The Centeno-Schultz Clinic
403 Summit Blvd. # 201
Broomfield, Colorado 80021
Phone: 303-429-6448/ Fax: 303-429-6373

HIPAA AUTHORIZATION FOR MEDICAL RECORDS

Written Records *Verbal Patient Medical Information*

Please Print

Patient Name: _____ Date of Birth: _____

Social Security Number: Please call patient for this if needed. Phone Number: _____

Release **TO:** _____

Address: _____

Phone: _____ Fax: _____

Release **FROM**: _____

Address: _____

Phone: _____ Fax: _____

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s),

1) Drug Abuse/Alcohol Abuse (Fed Reg.42 CFR, part 2)
2) Psychological or psychiatric conditions
3) A test for the presence of antibodies (HIV) virus which causes AIDS
4) An AIDS diagnosis and/or AIDS related condition
5) Any third party source (hospital, pc, lab)

***According to Colorado State Statutes (**GCCR 1101-1, XIV**), there is a charge for copies of medical records. The charge is $14.00 for the first 10 pages, $.50/pages 11-39, and $.33/pages 40 and above.

Information Requested (Please circle for all items you authorize to be released):

Entire Record X-ray reports Pathology reports

Doctor Notes Third party record Diagnostic Studies

Psychological/psychiatric evaluations

Other _____

Treatment Dates: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extend that action has already been taken to comply with it. *In any event, this authorization expires ninety (90) days form the date of signature. I release the above name form liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.*

Signature of Patient _____ Date_____

OR

Signature of legal guardian/executor _____ Date_____

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

DEMOGRAPHIC FORM

Today's Date: _____

Height:_____ Weight:_____

Patient Name: _____ Date Injured: _____

Address: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ O

City: _____ State: _____ Zip: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Home Ph#: _____Work Ph#:_____Cell Ph#:_____Okay to Text?: ☐ Y ☐ N

Email Address:_____

Employer Name: _____ Workers Comp: ☐ Y ☐ N

Employer: _____ Auto Accident ☐ Y ☐ N If yes, what State? _____

Address: _____ _____

State, City & Zip:

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL ☐ **SELF**

Insured (**Responsible**) Party Name: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____ SS#: _____

City: _____ State: _____ Zip: _____

Home Ph#: _____Work Ph#:_____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____ Group #: _____Subscriber/SS#: _____

Pt. Relation to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Do you have Secondary Insurance? ☐ Y ☐ N

Adjuster: _____Claim #: _____

Is your case in litigation? ☐ Y ☐ N Name: _____

Attorney's Name: _____

I authorize the release of any private health information necessary to process this claim.

I, the undersigned agree, whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to The Centeno-Schultz Clinic, **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records.

I have read, understand and signed Centeno-Schultz Clinic *Financial Policy* and the *Notice of Privacy Practices*.

Signed: _____ **Dated:** _____

Insured and/or Responsible Party

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my physician and/or provider, may be considered necessary or advisable while a patient at Centeno-Schultz Clinic. I also understand that Centeno-Schultz Clinic may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Signed: _____ **Dated:** _____

Insured and/or Responsible Party

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

Medicare Agreement

☐ I do not have Medicare

This agreement is between Dr.'s Christopher Centeno and John Schultz (10/01/20-10/01/23), Dr.'s John Pitts and Dr. Jason Markle (10/01/20-10/01/23), Dr. Brandon Money (10/01/2020-10/01/23, whose principal place of business is The Centeno-Schultz Clinic, with locations at 403 Summit Blvd, Suite 201 and 9777 S. Yosemite St. 2nd Floor Suite 220 [PATIENT'S NAME] _____and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The physician has informed patient that physician has opted out of the Medicare program effective on October 1, 2013 for a period of at least two years and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to patient (the "services"):

Medical services for pain and musculoskeletal issues

In exchange for the services, the patient agrees to make payments to The Centeno-Schultz Clinic pursuant to the practice fee schedule. Patient also agrees, understands, and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that physician or The Centeno-Schultz Clinic submit a claim) to the Medicare program with respect to the services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that neither physician nor The Centeno-Schultz Clinic will submit a Medicare claim for the services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him/her.

Executed on _____

Physician Name: _____

_____ _____

[Patient signature] **[Physician signature]**

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

FINANCIAL POLICY

Welcome to the Centeno-Schultz Clinic ("CSC"). We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The services that you receive and the bill, is an agreement between you and CSC. **It is your responsibility to see that your bill is paid in full**. Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying CSC within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All co-pays and deductibles are due prior to treatment. If your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph. If you receive payment made out to both CSC and you, please endorse the check and forward to us.

