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, tothird 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 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 all costs incurred on the collection of myaccount, 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 **$75.00 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

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: _____

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DEMOGRAPHIC FORM

Today's Date: _____

Patient Name: _____ Date Injured: _____

Address:_____ SS#:_____ 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: _____ Primary Care Physician_____Ph#: _____

Pharmacy:_____ Ph#_____

Person who signs consent and is responsible for bill?

Insured (**Responsible**) Party Name: _____ Home Ph#: Work Ph#:

Address:_____ Relationship to Patient:

City:_____ State:_____ Date of Birth:_____

Zip: _____ SS#(optional): _____

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 N

I authorize the release of any private health information necessary to process this claim.

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.

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 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:_____ Dated: _____

Insured and/or Responsible Party

ASHEVILLE
REGENERATIVE ORTHOPEDICS
&
SPORTS MEDICINE

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REFERRAL INFORMATION

Patient Name:_____ **Today's Date:** _____

Tell us, who referred you?

- ☐ 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 agree 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):

Written communication_____
Home Telephone_____
Leave a detailed voice message_____
Leave message with call back number ONLY_____
Mail to home address_____
Fax to this number_____

Work telephone_____

OK to leave info with specified people (i.e., attorney, spouse, friend)_____

OK to leave a detailed message at work____
OK to mail to my work address___

Leave message with call back number ONLY_____

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REGENERATIVE ORTHOPEDICS
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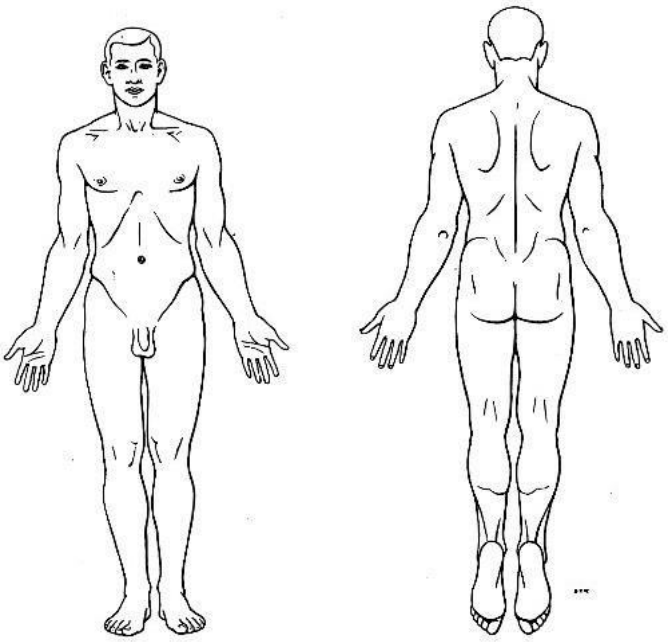
MEDICAL HISTORY FORM

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._____

When did this begin?_____

Since the injury or when your problem began, your symptoms are:	Better	Worse	Unchanged	
List 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	5-6 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

	Diagnosis	Treating Physician
PAST MEDICAL HISTORY *(Current medical problems such as diabetes, hypertension or high cholesterol)*		

ALLERGIES *(medications or environmental)*

	Medication	Dose	How Often	When Started	Why?
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***					

	Surgery	Date	Surgeon
SURGICAL HISTORY			

FAMILY HISTORY	Disability	Yes	No	Alcoholism	Yes	No
	Arthritis	Yes	No	Rheumatoid 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 antibioticresistant 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			
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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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 AROSM harmless to any complications that may arise from such an arrangement.

_____ I have a drive 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 when you are flying out:

Signed:_____ Dated:_____