Cover Letter & What to Bring to Your Appointment:

Thank you for scheduling your appointment, procedures and care at Rejuv Medical. We look forward to serving you with the highest level of professionalism while providing exceptional patient outcomes.

Dr. Joel Baumgartner M.D., a board certified medical physician specializing in non-surgical orthopedic and sports medicine, designed this medical center with a mission to reverse the impact of disease and degeneration through evidence-based treatments. Rejuv is a state licensed Medicare certified medical practice. Rejuv is committed to meeting the needs of those we serve and our goal is to afford the community access to quality health care in a comfortable and cost-effective environment.

In order to ensure we are able to ensure the best possible visit it's important that all paper work and necessary requested medical information be provided during your visit. Below is a check list of the need paperwork and records to make the most of your time and the physicians. If you do not have the paperwork completed, please arrive 30 minutes before your appointment.

_____Medical History

_____Demographics

_____Insurance & Financials Polices

_____Privacy Notices

_____Release of Information

_____How Did You Hear About Us?

_____6-month History of Labs

_____6-month History of X-rays or MRI's

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

New Patient Intake Paperwork

Your completed intake paperwork helps our providers get to know you and your medical history. We know this is a lengthy form but we rely on its accuracy and completeness to provide you with the best possible care and a successful first visit. If you have any questions about completing the forms, please contact us at FrontDesk@RejuvMedical.com or by phone at (320) 217-8480.

Goals for Treatment

At Rejuv Medical we start with the goal in mind to tailor the treatment plan to your specific goals.

What are your goals? _____

What do you perceive as barriers to achieving these goals? _____

Can you imagine life without pain? ❑ Yes ❑ No When I have less pain, I will… _____

If you could make only one improvement in your health, what would it be? _____

Problem Description

Where is your worst area of pain located? _____

Does this pain radiate? If so, where?_____

Please list any additional areas of pain: _____

Check all of the following that describe of your pain:

❑ Aching	❑ Sharp	❑ Exhausting
❑ Throbbing	❑ Tender	❑ Tiring
❑ Shooting	❑ Hot/Burning	❑ Sickening
❑ Stabbing	❑ Cramping	❑ Fearful
❑ Gnawing	❑ Heavy	❑ Punishing-Cruel

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night ❑ With movement ❑ After activity

Approximately when did this pain begin? _____

What caused your current pain episode? _____

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury (legal term describing injury sustained to your person by negligence of another) ❑ Yes ❑ No

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

What makes the pain better?_____

What makes it worse? _____

Any other associated problems you would like to address? _____

Pain Interference Scale

Check the ONE number in each category that best describes how, **during the PAST 24 HOURS**, pain has interfered with the following:

	Does not interfere									Completely interferes
General Activity:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Mood:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Walking ability:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Normal Work:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

(Include both work outside the home and housework)

Relationships:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Sleep:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Enjoyment of life:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

Pain Scale

Pain is a *subjective* experience. Use the following pain descriptions to help us understand your pain better.

1-4	Pain that does not prevent you from participating and completing daily activities
5	Pain that makes you feel you need medication, but does not force you to stop your activity
6-7	Pain that is severe enough to stop any task and necessitates immediate medication
8-9	Pain so severe and debilitating that someone else has to get your medications for you
10	Absolutely the worst pain. You are completely disabled.

0 1 2 3 4 5 6 7 8 9 10

No Pain Hurts a little Hurts more Hurts a lot Hurts terribly Worst Pain

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

How much you hurt ***right now***? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