Many insurance companies require a referral from your Primary Care Physician (PCP) to a specialist prior to any appointment. **It is your responsibility to ensure that this referral is obtained prior to all scheduled appointments**. To obtain a referral you will need to contact your PCP and request one. Failure to have a referral on file in our office prior to your appointment will require a waiver and payment in full at the time of service, or for the appointment to be rescheduled.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **Please be aware that some, and perhaps all, of the services provided may be non-covered services and are considered investigative under the Medicare Program and/or other medical insurances.**

Like any medical or surgical procedures, any individual may or may not respond to blood-derived procedures as hoped. By signing this form, you acknowledge that there is no guarantee being provided that this procedure will be effective for your medical condition, and you are waiving any rights to a refund of monies paid if the procedure(s) ultimately does not solve your medical problem(s).

Ortho biologic procedures are an uncovered benefit and there are no numerical procedures codes that insurance companies will recognize.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage.

RGXX Corporation Patient- Follow your guidelines based off your benefits through your employer.

There is a $25.00 charge will be made to your account if there is an NSF check.

DEPOSITS

All New Patient Evaluations and Follow Up appointments require a non-refundable $50.00 deposit. Our clinic is extremely busy, and we try to keep our waiting list to a minimum. Your deposit will be applied to any future treatment costs or co-ins/deductible or copay.

NO SHOW & LATE CANCELLATION

Our no show/late cancellation policy requires a 48-hour notice if you are unable to make your appointment. If no notice or less than 48- hour notice is provided, there will be a **$50.00 fee** for New Patient Evaluation or follow up visit. **For any procedures,** the clinic must be notified at least 2 weeks prior to procedure date, or the patient will be responsible/forfeiting the Booking Fee paid on all procedures.

I have read the *Financial Policy*. I understand and agree to this *Financial Policy*. I acknowledge the receipt of The Centeno-Schultz Clinic's *HIPAA Notice of Privacy Practices*.

Signed: _____ **Date:** _____

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

Regenerative Medicine and Interventional Orthopedics

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
** Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize **The Centeno-Schultz Clinic** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

****You may add just the last four numbers of your credit card if you will be providing the full number over the phone at the time of scheduling your appointment.**

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

PATIENT RECORD OF DISCLOSURES & COORDINATION OF CARE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

____Centeno-Schultz is committed to providing excellent, personalized patient care. To do so, we understand that you may need to email and/or text your provider during your treatment. Communication through email and/or text is not encrypted and may pose a HIPAA risk if a breech were to occur. By initialing, you are in agreement that if you use electronic communication with your provider, you are assuming this unlikely risk.

It is company policy to not have recorded evaluations. We encourage the patient to take notes. Upon request, the company can provide a copy of the Doctor's evaluation.

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

☐ Yes ☐ No If Yes, person's name: _____ Relationship:_____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

☐ Home telephone_____
- ☐ OK to leave a detailed message
- ☐ Leave message with call back number ONLY

☐ Work telephone_____
- ☐ OK to leave a detailed message at work
- ☐ OK to mail to my work address

☐ Written communication
- ☐ OK to mail to home address
- ☐ OK to fax to this number_____

☐ OK to leave info with specified people (i.e., attorney, spouse, friend)_____

☐ Leave message with call back number ONLY

COORDINATION OF CARE DISCLOSURE

Are you seeing any other physicians, physical therapists, chiropractors and/or acupuncturists for this condition?
☐ Yes. If yes, please provide information below ☐ No

Practice name:_____ Physician/Provider Name:_____
Address:_____ Specialty:_____
City:_____ State:_____ Zip:_____
Telephone:_____ Fax: _____

Practice name:_____ Physician/Provider Name:_____
Address:_____ Specialty:_____
City:_____ State:_____ Zip:_____
Telephone:_____ Fax: _____

Practice name:_____ Physician/Provider Name:_____
Address:_____ Specialty:_____
City:_____ State:_____ Zip:_____

Patient Signature: _____ Dated: _____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

REFERRAL INFORMATION

Patient Name: _____ **Today's Date:** _____

Tell us who referred you to our office?

- ☐ Internet - Internet Search Engine (i.e., Google, Yahoo!, etc.) _____
- ☐ Website - Website name _____
- ☐ Social Media – which media (i.e., Facebook, Twitter, Instagram) _____
- ☐ Employer
- ☐ Physician: _____
- ☐ Emergency room
- ☐ Friend / Relative
- ☐ Self
- ☐ Magazine article
- ☐ Other: _____

