wellward
Regenerative Medicine

New Patient

DATE:……………………..

Referring Physician…………………………….….… Family Physician……………………………………………….

Referring Physician Telephone Number (…………)………………..…… Fax (…………)……………………..………

Reason for CONSULT………………………………………………………………………………………….........

PERSONAL INFORMATION

Last Name………………………………………………….. First……………………………………. MI………………

Social Security Number ……………-………..-.................

Date of Birth: …………..…/……../……………………… Age: ………. Male / Female

Home Address……………………………………………City……………………………State………..Zip………………

Home Phone (………..)………………………………. Cell Phone (………..)………………………….…………

E-Mail Address: ……………..……………………………………………………………………..………………

SOCIAL HISTORY

Marital Status (Circle One): Single Married Divorced Widowed Separated

Spouse's Name………………………………………Date of birth………/……../……….

Do you still work? Yes or No What do you or did you do for employment?...

Are you currently smoking? Yes or No How much? ……………………………..

MEDICAL :

Please list all **medication allergies** and your **reaction** to them…………………………………………………………

Have medications that I take on a daily basis? Yes or No

I have had the following surgeries: ………………………………………………………………………………………

REVIEW OF SYSTEMS: Please read this list carefully and check any that apply. Please check "normal" if no symptoms are present:

Normal

- □ GENERAL: □Sudden Weight loss, □Weight gain, □Recent Fevers/chills, □Obesity, □Anorexia, □Change in energy
- □ SKIN: □Excessive sweating, □Change in texture, □Ulcer, □Skin Color Changes, □Dryness, □Nail changes, □Itching, □Rash
- □ HEENT: □Headache, □Facial Numbness/Pain, □Head Injury <3 months ago, □Dental difficulties, □Visual changes, □Trauma, □Nose bleed
- □ RESPIRATORY: □COPD/Emphysema, □Regular Wheezing, □Asthma, □Trouble breathing lying flat, □Cough, □Short of breath, □Sleep apnea
- □ CVS: □Chest pain, □Heart Attack, □Heart surgery/Stent, □Irregular heartbeat, □Pacemaker, □Edema, □Murmur, □Hypertension
- □ GI: □Heartburn, □Constipation, □Diarrhea, □Liver problems, □ Hepatitis, □Abdominal pain, □Nausea, □Vomiting, □Yellow skin
- □ GU: □Frequent Pelvic Pain, □Incontinence, □Kidney Disease, □Decreased sexual desire, □Blood in urine, □Painful urination, □Urine leakage
- □ MUSCULOSKELETAL: □Arthritis, □Joint Redness, □Decreased range of motion, □Muscle Weakness, □Swelling of extremities, □Redness
- □ NEUROLOGICAL: □Seizures, □Stroke, □Muscular coordination, □Dizziness, □Passing out, □Sensory change, □Memory loss
- □ PSYCHIATRIC: □Anxiety, Depression, □Hallucinations, □Drug abuse, □Alcohol abuse
- □ ENDOCRINE: □Diabetes, □Thyroid Problem, □Excessive urination, □Hair changes, □Excessive Drinking(Non-alcoholic), □Hot/cold flashes
- □ HEMATOLOGY: □Easy bleeding/bruising, □Blood clots, □HIV/Aids, □On Blood thinners(type):____________________, □Excessive bleeding

____

Patient Signautre

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New Patient

Treatment Consent Form

Treatment Authorization

I hereby grant permission to Dr. Manoochehr Mazloomdoost, Dr. Danesh Mazloomdoost, and/or Dr Camellia Shirazi Mazloomdoost to administer medication and/or treatment as needed. I also allow medical students to attend any evaluation and be present in all of my visits and procedures.

Medical Records

I hereby grant permission to send my medical records and financial information for purpose(s) of proper medical treatment, insurance, insurance filing, worker's compensation, or attorney requests. I also grant permission to communicate in writing and/or verbally to my family doctor and all other physicians involved with my care.

Payment for Services Rendered

I hereby assign all benefits to Dr. Manoochehr Mazloomdoost, Dr. Danesh Mazloomdoost, and Dr. Camellia Shirazi Mazloomdoost and understand that the balance not paid by my insurance and/or any amount predetermined not to be covered by my insurance carrier will be my responsibility. After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. Should it be necessary to place this account in the hands of an attorney for collection, the undersigned patient or responsible party, as appropriate, agrees to pay the costs of collection, including any court costs and all reasonable fees to the attorney employed by the office to collect said amount.