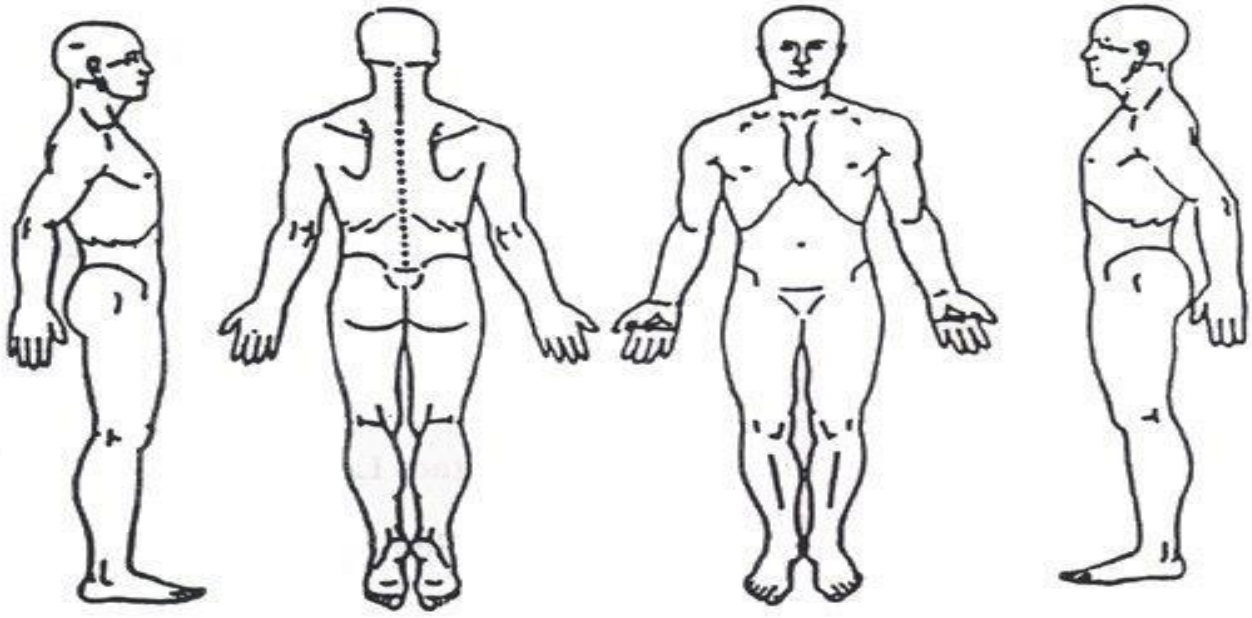
At its ***worst*** in the last 24 hours? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

At its ***least*** in the last 24 hours? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How much do you hurt on ***average***? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Pain Description

Indicate the location and type of your pain. Mark the diagram with and X at the site of your problem:



Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

❑ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

❑ MRI of the_____ Date:_____ Facility: _____

❑ X-rays of the_____ Date:_____ Facility: _____

❑ CT scan of the_____ Date:_____ Facility: _____

❑ EMG/Nerve conduction study of the_____ Date:_____ Facility: _____

❑ Other diagnostic testing: _____

Have you seen any other specialists for this problem? ❑ Yes ❑ No

If yes, who, what specialty, and what treatment was offered?

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Name of Specialist	Specialty	Treatment offered?	Outcome of treatment

Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT COMPLAINTS.**

❑ Chiropractic ❑ Physical Therapy ❑ Psychological Therapy/Counseling

❑ Spine Surgery ❑ Podiatrist Treatment

❑ Discogram (check all that apply) ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Epidural Steroid Injection (check all that apply) ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Joint Injection – What joint: _____

❑ Medial Branch Blocks or Facet Injections (check all that apply) ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Nerve Blocks – Area/Nerve(s) _____

❑ Radiofrequency Ablation – (check all that apply) ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Spinal Column Stimulator – ❑ Trial only ❑ Permanent Implant

❑ Trigger Point Injection – Where? _____

❑ Vertebroplasty / Kyphoplasty – Level(s) _____

❑ Medications:

Name	Strength	How did you take it?	Why was it stopped?

❑ Other treatments: _____

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Treatments Coordinated by Rejuv Medical

What types of treatments might you be interested in exploring? (Check all that apply)

❑ Diet changes ❑ Dietary supplements ❑ Chiropractic
❑ Weight loss program ❑ Hair Restoration ❑ Medical Fitness/Exercise program
❑ Physical Therapy ❑ Regenerative Therapy ❑ Joint injections ❑ Medications
❑ Prolotherapy ❑ Platelet Rich Plasma (PRP) Injections

Review of Systems

Mark any events that have occurred in the LAST MONTH:

