ReGen Clinic of West Texas

801 Tradewinds, Suite B• P.O. Box 7848 • Midland, TX 79706
(432) 203-3300 • (432) 695-6957 fax

CONSENT FOR TREATMENT: I understand that if medical treatment is necessary, a physician, nurse practitioner, physician assistant, or other appropriate healthcare provider of the ReGen Clinic of West Texas will perform such medical treatment and procedures.

I understand that Nurse Practitioners (NP) and Physician Assistants (PA) are not physicians, but do function under the supervision of a physician, either directly or via protocols established by a physician and that NPs and PA's are formally trained to provide diagnostic, therapeutic, and preventive health care services, as delegated by a physician. I also understand that as working as members of the health care team, NPs and PA's take medical histories, examine patients, order and interpret laboratory tests and x-rays, and make diagnoses. They also treat minor injuries by suturing, splinting, and casting. NP's and PA's record progress notes, instruct and counsel patients, and order or carry out therapy.

	I consent to the presence of student nurses during examination and treatment and agrees that student nurses may participate in the care and treatment the patient receives.
	I **DO NOT** consent to the presence of student nurses during examination and treatment and agrees that student nurses may not participate in the care and treatment the patient receives.

Medicare Patient's Certification: Authorization to release information and payment request. I certify that the information given by me in applying for payment under Titles XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefits: I hereby authorize payment directly to ReGen Clinic of West Texas of healthcare benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, including major medical, directly to the attending physician but not to exceed regular charges for these services. I understand that I am financially responsible to ReGen Clinic of West Texas and physician for charges not covered by this assignment.

Authorization for Release of Medical Information: The clinic and physician are authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency, which may be assisting in payment for my care.

Refund of Insurance Benefits: I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverages are subject to a coordination of benefits clause.

I have read and fully understand the above Acknowledgement for Treatment and hereby grant my authorization and consent for such treatment and procedures.

____________________________ ____________________________
Patient/Legal Guardian Signature Date

____________________________ ____________________________
Witness Date

Cellular Therapy Pain Management Wellness Medical Spa

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Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that part of the provision of healthcare services, ReGen Clinic of West Texas creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used of disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure or protected health information about me for purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance of my prior consent. The consent is given freely with the understanding that: Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

1. A photocopy or fax of this consent is as valid as this original.
2. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_______________________________________ ____

PATIENT'S NAME PRINTED DATE

____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

______________________________________ _______________________________________

WITNESS DATE

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PATIENT INFORMATION AND MEDICAL HISTORY

Last Name__________________________ First Name_____________________________ Today's Date______________

Address_____________________________________ City_____________________State___________Zip____________

Home Phone____________________ Mobile Phone___________________ E-mail Address________________________

Date of Birth______________ SS #____________________ Age_____ Sex_____Language___________Race__________

Ethnicity_______________ Martial Status ______________ Who referred you? _________________________________

Contact Preference (Please Circle)- Home Phone / Mobile Phone / Text / Email / ReGen Portal

Guarantor Information if minor (To whom statements are sent)

Last Name__________________________ First Name_____________________________

Address____________________________________ City_____________________State____________Zip____________

Primary Insurance Information/Not necessary if here for medical spa

Insurance Plan Name _____________________________ ID#_______________________ Group#___________________

Policy holder's Last Name________________________ Policy holder's First Name________________________________

Insurance Address_____________________________________ City_____________________State___________Zip____________

Policy holder's Date of Birth______________ Policy holder's SS #__________________ Policy holder's Sex M/F

Employer's Name__________________________ Patient's relationship to policy holder __________________________

Secondary Insurance Information

Insurance Plan Name _____________________________ID#________________________ Group#__________________

Policy holder's Last Name________________________ Policy holder's First Name________________________________

Insurance Address_____________________________________ City_____________________State___________Zip____________

Policy holder's Date of Birth______________ Policy holder's SS #__________________ Policy holder's Sex____________

Employer's Name__________________________ Patient's relationship to policy holder __________________________

Emergency Contact and Release of information to

Name________________________ Relationship_____________________ Mobile Phone__________________________

May we release medical information to the above, named contact? Yes No

Patient Employer's Information

Employer's Name ________________________ Address_________________________ Phone______________________

Pharmacy Information

Name ________________________ Address_________________________ Phone__________________

Allergies (Medications, Seasonal, and Food) ____

Active Medications____

Vaccines____

Family History: Medical Problems: Father: ____

Mother: ____

Brothers: ____

Sisters: ____

Social History:

Do you drink Alcohol? Yes No ___________ drinks per week

Do you smoke? Yes No ___________ packs per day

Do you take illicit drugs? Yes No What kind? ________________

Surgical History:

Have you ever had surgery? Yes No

If yes, please explain: ____

Primary Care Physician: ____

GYN History:____

Pregnancy History:____

Past Medical History: ____

____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature: ____ Date: ______________

Reviewed by: ____Date: ______________