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.
Brandon Money, D.O., M.S.
Mark Reilly, M.S., P.T.

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

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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 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. <u>If it is expected that insurance will not cover, payment is due at the time of service.</u>

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 <u>office visits</u>, **$500.00 fee** <u>for all procedures performed in the clinic.</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: _____ Dated: _____

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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

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: _____

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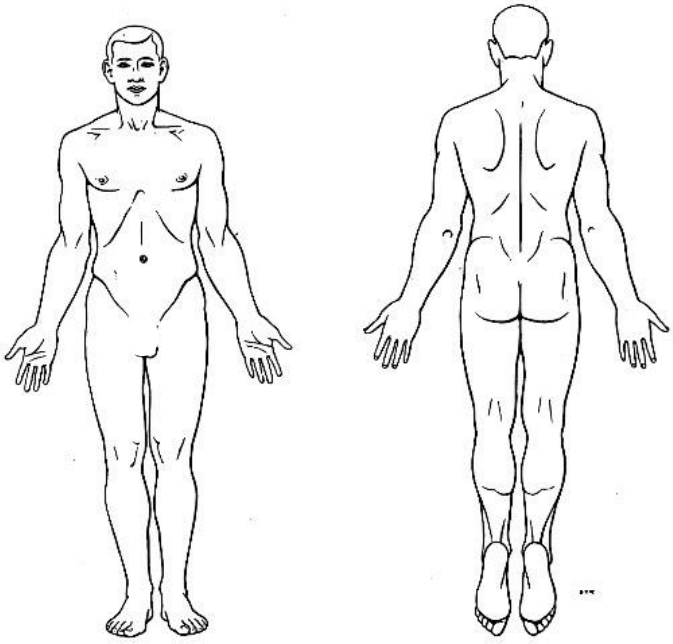
MEDICAL HISTORY FORM

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	☐	☐	☐	☐	☐	☐
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
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	☐	☐	☐

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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: _____

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_____