General:
❑ Change of appetite ❑ Weight loss ❑ Weight gain ❑ Belts fit differently
❑ Chills ❑ Always tired ❑ Change in appetite ❑ Excessive thirst
❑ Intolerant of cold ❑ Puffiness ❑ Night sweats ❑ Hot flashes
❑ Swelling ❑ Frequent infections ❑ Lack of libido ❑ Fever
❑ Changes in nails

Head/Eyes/Ears/Nose/Throat:
❑ Sinus pain ❑ Allergies (seasonal) ❑ Nasal discharge ❑ Nasal congestion
❑ Change in vision ❑ Ear pain ❑ Ear discharge ❑ Hearing loss
❑ Bleeding gums ❑ Hoarseness ❑ Trouble swallowing ❑ Tooth pain
❑ Sore throat

Respiratory:
❑ Cough ❑ Shortness of breath ❑ Wheezing ❑ Breathing discomfort
❑ Blood sputum ❑ Snoring ❑ Sleep apnea

Cardiovascular:
❑ Bleeding disorder ❑ Chest pain ❑ Fainting ❑ Irregular heartbeat
❑ Swelling in the feet ❑ High blood pressure ❑ Deep vein thrombosis ❑ Lightheadedness
❑ Shortness of breath during sleep ❑ Swelling of Hands or Feet ❑ Calf or leg pain

Gastrointestinal:
❑ Excess gas ❑ Nausea ❑ Vomiting/dry heaves ❑ Bloating
❑ Diarrhea ❑ Heartburn ❑ Dark and tarry stools ❑ Bloody stools
❑ Rectal pain ❑ Constipation ❑ Abdominal pain ❑ Abdominal cramps
❑ Rectal bleeding

Genitourinary:
❑ Urinary urgency ❑ Weak stream ❑ Loss of urine ❑ Painful urination
❑ Waking at night to urinate ❑ Foul urine odor ❑Increased frequency ❑ Difficulty starting stream

Skin:
❑ Change in hair, skin or nails ❑ Rash ❑ Tattoos ❑ New moles
❑ Discoloring

Lymphatic/Hematologic:
❑ Frequent infections ❑ Swollen glands ❑ Easily bruised ❑ Unexplained bruising

Neurological:
❑ Memory loss ❑ Headaches ❑Speech difficulties ❑ Seizures
❑ Tingling or numbness ❑ Visual disturbance ❑ Dizziness ❑ Difficult balance
❑ Arm/leg weakness ❑ Paralysis ❑ Tremors

Name_____ Date of Birth _____

Primary Care Provider _____

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Mental Health:
❑ Depression ❑ Difficulty sleeping ❑ Hallucinations
❑ Frequent awakenings ❑ Suicidal thoughts ❑ Loss of interest in hobbies or activities
❑ Sense of hopelessness ❑ Changes in behavior ❑ Difficulty concentrating ❑ Poor impulse control
❑ Difficulty organizing thoughts

Men:
❑ Penile discharge ❑ Erectile Dysfunction
❑ Dribbling after urination ❑ Scrotal pain ❑ Swelling in scrotum

Women:
❑ Irregular periods Last menstrual period Breast pain

❑ New breast lump(s) ❑ Breast discharge _____ ❑ Pelvis pain
❑ Frequent yeast infections ❑ No menstrual bleeding
❑ Vaginal dryness ❑ Post menstrual

Past Medical History

Mark the following conditions/diseases that you currently have or have been treated for in the past:

General Medicine
❑ Cancer:_____
❑ Diabetes Type: _____

❑ HIV / AIDS

Head / Eyes / Ears / Nose / Throat
❑ Headaches
❑ Migraines
❑ Head Injury
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Glaucoma

Cardiovascular / Hematologic
❑ Anemia
❑ Bleeding Disorders
❑ Heart Attack
❑ High Blood Pressure
❑ High Cholesterol
❑ Mitral Valve Prolapse
❑ Murmur
❑ Phlebitis
❑ Poor Circulation
❑ Stroke
❑ Coronary Artery Disease
❑ Pacemaker / Defibrillator

Respiratory
❑ Asthma
❑ Bronchitis
❑ Emphysema / COPD
❑ Pneumonia
❑ Tuberculosis

❑ Valley Fever

Gastrointestinal
❑ Bowel Incontinence
❑ GERD (Acid Reflux)
❑ Gastrointestinal Bleeding
❑ Constipation

