# CENTENO-SCHULTZ CLINIC

*Where Interventional Orthopedics Was Invented*


403 Summit Blvd. # 201
Broomfield, Colorado 80021
Phone: 303-495-4014/ 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: ____________________________ Phone Number: ________________________

Release **TO:** ____________________________ Release **FROM**: ____________________________

Address: ____________________________ Address: ____________________________

Phone: ______________ Fax: ______________ 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________________

Regenerative Medicine and Interventional Orthopedics

**Centeno-Schultz Clinic**
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John R. Schultz, M.D.
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Matthew Hyzy, D.O
Brandon Money D.O.
Mark Reilly, MS, PT

# DEMOGRAPHIC FORM

**Today's Date: ________________**

Patient Name: ________________ Date Injured: ___________
Height: ____________________ Weight: ___________________
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 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: _____

Regenerative Medicine and Interventional Orthopedics

Insured and/or Responsible Party


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This agreement is between Dr.'s Christopher Centeno and John Schultz (10/01/20-10/01/23), Dr.'s John Pitts and Matthew Hyzy (10/01/20-10/01/23), 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]

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# 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 not considered reasonable and necessary 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).

## 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.

We expect this payment within 15 days In the event a check is returned for any reason, a $25.00 charge will be made to your account.

Certain procedures may not be reimbursed by your insurance company. <u>If it is expected that insurance will not cover, payment is due at the time of service.</u>

## 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 <u>New Patient Evaluation or follow up visit</u>. **For any procedures,** <u>the clinic must be notified at least 1 week prior to procedure date or the patient will be responsible/forfeiting the Booking Fee paid on all procedures.</u>

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: _____________________________

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# 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

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## 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.*

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# 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: _____

Do you have any pending litigation or workman's comp claims we should know about?

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

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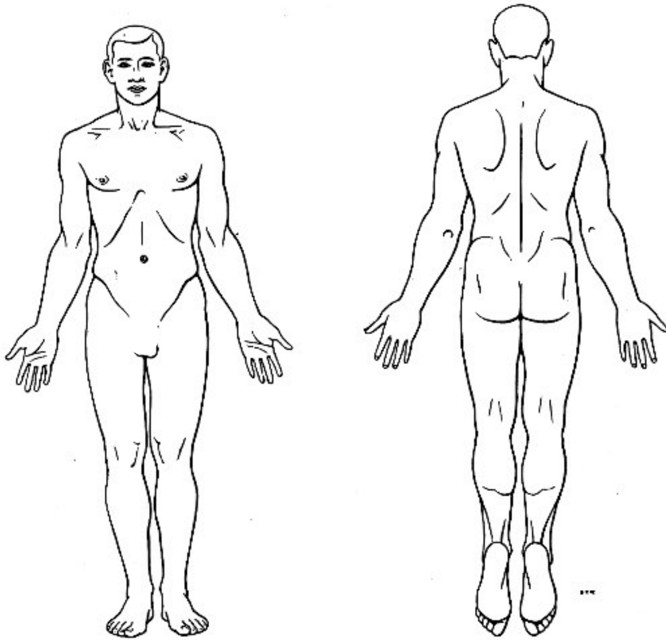
# MEDICAL HISTORY FORM

**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

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## 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) | _____ |

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

Regenerative Medicine and Interventional Orthopedics

**Centeno-Schultz Clinic**
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# 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: ____________________________