A 24-hour notice must be given on ALL office visit appointment cancellations. Failure to do so will result in a $50 fee that must be paid in full prior to any future appointments. There will also be an $80 fee for missed procedure appointments without a 48-hour notice of cancellation. These fees are NOT covered by your insurance. IT IS YOUR RESPONSIBILITY.

If the doctor or nurse is accidentally is stuck from a needle, I will allow them to withdraw blood from me to be tested for contagious diseases, including HIV, for their protection.

****

____

Patient Signature

____

Print Name (First, Last)

____

Date

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New Patient

Medication Agreement

Opiates for pain treatment are intended only to **take the edge off**. Do not expect to be absolutely pain free. Do not take pain medications to tolerate activities you normally could not do. Pain medicine will numb pain but it will not prevent you from damaging your body as a result of excessive strain. To further ensure your safety you must agree to the following:

1. I have never been diagnosed with, treated, or arrested for substance dependence or abuse.
2. I have never been involved in the sale, illegal possession, diversion, or illegal transport of controlled substances (narcotic, sleeping pills, nerve pills, or pain pills).
3. to supply to Wellward Regenerative Medicine the name, address, and telephone number of the pharmacy filling the prescription, and notify them when changing pharmacy.
4. to fill all medications at **one pharmacy only** and authorize your doctor to discuss your care with the pharmacist.
5. to NOT receive pain medication from any other source. If you are to undergo any medical or dental procedure requiring pain medication your physician or dentist must contact our office to coordinate your pain care.
6. to notify Wellward Regenerative Medicine of any emergency requiring **any change** in previously prescribed medicines within 24 hours. **This includes ER visits.**
7. to allow the physicians at Wellward Regenerative Medicine to discuss your care freely with other physicians treating the patient or pharmacies dispensing medications.
8. to take medications exactly as prescribed by the physicians at Pain Management Medicine. Any changes must be confirmed or discussed with the prescribing physician.
9. to not share, trade, or sell medications with other individuals.
10. to protect your pain medication from use by anyone other than yourself, especially children. If **for any reason** your medication is lost **OR** stolen, you must wait till your next visit for a refill. Under no circumstances will we refill lost or stolen medications.
11. to avoid any other mood altering substances such as alcohol, sleep aids, sedatives, or illicit substances due to the increased risk of death or serious injury.
12. to avoid driving, operating heavy machinery, climbing on elevated surface or equipment, or make any serious/ legal decisions within 8-10 hours of taking your medicine.
13. to **random** urine tests and pill counts. You must be able to take off work and present for pill counts or urine drug screen when called. If you cannot comply with this, we cannot prescribe any controlled substances
14. to be screened by the Kentucky All Schedule Prescription Electronic Reporting (KASPER) agency.
15. FEMALES only: to notify your physician if you plan on pregnancy, become pregnant, or even think you may be pregnant.
16. Anyone suspected, charged, or convicted of a misdemeanor or felony cannot be started or continued on opiate management until cleared of all charges.

The patient understands that prescriptions will be dispensed only after a scheduled office visit. No medication changes will be made during evenings, weekends, holidays, or prior to the next scheduled office visit.

AUTHORIZATION OF TERMS:

I have read the above conditions and terms stated above and have had all of my questions regarding these conditions and terms explained to my satisfaction. I have met the conditions, and I agree to honor all of the terms unconditionally. I understand that if I violate any term of this agreement, it is cause for the physicians at Wellward Regenerative Medicine to refuse prescriptions and/or treatment immediately. **I also understand that any person obtaining narcotics ("pain killers") from more than one physician without knowledge of all involved physicians may be charged with a class (d) felony under krs-218a.140 resulting in a penalty of 1 to 5 years in prison, $3,000.00 to $5,000.00 fine, or both.**

Please write ALL current and functioning telephone numbers. If we cannot reach you, or you cannot present when called, we will not be able to prescribe opiates.