Musculoskeletal
❑ Amputation
❑ Bursitis
❑ Carpal Tunnel Syndrome
❑ Chronic Low Back Pain
❑ Chronic Neck Pain
❑ Chronic Joint Pain
❑ Fibromyalgia
❑ Joint Injury
❑ Osteoarthritis
❑ Osteoporosis
❑ Phantom Limb Pain
❑ Rheumatoid Arthritis
❑ Tennis Elbow
❑ Vertebral Compression Fracture

Genitourinary / Nephrology
❑ Bladder Infection(s)
❑ Dialysis
❑ Kidney Infection(s)
❑ Kidney Stones

❑ Urinary Incontinence

Liver (Hepatic)
❑ Hepatitis A
(Active / Inactive / Unsure)
❑ Hepatitis B
(Active / Inactive / Unsure)
❑ Hepatitis C
(Active / Inactive / Unsure)

Neuro-psychosocial
❑ Alcohol Abuse
❑ Alzheimer Disease
❑ Bipolar Disorder
❑ Depression
❑ Epilepsy
❑ Prescription Drug Abuse
❑ Multiple Sclerosis
❑ Paralysis
❑ Peripheral Neuropathy
❑ Schizophrenia
❑ Seizures
❑ Reflex Sympathetic Dystrophy / CRPS

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

❑ Other Diagnosed Conditions (please list):

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.**

Spine / Back Surgery

❑ Discectomy (levels)_____

❑ Laminectomy_____

❑ Spinal fusion (levels)_____

❑ Spinal cord stimulator_____

❑ Other_____

Abdominal Surgery

❑ Gallbladder removal_____

❑ Appendectomy_____

❑ Gastric bypass_____

❑ Other_____

Female Surgeries

❑ Caesarean section_____

❑ Hysterectomy_____

❑ Laparoscopy_____

❑ Ovarian_____

❑ Other_____

Joint Surgery

❑ Ankle/Foot_____

❑ Shoulder_____

❑ Hip_____

❑ Knee_____

❑ Wrist/Hand_____

❑ Other_____

Heart Surgery

❑ Valve replacement _____

❑ Aneurysm repair _____

❑ Stent placement _____

Other Surgeries

❑ Hemorrhoid surgery _____

❑ Hernia repair _____

❑ Thyroidectomy _____

❑ Vascular surgery _____

❑ Other_____

❑ Have you ever had a reaction to anesthesia? ❑ Yes ❑ No Explain:_____

❑ Has anyone in your family ever had a reaction to anesthesia? ❑ Yes ❑ No Explain:_____

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Please list any other surgeries, details and dates:

Social History

Tobacco Use:

❑ Current tobacco User, Packs per day ❑ <1 ❑ 1 ❑ 1-2 ❑ >2

How many years of tobacco use? ❑ <5 ❑ 5-10 ❑ >10

❑ Former tobacco User ❑ Never used tobacco ❑ Second hand smoke exposure

❑ Smokeless/chewing tobacco ❑ Electronic cigarette

Alcohol Use: ❑ Rarely ❑ Never Drink Alcohol ❑ Active in AA ❑ DUI in last 10 years

❑ Daily_____# per day ❑ Weekly_____# per week

Illegal Drug Use:

❑ Not now and never used any illegal drugs

❑ Currently use illegal drugs (Which:_____)

❑ Currently use someone else's prescription medications (Which:_____)

❑ Formerly used illegal drugs (not currently using) (Which:_____)

❑ Active in NA

Have you ever abused narcotic or prescription medications? ❑ No ❑ Yes (Which:_____)

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other_____

Genetic/ethnic background/ancestry (Ex. Irish, Middle Eastern, etc.): _____

Are you Working: ❑ Yes ❑ No ❑ Retired If Yes, Employer:_____

Job Description:_____If retired, what type of work did you do?_____

Are you on disability? ❑ Yes ❑ No If yes, why and since when? _____

Are you capable of becoming pregnant? ❑ Yes ❑ No *If so*, are you currently pregnant? ❑ Yes ❑ No

Highest level of education obtained: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