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

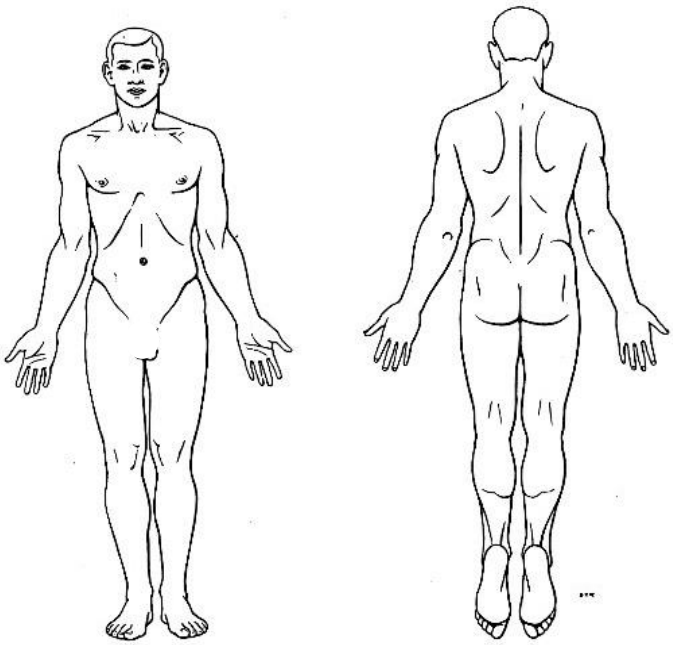
MEDICAL HISTORY FORM

Date:_____

Patient Name:_____ Age:_____Sex: ☐ F ☐ M WEIGHT_ __

CURRENTLY

The following questions are about how your illness is affecting you now. During your medical evaluation, please be prepared to indicate where your pain is on the drawing below. You may indicate it with X's or shades. Pay special attention to the directions with the arrows showing each part of the body.



List your pain and problems in order of severity (most severe first):

1._____

2._____

3._____

4._____

Please describe how your illness or pain began:_____

Since the injury or when your problem began, your symptoms are: ☐ Better ☐ Worse ☐ Unchanged

At this time are your symptoms: ☐ Better ☐ Improving ☐ Getting Worse ☐ Unchanged

Is there anything that INCREASES your pain/symptoms?	Is there anything that RELIEVES your pain/symptoms?
_____	_____

Check the box (X) that describes:	0 None	1-2 Mild	3-4 Uncomfortable	5-6 Distressing (fairly severe)	7-8 Very severe (horrible)	9-10 Unbearable (excruciating)
Your pain as it usually feels	☐	☐	☐	☐	☐	☐
Your pain as it is right now	☐	☐	☐	☐	☐	☐
Your pain at it's worst	☐	☐	☐	☐	☐	☐
Your pain when it hurts the least	☐	☐	☐	☐	☐	☐

How many days a week do you experience pain? ☐ Daily ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Intermittent

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

PAST / OTHER MEDICAL HISTORY

PAST MEDICAL HISTORY
(Current medical problems such as diabetes, hypertension or high cholesterol)

Diagnosis	Treating Physician

PREVIOUS TRAUMA
(Automobile accident, fractures, strains, any other)

Date	Injury/Accident	Remaining Problems

ALLERGIES
(medications or environmental)

MEDICATION AND SUPPLEMENTS
(please all medications you take—even if only occasionally) ***if more room is needed, please list on a seperate sheet of paper***

Medication	Dose	How Often	When Started	Why?

SURGICAL HISTORY

Surgery	Date	Surgeon

FAMILY HISTORY

Disability	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Rheumatolid Arthritis	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Degenerative Disc Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Drug Abuse	☐ Yes ☐ No

SOCIAL HISTORY

Occupation?	_____		
Do you smoke?	☐ Yes ☐ No	If yes, how much?	_____
Do you drink alcohol?	☐ Yes ☐ No	If yes, how much/often?	_____
Do you use recreational drugs?	☐ Yes ☐ No	If yes, how much/often?	_____

ACTIVITY LEVEL

Recreational activity level?	_____
Goals for treatment?	_____

COMMUNICABLE DISEASES

Hep A	☐ Yes ☐ No	HTLV	☐ Yes ☐ No
Hep B	☐ Yes ☐ No	Syphilis	☐ Yes ☐ No
Hep C	☐ Yes ☐ No	MRSA	☐ Yes ☐ No
HIV	☐ Yes ☐ No	C-Diff	☐ Yes ☐ No
Any other antibiotic resistant bacteria? (please list)	_____	Any other? (Please list)	_____

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

SYMPTOMS

The following is a record of any symptoms you may have had in the past or are ongoing. Please check the appropriate boxes for each

