



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.
Matthew Hyzy, D.O.
Mark Reilly, MS, PT
Mairin Jerome, M.D.
Sarah Pastoriza, D.O.

DEMOGRAPHIC FORM

Today's Date: _____

Patient Name: _____

Date Injured: _____

Address: _____

SS#: _____ 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 Address: _____

Auto Accident Y N If yes, what State? _____

City: _____ State: _____ 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



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.
Matthew Hyzy, D.O.
Mark Reilly, MS, PT
Mairin Jerome, M.D.
Sarah Pastoriza, D.O.

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 ultimately 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. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a \$20.00 charge will be made to your account.

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.

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.

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 not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with the business office at 303-429-6448.

If we bill your insurance and reimbursement is 100% denied, we will bill you our Self Pay rates. If you are unsure of self pay rates, it is your responsibility to ask.

If you are a cash pay patient and you do not pay at the time of service or an arrangement to be billed by our billing department has not been set-up, you will be charged an 18% per annum service charge.

On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service.

Interest is charged on accounts due beyond the grace period. We allow a grace period for 2 months after receiving a final determination from your insurance company or date of service if you are a cash pay payment.

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 office visits, \$500.00 fee for all procedures performed in the clinic.**

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: _____

Dated: _____



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.
Matthew Hyzy, D.O.
Mark Reilly, MS, PT
Mairin Jerome, M.D.
Sarah Pastoriza, D.O.

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 breach 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 _____ Written communication
- OK to leave a detailed message OK to mail to home address
- Leave message with call back number ONLY OK to fax to this number _____
- Work telephone _____ OK to leave info with specified people (i.e., attorney, spouse, friend) _____
- OK to leave a detailed message at work Leave message with call back number ONLY
- OK to mail to my work address

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.



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.
Matthew Hyzy, D.O.
Mark Reilly, MS, PT
Mairin Jerome, M.D.
Sarah Pastoriza, D.O.

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: _____



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.
Matthew Hyzy, D.O.
Mark Reilly, MS, PT
Mairin Jerome, M.D.
Sarah Pastoriza, D.O.

MEDICAL HISTORY FORM

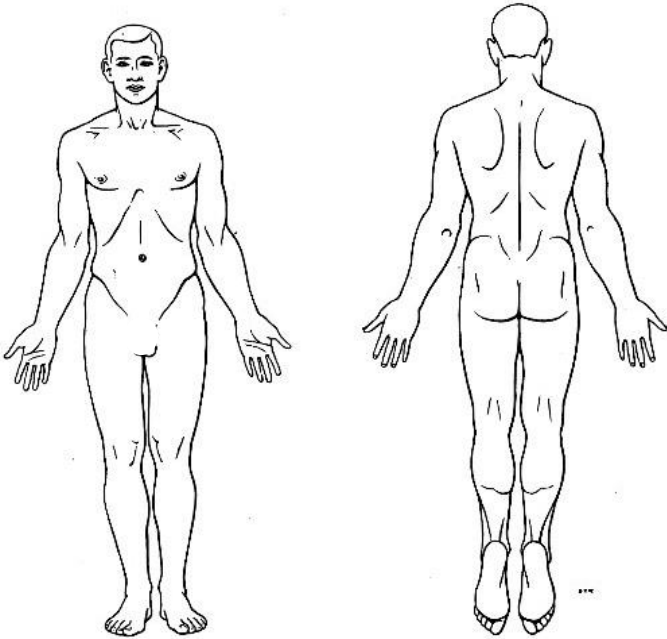
Date: _____

Patient Name: _____

Age: _____ Sex: F M

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your pain as it is right now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your pain at it's worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your pain when it hurts the least	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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



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 separate sheet of paper	Medication	Dose	How Often	When Started	Why?	
SURGICAL HISTORY	Surgery		Date	Surgeon		
FAMILY HISTORY	Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		Degenerative Disc Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SOCIAL HISTORY	Occupation?	_____				
	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much?	_____	
	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much/often?	_____	
	Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much/often?	_____	
ACTIVITY LEVEL	Recreational activity level?	_____				
	Goals for treatment?	_____				
COMMUNICABLE DISEASES	Hep A	<input type="checkbox"/> Yes <input type="checkbox"/> No		HTLV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hep B	<input type="checkbox"/> Yes <input type="checkbox"/> No		Syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hep C	<input type="checkbox"/> Yes <input type="checkbox"/> No		MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No		C-Diff	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Any other antibiotic resistant bacteria? (please list)	_____		Any other? (Please list)	_____	



SYMPTOMS									
<i>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</i>			Never	Occasional	Frequent		Never	Occasional	Frequent
GENERAL						EYES			
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EARS					
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringling/buzzing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEAD/NEUROLOGIC						FACE/THROAT			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in your jaw(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slurred speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS					
Concentration problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal tunnel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BONES/JOINTS						Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEART					
Cramps/spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-with activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps (walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or numbness in:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CIRCULATION					
-shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-wrists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKIN					
-hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL					
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEYS/BLADDER						Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY						Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Pelvic pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						



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.
Matthew Hyzy, D.O.
Mark Reilly, MS, PT
Mairin Jerome, M.D.
Sarah Pastoriza, D.O.

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: _____