Do you have any history of physical, sexual, or emotional abuse? ❑ Yes ❑ No

If you feel comfortable doing so, please explain_____

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Exercise

Height_____Weight _____

Do you exercise? ❑ Yes ❑ No If yes, how many days per week? ❑ 1-2 ❑ 3-4 ❑ 5-7

What type of exercise do you enjoy? _____

How much time do you exercise on the days you do exercise? ❑ 15-30 min ❑ 30-60 min ❑ >60 min

Explain your exercise goals: _____

Are you involved in any sports or hobbies? ❑ Yes ❑ No Please list _____

Sleep

How many hours do you sleep on average each night? ❑ <5 ❑ 6 ❑ 7 ❑ 8 ❑ >8

Do you wake feeling refreshed? ❑ Yes ❑ No Do you snore? ❑ Yes ❑ No

Have you ever had a sleep study? ❑ Yes ❑ No

If yes, when and what were the results? _____

Stress

Do you have a lot of stress in your life currently? ❑ Yes ❑ No

If yes, what is the usual source of the stress? _____

What is your typical daily stress level? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Are you easily upset or irritated? ❑ Yes ❑ No Are you constantly keyed up or jittery? ❑ Yes ❑ No

What is your current outlet or strategy to deal with stress? _____

Diet

Do you feel you eat a healthy diet on a daily basis? ❑ Yes ❑ No

Do you follow a specific dietary lifestyle? ❑ Vegan ❑ Vegetarian ❑ Paleo ❑ South Beach ❑ Mediterranean ❑ Intermittent Fasting ❑ Atkins ❑ No specific dietary approach

Have you ever had an eating disorder? ❑ No ❑ Yes, Type: _____

How much water do you consume daily? ❑ < 64 ounces ❑ > 64 ounces

Do you consume less than 5 servings of fruits and vegetables per day? ❑ Yes ❑ No

Do you consume caffeinated beverages? ❑ Yes ❑ No If yes, how many per day? ❑ 1-2 ❑ 3-4 ❑ 5-7

Do you eat at restaurants frequently? ❑ Yes ❑ No Fast Food? ❑ Yes ❑ No

Do you consume any foods with artificial colors, sweeteners, or preservatives? ❑ Yes ❑ No

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Nutritional Supplements

Please use the table below to list all vitamins, minerals, amino acids, or other supplemental products (meal replacements, bars, shakes, protein supplements, etc.) you are currently taking.

Name	Brand	How long have you taken?	Form (capsule, tablet, liquid, chewable)	How much do you take at a time?	How many times per day?	Prescribed by a health professional? (Yes/No; if yes, by who?)
Ex: Vitamin E	Nature's Made	6 months	Soft gel cap	400 IU	2 times a day	Dr. X

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Allergies to Foods

Do you have any known food allergies, sensitivities, or intolerances? ❑ Yes ❑ No

If yes, please list all foods and the reaction:

Food	Reaction
Example: gluten	Joint pain

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: _____

❑ I have no significant family medical history. ❑ I am adopted (No Medical History Available).

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Allergies to Medications

Do you have any known drug allergies? ❑Yes ❑ No If so, please list all medications you are allergic to.

Drug name	Reaction
Example: Penicillin	Rash

Topical Allergies: ❑ Iodine ❑ Latex ❑ Tape Are you allergic to shellfish? ❑ Yes ❑ No

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Current Medications

Please use the table below to list all medications you are currently taking.

Drug name	Dose per pill	Do you take this every day?	When do you take this during the day?	How many do you take at a time?	How many do you take per day?	Who prescribes this medication?
Example: Benadryl	25mg	Yes/No	At bedtime	1 or 2	2 times a day	Dr. X

Please indicate which (if any) of the following **blood-thinners** you are taking:

❑ Aggrenox ❑ Coumadin/Warfarin ❑ Effient ❑ Lovenox ❑ Plavix ❑ Pletal

❑ Pradaxa ❑ Prasugrel ❑ Ticlid ❑ Other _____

❑ **I AM NOT ON ANY BLOOD THINNING MEDICATIONS**

Name_____ Date of Birth _____

Primary Care Provider _____

Referring Provider _____

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Rejuv Medical and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Rejuv Medical to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Rejuv Medical Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Rejuv Medical to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Rejuv Medical to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Rejuv Medical will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked.

