PREMIER REGENERATIVE
Stem Cell and Wellness Centers

Patient Information Form

Today's Date ___/___/___

Patient

_____M___F___Age____Date of Birth_____
Legal last name First M.I.

Mailing Address_____
Street City State Zip code

Referred by:_____

Phone (____) _____Cell (____) _____ Business phone (___) _____

Your email address:_____

Employed by_____ Occupation_____

Soc Sec #_____Marital Status: M S D W spouse_____ Bus. Phone_____

Ethnicity _____ Preferred Language _____

Person Responsible for Payment

☐ **SELF**

Name_____ Relationship to Patient_____
Last First M.I.

Address_____
Street City State Zip code

Phone (____) _____Cell (____) _____ Business phone (___) _____

Soc Sec #_____ Occupation_____ Employer_____

Employer's Address_____

Person to Notify in Case of Emergency

(Other than person listed above)

Name_____ Relationship_____ Phone (___) _____

Insurance Information (please present most recent insurance card at time of check in)

→ **Primary Insurance** _____**Policy holder's name & DOB**_____
(Circle) PPO HMO OTHER Policy # _____ Group_____ Phone (___) _____
Address_____

Do you have secondary insurance? ☐Yes ☐No Insurance Name: _____

Work Comp_____ Have you notified your employer? Y____ N____
Claim Number:_____ Date of Injury ____/____/____

Auto Injury_____ Claim Number:_____Date of Injury:____/____/____

Auto and W.C.: Adjustor/case manager's name & phone _____
Billing Address_____

Briefly describe how this accident/injury occurred _____
_____Date of Injury ___/___/___

Attorney involved: Name _____ Phone (___) _____

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Authorization for Treatment, Fees and Disclosures

A. PAYMENT POLICY

1. **All procedures done at PRSC are cash only. Half payment is due at the time of booking and balance due on or before the day of your procedure at PRSC. Your payment is then placed in an escrow account until the date of the scheduled procedure. Once the procedure has been provided, your payment will be applied to your balance at PRSC.**
2. We accept cash, checks, Visa, Master Card, Discover, American Express, HSA, and Flex benefits.

B. INSURANCE POLICY

1. **NO** procedures performed at Premier Regenerative Stem Cell and Wellness Centers (PRSC) are covered by Medicare or Private Health Insurance. By signing below, you recognize that all procedures incurred at PRSC are **SELF PAY ONLY** and that **you are not entitled to submit remittance of payment to an insurance company**. You **MUST** sign an ABN form that recognizes that you understand this policy.
2. You MUST have an MRI or CT scan for spine evaluation and/or x-ray for peripheral joints that is LESS THAN ONE year old when you are to be evaluated by the physician to see if you are an appropriate candidate for stem cell therapy or PRP treatments. You may bill your insurance for the imaging at the imaging center of your choice.

C. FEES

1. Our charges for service include: pre-procedure visit (on day of procedure), procedure including MD, RN, anesthesia, immediate post-procedure care and radiology tech. Procedure fees are based on the severity and complexity of your injury as well as the time spent treating you. Please do not hesitate to inquire about the charges for our services.
2. Once it has been determined that you are an optimal candidate for stem cell therapy or PRP treatment and the procedure has been agreed upon between you (the Patient) and the Physician(s) , a statement of fees for the procedure will be provided to you at the time of the office visit prior to the procedure.
3. We begin preparing for your procedure as soon as you confirm your appointment by scheduling your time with the doctor and staff and ordering supplies. Therefore, we are unable to provide refunds.

D. STATEMENTS

1. We can provide you a receipt for payment and an invoice for the procedure, but we do not issue regular statements. Procedures need to be paid in full at time of procedure.

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CONSENT FOR PAYMENT

I understand that insurance **DOES NOT** cover this procedure and that I may not submit an invoice to my insurance for reimbursement. I understand that this procedure is an elective, **cash** based procedure. I understand that this procedure is still considered experimental and that I am not entitled to a refund if results aren't as I anticipated.

_____ (initial)

CONSENT FOR TREATMENT DATA

I understand that Premier Regenerative Stem Cell and Wellness Centers may use my patient treatment data for research purposes and quality assurance and that my identity will not be included in this data.

_____ (initial)

CONSENT FOR TREATMENT

I hereby consent to treatment procedures and patient care, which may be considered recommended by the doctor while a patient with Premier Regenerative Stem Cell and Wellness Centers. I acknowledge that any complications or adverse reactions outside of the care window is neither the responsibility nor any act of negligence of Premier Regenerative Stem Cell and Wellness Centers, and will be my own responsibility to be followed up by the appropriate medical personnel.

_____ (initial)

RELEASE OF INFORMATION AND DISCLOSURES

I hereby authorize PRSC to collect payment from cash pay, credit card. I agree that payment will be made in full at the time of the procedure and that I am not entitled to a refund after procedure has been performed. This will be considered a life time signature for all patients.

_____ (initial)

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____