Asheville Regenerative Orthopedics
and Sports Medicine

Christie Lehman, M.D.

FINANCIAL POLICY

Welcome to the Asheville Regenerative Orthopedics and Sports Medicine ("ARO") 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.

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of the practice's financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Asheville Regenerative Orthopedics & Sports Medicine PLLC any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Asheville Regenerative Orthopedics & Sports Medicine PLLC for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

If my insurance has a contract with Asheville Regenerative Orthopedics & Sports Medicine PLLC, I am not responsible for amounts she has agreed to write-off per the contract. If my insurance does not have a contract with Asheville Regenerative Orthopedics & Sports Medicine PLLC I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

PAYMENT FOR SERVICES

All co-pays and deductibles are due prior to treatment. Payment is due in full at the time of service for cash-based services and those not utilizing insurance.

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 **$25.00 fee** for office visits, **$200.00 fee** for all Regenerative Medicine procedures.

Completion of Forms may be subject to an additional charge.

I acknowledge that I received a copy of the ARO's financial policy and agree to the terms of payment due.
I acknowledge the receipt of ARO's *HIPAA Notice of Privacy Practices*, and had the opportunity to ask questions.

Signed:_____ Dated: _____

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Authorization for Credit/Debit Card On File Payment

Our practice uses a Credit Card on File process to collect patient-owed fees. This means that we do not accept checks or cash and only accept credit card payments. Credit Card on File allows our practice to eliminate the duplication and waste of statements and control costs to keep our fees reasonable. At your first appointment, you will be asked to sign an agreement allowing the practice to securely house your credit card and the terms of charging your credit card for monies owed by you. **Unfortunately, if you are unwilling to place a credit card on file with us, we will not be able to admit you as a patient.**

NOTE: Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.

AUTHORIZATION
Until further notice, I authorize Asheville Regenerative Orthopedics & Sports Medicine PLLC to charge the patient-responsible balances on my account, including old balances, no-show and forms fees, co-pays, co-insurance, deductibles and non-covered services, to the credit/debit card on file. If my credit or debit card expires, I agree to give Asheville Regenerative Orthopedics & Sports Medicine PLLC a valid replacement card upon request.

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Asheville Regenerative Orthopedics & Sports Medicine PLLC may charge my credit/debit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $150.00, I will receive a courtesy call prior to my card being charged.

Printed Name:_____ Date of Birth:

Signed:_____ Dated: _____

Asheville Regenerative Orthopedics
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Today's Date: _____

Patient Name: _____ **Date of Birth:** _____ **SS#:** _____

Date injured: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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? _____

Height: _____ Weight:_____ Sex: ____

City:_____State:_____Zip: _____ Primary Care Physician_____Ph#: _____

Pharmacy: _____

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL ☐ **SELF**

Insured (**Responsible**) Party Name: _____ Relationship to Patient: _____

Address:_____ Date of Birth:_____SS#(optional): _____

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:_____

Insured and/or Responsible Party

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 Asheville Regenerative Orthopedics and Sports Medicine, **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 Asheville Regenerative Orthopedics and Sports Medicine *Financial Policy* and the *Notice of Privacy Practices*.

Signed: _____ Dated: _____

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 Asheville Regenerative Orthopedics and Sports Medicine. I also understand that Asheville Regenerative Orthopedics and Sports Medicine 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:_____

Insured and/or Responsible Party

Dated: _____

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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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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.

____ ARO 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: _____

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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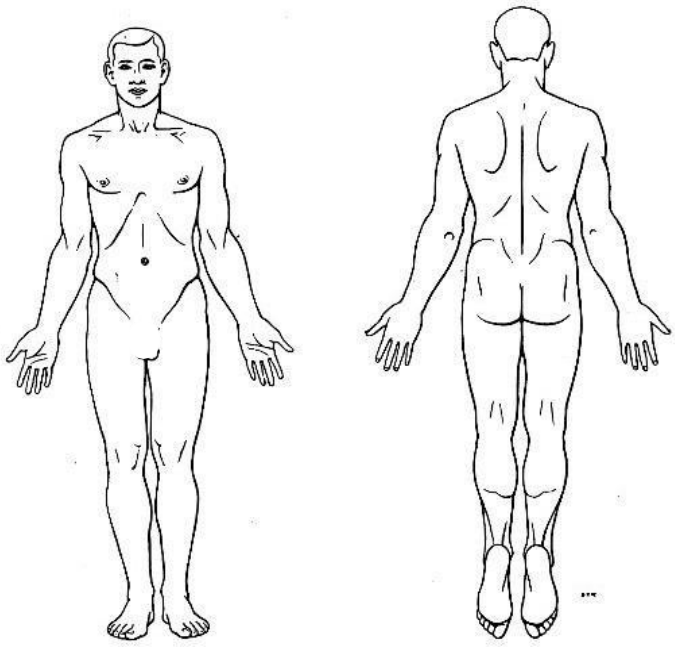
MEDICAL HISTORY FORM

Date:_____

Patient Name:_____ **Pharmacy:**_____ **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._____

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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Patient Name: _____ DOB: _____

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)	_____

ASHEVILLE REGENERATIVE ORTHOPEDICS & SPORTS MEDICINE

Asheville Regenerative Orthopedics and Sports Medicine

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Patient Name:_____ DOB: _____

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	☐	☐	☐				

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Patient Name: _____ DOB: _____

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: _____