Signed:_____ Date: _____

Parent/Guardian Name (if under 18) _____

Payment and Appointment Policy

Copayments / Coinsurance / Deductible: Copayments, coinsurance, and deductibles for clinic visits and procedures are due at the time of service. If you are unable to make your copayment at the time of service, Rejuv Medical reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

Missed Appointments and Late Arrivals. If you are more than 15 minutes late we may reschedule your appointment. ("Late" means arriving after the time you are asked to arrive at the clinic.) If you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed appointments are subject to a $50 charge. These charges are your responsibility and will not be billed to any insurance carrier.

I understand and agree to the Financial and Appointment Policy.

Signed:_____ Date: _____

Parent/Guardian Name (if under 18) _____

Acknowledgement of Receipt of Privacy Notice (HIPAA)

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Signed:_____ Date: _____

Parent/Guardian Name (if under 18) _____

Demographics

First Name	M.I.	Last Name	
Primary Contact Number ( )		Secondary Contact Number ( )	
Street Address		Apt/Suite #	Date of Birth / /
City		State	Zip Code
If Patient is a Minor; Name of Responsible Party			Social Security Number - -
Email (We do not sell, rent or distribute your email address per HIPAA Law)		Gender (circle) Female Male	Marital Status
Employer			Occupation
Work Phone Number/Extension		Employment Status (circle) Full-Time Part-Time Disabled Retired Student Not-Employed N/A	
Race _____White _____Black/African American _____American Indian Asian Other:			
Ethnicity _____Hispanic or Latino _____Not Hispanic or Latino _____Declined to Provide this Information			
Preferred Language English Spanish Other:			
Which method would you prefer your appointment confirmations be made? _____Text _____Phone _____Email _____Do Not Want Appointment Confirmation			

Emergency Contact Person	Relationship	Emergency Contact Number

Primary Insurance Carrier		ID Number	Group Number
Primary Insurance Carrier Address, City, State, Zip Code			
Name of Insured/Policy Holder	Relationship to Insured	Date of Birth	Gender (circle) Female Male
Secondary Insurance Carrier		ID Number	Group Number

Secondary Insurance Carrier Address, City, State, Zip Code			
Name of Insured/Policy Holder	**Relationship to Insured**	**Date of Birth**	**Gender (circle) Female Male**

_____ Rejuv Medical cannot guarantee insurance coverage by your insurance carrier. The information you provide will assist us in determining if some of the expenses are reimbursable by your HMO or insurance.

_____ I certify that the information I am providing is true & correct. That I (or my dependent) have insurance coverage and assign directly to Rejuv Medical all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment that may not be covered.

_____ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

_____ I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

(Patient/Responsible Party Signature) (Relationship) Date

INSURANCE

If you have insurance, we will do our best to help you receive your maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. We will file insurance claims with insurance carrier(s) if you provide us with all of the necessary information. Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered v. non-covered charges, secondary insurance, "usual and customary" charges, procedures they consider experimental, etc., other than supply factual information as necessary. You are responsible for the items listed above as well as any services considered "not medically necessary" by your insurance company.

In-Network vs. Out-of-Network

Rejuv Medical is **IN-network** with the following carriers: BCBS, Health Partners, Preferred One, Tricare, Medicare, Ucare, Medicaid and others.

Rejuv Medical is **OUT-of-network** with PrimeWest, Medica, United Health Care, and Humana Medicare.

Out of Network Insurance

Although Rejuv Medical is not a participating provider with your insurance plan, please be assured that you will not incur any additional costs or penalties from using our facilities beyond your In-Network clinics as long as your financial position would be hindered by additional costs. Though we do not know how much of the billed charge your health plan will pay. We will only charge you for any remaining deductible to the extent your health plan will give you the credit for satisfying you're In-network deductible requirement, the additional amount we charge is calculated such that it will not exceed what you would pay as the copayment or coinsurance pursuant to your In-network benefit. We must have a copy of a recent pay stub or W-2 and a signed note stating that the financial difference would prevent you from being able to use our services. We look forward to assisting you in this process to determine if you qualify by calling the billing office and supplying appropriate information.