	Never	Occasional	Frequent
GENERAL			
Fatigue	☐	☐	☐
Irritable	☐	☐	☐
Hot/cold	☐	☐	☐
Chills	☐	☐	☐
Sweats	☐	☐	☐
Tremors	☐	☐	☐
Weight gain	☐	☐	☐
Weight loss	☐	☐	☐
HEAD/NEUROLOGIC			
Headaches	☐	☐	☐
Head injury	☐	☐	☐
Neck injury	☐	☐	☐
Dizziness	☐	☐	☐
Convulsions	☐	☐	☐
Slurred speech	☐	☐	☐
Memory loss	☐	☐	☐
Concentration problems	☐	☐	☐
Weakness	☐	☐	☐
Strokes	☐	☐	☐
Carpal tunnel	☐	☐	☐
BONES/JOINTS			
Arthritis	☐	☐	☐
Bursitis	☐	☐	☐
Tendonitis	☐	☐	☐
Cramps/spasms	☐	☐	☐
Swollen joints	☐	☐	☐
Pain between shoulders	☐	☐	☐
Back pain	☐	☐	☐
Chiropractic treatment	☐	☐	☐
Dislocations	☐	☐	☐
Gout	☐	☐	☐
Stiffness	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain or numbness in:	☐	☐	☐
-shoulders	☐	☐	☐
-arms	☐	☐	☐
-elbows	☐	☐	☐
-wrists	☐	☐	☐
-hands	☐	☐	☐
-hips	☐	☐	☐
-legs	☐	☐	☐
-knees	☐	☐	☐
-feet	☐	☐	☐
Painful tailbone	☐	☐	☐
Poor posture	☐	☐	☐
Sciatica	☐	☐	☐
Spinal curvature	☐	☐	☐
KIDNEYS/BLADDER			
Blood in urine	☐	☐	☐
Frequent urination	☐	☐	☐
Painful urination	☐	☐	☐
Kidney stones	☐	☐	☐
Urinary infections	☐	☐	☐
Incontinence	☐	☐	☐
FEMALES ONLY			
Painful menstruation	☐	☐	☐
Are you pregnant? ☐yes ☐no	☐	☐	☐
Pelvic pap smear	☐	☐	☐
Hot flashes	☐	☐	☐

	Never	Occasional	Frequent
EYES			
Blurry vision	☐	☐	☐
Double vision	☐	☐	☐
Eye pain	☐	☐	☐
EARS			
Ringing/buzzing	☐	☐	☐
Drainage	☐	☐	☐
Motion sickness	☐	☐	☐
Loss of hearing	☐	☐	☐
FACE/THROAT			
Sinusitis	☐	☐	☐
Frequent colds	☐	☐	☐
Problems swallowing	☐	☐	☐
Pain in chewing	☐	☐	☐
Pain in your jaw(s)	☐	☐	☐
Dentures	☐	☐	☐
LUNGS			
Tuberculosis	☐	☐	☐
Asthma	☐	☐	☐
Pneumonia	☐	☐	☐
Shortness of breath	☐	☐	☐
Chronic cough	☐	☐	☐
Wheezing	☐	☐	☐
Blood clots	☐	☐	☐
HEART			
Palpitations	☐	☐	☐
Rapid heart rate	☐	☐	☐
Chest pain	☐	☐	☐
High blood pressure	☐	☐	☐
Shortness of breath:	☐	☐	☐
-with activity	☐	☐	☐
-lying down	☐	☐	☐
Leg cramps (walking)	☐	☐	☐
Swollen feet/ankles	☐	☐	☐
CIRCULATION			
Varicose veins	☐	☐	☐
Blood clots	☐	☐	☐
Easy bleeding	☐	☐	☐
Anemia	☐	☐	☐
SKIN			
Pain	☐	☐	☐
Itching	☐	☐	☐
Dryness	☐	☐	☐
Eczema	☐	☐	☐
Rashes	☐	☐	☐
GASTROINTESTINAL			
Regurgitation	☐	☐	☐
Ulcers	☐	☐	☐
Abdominal pain	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Diarrhea (frequent)	☐	☐	☐
Constipation	☐	☐	☐
Blood in stool	☐	☐	☐
Hepatitis	☐	☐	☐
Pancreatitis	☐	☐	☐

Regenexx
The Trusted Alternative to Orthopedic Surgery
Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
Christopher J. Centeno, M.D.
John R. Schultz, M.D.
John Pitts, M.D.
Jason Markle, D.O.
Brandon Money D.O.
Mark Reilly, MS, PT

OUT OF TOWN PATIENT CARE

You are strongly encouraged to have someone with you to help take care of you after your procedures. Sometimes, pain, medication side effects, or unforeseen circumstances can make it difficult for you to manage alone. If you choose not to have someone care or drive for you after a procedure, you are assuming responsibility for any complications that may arise.

_____ I understand the risk and potential complications of not having someone to take care of me after my procedure(s) and hold CSC harmless to any complications that may arise from such arrangement.

_____ I have a driver and someone to care for me.

Name of person taking care of you: _____

Care person's phone number: _____

Name of hotel you are staying at: _____

Date of when you are flying out: _____

Signed: _____ Dated: _____