasis, acne rosacea) _____
□**Yes** □**No** Mental Health (depression, anxiety, schizophrenic, bipolar) _____
□**Yes** □**No** Cancer (list type or location & date) _____
□**Yes** □**No** Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis) _____
Other Problems _____
Previous Surgery (date/reason)_____
_____

Do you have night sweats? □**Yes** □**No**

Have you had any recent weight loss? □**Yes** □**No**

Have you had any chest or heart surgery? □**Yes** □**No**
If yes, please explain_____

Is there a family history of any of the following conditions (please indicate which relative)?
❑ Heart Disease _____ ❑ Diabetes _____ ❑ Lung Disease _____
❑Cancer _____ ❑ Arthritis _____ ❑ Other _____

List All Medications

Include over-the-counter/ Vitamins/ Herbal Supplements

Name	Dosage	How many/ How often

Pharmacy: _____

Allergies and Reactions:

❑ No Known Drug Allergies

Medication	Reaction

Consent for Purposes of Treatment, Payment and Healthcare Operations

Consultations: I understand that the Consultation is complimentary. I agree to provide all the information needed to evaluate my health concern. I understand if there is any treatment, procedures or services provided that go beyond evaluating if I am a candidate, I will be charged for a new patient appointment.

WHAT IS A FREE CONSULTATION?

An initial meeting between the doctor and the patient typically lasts thirty minutes, but may be longer depending on your specific case. At the end of the meeting you are free to decide that you do not want to enlist the services of the doctor or learn more details about your case and, likewise, the doctor may decide that you are not a candidate for the program or that he cannot help you with your problem. Your relationship with the doctor ends there. Although it requires a significant amount of work to process your visit, there is no charge for this initial consultation and no obligation. We welcome your questions but you are not a patient of our clinic and we are under no obligation to provide any medical services to you.

WHAT IS NOT FREE?

Anything beyond this first visit is not free. If you schedule a return visit, you are becoming a patient of our clinic.

By going forward, you are electing to become a patient of Dr. Yeargans. At that point we take on a legal responsibility for treating you as a medical patient. If we order physical or occupational therapy, nerve studies, x-rays or other imaging studies like an MRI or CT scan, that is not free and requires a lot of work on our end. Occasionally, our doctor will need to discuss your case with your other doctors. Dr. Yeargan will spend time assembling your case to determine the best clinical option.

FEE SCHEDULE
Clinic Visit/ appointment - $250

Financial Agreement: I understand that I am financially responsible to Regenerative Medicine Clinic of Wilmington for all charges. I understand payment is due at the time of service.

Financial Policy: I agree to abide by Regenerative Medicine Clinic of Wilmington's financial policy. I understand to schedule a procedure 50% down payment is required; the remaining balance is due 2 weeks prior

to the date of service, if not received the procedure may be cancelled. *We accept all major credit cards, health saving cards, cash, check and Care Credit.

Insurance: I understand Regenerative Medicine Clinic of Wilmington only submits claims to Blue Cross and Blue Shield. I understand Regenerative Medicine Clinic of Wilmington is not associated with Medicare/ Medicaid. I understand Regenerative Medicine Clinic does not submit any insurance claims with the above-mentioned entities. Additional claims may be submitted on behalf of Dr. Yeargan by the rendering provider (labs, radiology, and physical therapy).
Insurance is a contract between you and your insurance company. We are not a party to this contract. We cannot become involved in disagreements between you and your insurance.
*If you have insurance that is not Medicare/ Medicaid or BCBS you may submit a Member Claim to your insurance company. The claim may be considered out-of-network. We will be happy to assist you in this matter.

Medicare and Medicaid: Patients that receive Medicaid and Medicare benefits must sign an additional Physician-Patient Private Contract.

Consent To Disclosure of PHI to Family Members, Relatives, Friends or Others: I agree that Regenerative Medicine Clinic may disclose my PHI or leave messages with the following family members, relatives, friends or others. I understand that, if I am present, Regenerative Medicine Clinic may disclose my PHI to other family members, relatives or friends if I orally agree or do not object. I also understand that, if I am not present or am incapacitated, Regenerative Medicine Clinic may make limited disclosure of my PHI to other family members, relatives or friends if Regenerative Medicine Clinic determines in its professional judgment that such disclosure is in my best interest.

Name: _____Telephone: _____

Name: _____Telephone: _____

HIPPA Notice of Privacy Practices: I acknowledge that I have received or have been offered a copy of Regenerative Medicine Clinic of Wilmington PLLC, HIPAA Notice of Privacy Practices, effective January 1, 2016, which provides information about how my personal health information (PHI) is used and disclosed.
A current Notice of Privacy Practices for Regenerative Medicine Clinic of Wilmington PLLC, is available at the front desk

Consent for Treatment: I hereby authorize Dr. Yeargan and appointed staff to perform any evaluation or treatment as is necessary, and to perform services and or procedures with my consent. I hereby certify that no guarantee or assurance has been made as to the results that may be obtained from examination or treatment. I have been informed of the patient's rights and responsibilities. I further consent that Regenerative Medicine Clinic may obtain and use information from other healthcare providers such as diagnostic centers, pharmacies and hospitals.

I understand that if I am candidate for Stem Cell Therapy and/ or Platelet Rich Plasma Treatment, it is not covered by insurance.

Acknowledgment: I have read, understand and agree with the foregoing statements. A copy of this Agreement has been provided. I acknowledge all questions or concerns have been addressed.

_____	_____
Patient Signature	Date
_____	_____
Guardian/ Representative Signature	Relationship