It is the policy of Rejuv Medical to ensure that none of our patients pay more than they would have had they gone to an In-network facility so long as there is financial hardship if you were to have to pay a higher than In-network deductible. Someone from our staff will be calling you to discuss payments once the insurance has processed the visit and procedure. Please understand that co-pays will be billed separately.

It is possible that your insurance payment for your visit to Rejuv Medical will be sent directly to you. We ask that you please endorse the check over to Rejuv Medical, and mail it, along with your Explanation of Benefits. By sending such payment you receive directly to the center you avoid the possibility of additional costs for using our facility. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and to make any unnecessary adjustment.

If you have any questions or concerns, please do not hesitate to contact our billing office at 320-227-6398 between the hours of 8:00 a.m. - 5:00 p.m. Monday through Friday.

Referrals / Pre-authorizations

If your insurance requires a referral and/or pre-authorization for services, you are responsible for obtaining it. Failure to obtain a referral or pre-authorization may result in a lower or no payment from your insurance company. Know your insurance benefits. **You are financially responsible for any unpaid balances on your account**.

Worker's Compensation (WC)

We require written approval or authorization by your worker's compensation carrier prior to your initial visit. All necessary information must be provided to file your claim. Our office will not become involved in disputes arising from Worker's Compensation claims. **If your WC carrier denies your claim, we will bill your personal health insurance carrier(s) as outlined above**. If you have no health insurance coverage, you are responsible for payment in full. All bills will be sent directly to you and it is your responsibility to forward the bills to your attorney if you wish.

Personal Injury

If you are being treated as part of a personal injury lawsuit or claim, we require that you allow us to bill your health insurance carrier pending settlement of your case. In the absence of personal health insurance, other financial arrangements may be made. Payment of your bill remains your responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. If you do involve an attorney you will be required to obtain a Letter of Protection before any other services are rendered,

Responsible Parties of Minors

The parent or legal guardian who signs the "Financially Responsible Party" is responsible for payment of services rendered.

Transferring of Records

If you want copies of your records transferred to another doctor, you must make the request in writing. We reserve the right to charge reasonable copying fees.

Payments and Financial Details

Payments Due at Time of Service: As a result of the contracts we have with our in-network carries, we are required to collect copays and part of the deductible at the time of service. We cannot habitually bill you for your copays they are designated to be collected at time of service.

Same Day Service and Procedure Policy for Insured Patients with Remaining Deductibles

In addition to your "clinic" co-pay, you may be asked to pay a portion of your un-met deductible balance after your service has been performed. Ultimately patients are responsible for deductibles and payments to Rejuv Medical its providers for services rendered. If you have a remaining deductible, we will request 60% of your estimated patient responsibility same day after office visits and or any procedures. The payment will be applied to the charges incurred and you will receive a statement indicating the balance due (if applicable). Your benefits and the status of your current deductible (if applicable) will be verified. If you owe a deposit, you will be asked to pay after your visit is complete.
Payments will be requested before some procedures are performed if procedure is performed on same day as original office visit.

Payment of remaining balances are expected to be paid within 30 days of receipt of statement. If you are unable to pay your balance in full, please contact our billing department to discuss acceptable payment plan options. A monthly plan is required to keep your account current.

Late Fee

If you do not pay a required patient responsibility after the first statement cycle. We reserve the right to charge a 6% Late Fee that will be continually billed to your account until the account is brought current.

Statements

Insurance payments on your account are generally received within 14-30 business days after your clinic visit. Once we receive payment from your insurance, a statement will be sent to you if there is a remaining unpaid balance on your account. Your unpaid balance is due upon receipt of your statement, unless other arrangements have been approved by us. Payments may be made by cash, check or credit/debit card. We do except Care Credit. Statements will be sent to the address listed on your registration form. Please notify our office if you want your statements to go to an alternate address.

Returned Check Fee

There is a $25.00 fee for returned checks.

Collections

If your account becomes past due, we will take necessary steps to collect your debt. You will be responsible for all fees associated with debt collection attempts, including but not limited to collection agency and legal fees. If we refer your debt to a collection agency, you will be required to pre-pay for your next visit(s) until the debt is paid.

Patient Balance and Service Payment Policy

All cash balances need to be paid at time of service. If balance is not able to be paid at the time of service a payment Electronic Funds Transfer (EFT or ACH) arrangement may be made with the billing department.

Payments may be made with cash, personal check, credit card (VISA, MC, AmEx, and Discover), Care Credit, or (EFT/ACH).

If payment cannot be arranged, a non-emergency service would need to be rescheduled, as well as future appointments will have to wait until a payment is received or payment plan is implemented.

Payment plan policy options as follows:

Balance Range	Payment Plan Duration	Minimum Payment
$5 to $499.99	NA	5% or $25 whichever is greater
$500 and above	10 months (Sup approval for extended)	10% of current balance

Cancelation/No-show Policy

If you are unable to keep your scheduled appointment, please call us at least 24 hours in advance to reschedule/cancel your appointment.

If you no-show or cancel appointment without calling at least 24 hours in advance, there will be a $25.00 hold required before scheduling any future appointments.

If you have two consecutive no-show or canceled appointments, you will be charged the initial $25.00 hold and there will be a $75.00 hold to schedule any future appointments. If you would miss that appointment without a 24-hour notification the $75.00 hold would be non-refundable.

Would you agree that it is important to have appointment times available when you need them most? Rejuv Medical is leading the Orthopedic and Sports Medicine industry in physician availability. How do we achieve this? We have an appointment policy in place to ensure patient accountability. Rejuv is committed to the highest quality of care!

SIGNATURE BELOW CONFIRMS THAT YOU HAVE BOTH READ AND UNDERSTAND ALL POLICIES AND CONDITIONS.

_____ _____

Patient Name Relationship (if patient is a minor)

_____ _____

Patient (or responsible party) Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Rejuv Medical's health care operations. The Notice of Privacy Practices also describes my rights and Rejuv Medical's duties with respect to my protected health information. The Notice of Privacy Practices is available from your therapist.

Rejuv Medical reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____ _____
Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

Release of Information

How Did You Hear About Us

Health Records

Attach 6 months of Labs

Attach 6 month of X-rays or MRI's

PERMISSION FOR VERBAL COMMUNICATIONS

901 3rd. Street North
Waite Park, MN 56387
Phone: 320-217-8480
Fax: 320-217-8490

(Print name of patient) (Date of Birth)

(Street address) (Phone)

(City, State, Zip)

I permit Rejuv Medical, their physicians, nurses, and other personnel to discuss health information, in person or by telephone, with the following people or organizations involved in my medical care.

This authorization is limited to discussions regarding the following medical condition.

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care)

Name	Phone Number	Relationship

Release of information under this document is limited to verbal discussions with my health care providers. This document does not permit the release of any written health information to the individuals named above with exception given to other health care providers needing information for continuation of care.

This authorization is valid for 1 year from signing or until_____

I understand that I may revoke this permission at any time but I must notify Rejuv Medical, who I wish to remove from the list and the date they need to be removed. This may be done either in writing or by talking with the Release of Information/ Business Office.

Patient's Signature Date

If this Release is signed by a representative on behalf of the patient, please complete the following:

Name and Relationship to patient _____

Reason not signed by the patient _____

Return completed form to
Rejuv Medical
901 3rd Street North
Waite Park, MN 56387
Attention: Release of Information

How did you hear about us?

Please Check all that apply

Your Name: _____ Date: _____

Professional Referral

☐Physician/Nurse ☐Chiropractor ☐Salon/Spa/Massage
☐Work comp Adjuster ☐Sports Team Sponsor ☐Athletic Trainer/Coach
Name of Professional Referral: _____

Radio Advertisement

☐Wild Country 99 ☐Lite 99.9 ☐104.7 KCLD
☐Mix 94.9 ☐AM1240 WJON ☐98.1 Country
☐Spirit 92.9 ☐KFAN ☐Other_____

Internet Advertisement

☐Google/Search ☐Facebook/Social Site ☐YouTube

Direct Mail Item

☐Postcard/Flyer ☐Promopak ☐Coupon Magazine
☐Coupon Book ☐Newcomers Mailing

Other

☐Billboard ☐Newspaper ☐Sports Program
☐Prize Box at a Business ☐Email ☐Expo _____
☐Friend/Family _____ ☐Networking Group _____