PATIENT'S SIGNATURE: ______________________________________ DATE: __________________________

PRINT NAME (FIRST, LAST) : ____

Pharmacy Name ____

Pharmacy Street Address ____

Pharmacy City, State Zip ____

Pharmacy Telephone ____

Pharmacy Fax Number ____

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New Patient

HIPPA Authorization

Notice of Privacy Practices
Effective April 14, 2003

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)
We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information" (PHI) includes information about you past, present, or future health, healthcare we provide you and payment for your healthcare contained in the record of care and services provided by Wellward Regenerative Medicine. The purpose of this Notice is to explain who, what, when, where and why your PHI may be used or disclosed, and assist you in making informed decisions when authorizing anyone to use or disclosure your PHI.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- To request in writing to the Privacy Officer a restriction on the uses and disclosures of PHI as described in this notice. We are not required to agree to the restriction you request. We may not be able to comply with you request in certain situation, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures that do not require you authorization.
- To obtain a paper copy of this Notice and upon written request submitted Wellward Regenerative Medicine inspect and/or obtain a copy of your health record.
- To amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. We may deny your request if a) the record was not created by us, unless the person that created the record is no longer available to make the amendment; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.
- To request in writing to the Privacy Officer a written list of disclosures we made of your health information, except that we are not required to account for disclosures for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization. To request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax, and/or telephone.
- To revoke your authorization to use or disclose PHI at any time except, unless you authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. You revocation request must be made in writing to the Privacy Officer.

OUR RESPONSIBILITIES We are required by law to:

- Maintain the privacy of your PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your PHI, including information obtained prior to the change.
- Post notice of any changes to our Privacy Policy in the lobby and make a copy available to you upon request.

CONTACT FOR QUESTIONS/ COMPLAINTS/ REQUESTS
Direct your questions, complaints and requests made pursuant to this Notice to: Privacy Officer, **Andrea Brock 101 N Eagle Creek Dr, Lexington KY 40509 (859) 275-4878.** You may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

HOW WE MAY USE AND DISCLOSE YOUR PHI
We may use and disclose you PHI for the following purposes:
Treatment: We may use and disclose your PHI to anyone involved in the provision of health care to you, including for example, physician assistant, office employees and other medical professionals.
We may also disclose your PHI to outside treating medical professionals and staff as deemed necessary for your health care.
Payment: We may use and disclose your PHI to billing and collection agencies, insurance companies and health plans to collect payment for our services.
Health Care Options: We may use and disclose your PHI for our own health care operations. For example, we may use your PHI to assess your care in an effort to improve the quality of our service to you; to evaluate the skills, qualifications and performance of our health care providers; to provide training programs to students, trainees and other health care providers. In addition, our accountants, auditors and attorneys may use your PHI to assist our compliance with applicable law.
Business Associates: There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
Individuals Involved With Your Care: We may disclose your PHI to family or others identified by you or who is involved in your care or payment for your care. We may also notify a family member, or another person responsible for your care, about your location and general condition, unless you object by contacting registration for the facility providing your care.
Legally Required Disclosures & Public Health: We may disclose PHI as required by law, including to government officials to prevent or control disease, to report child, adult or spouse abuse, to report reactions or problems with products, and to report births and deaths.
Health Oversight Activities: We may disclose your PHI to federal or state health oversight agency that is authorized to oversee our operations.
Workers Compensation: We may disclose PHI for workers compensation programs.

Law Enforcement & Subpoenas: We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
Inmates: We may disclose your PHI to a correctional facility which has custody of you if necessary a) to provide health care to you; b) for the health and safety of others; or, c) for the safety and security of the correctional facility.
Information Regarding Decedents: We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donations.
Research: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
Marketing & Fund Raising: We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you as part of a fund raising effort.
Directory Information: We may disclose your name, location and general condition to those persons who ask for you by name or to members of the clergy. You may object to such disclosure by contacting registration at the facility from which you receive this notice.
Appointment Reminders: We may use and disclose your PHI provide a reminder to you about an appointment.
Treatment Alternatives: We may use and disclose your PHI to contact you about treatment alternatives that may be of interest to you.

DISCLOSURES REQUIRING AUTHORIZATION
All other disclosures of you PHI will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already made disclosures pursuant to your authorization.

Changes To This Notice
We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by posting the revised notice at our facilities, making copies of the revised notice upon request to the facility or the Privacy Officer.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our Privacy Officer at (859) 275-4878, or discuss any questions you may have with your physician.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:

I, ____________________________ acknowledge that I have received a Notice of Privacy Practices from Wellward Regenerative Medicine.

____
Patient Signature

____
Print Name (First, Last)

____
Date

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New Patient

Authorization for Medical Records Disclosure

****Please only fill out the box and sign below. This form will remain on file for use only when/if we need to obtain further records from your other past or current treating physicians.****

PATIENT:

____
(Name of Patient)

____
(Social Security Number)

____
(Date of Birth)

Authorizes: ____
(Name or specific identification of the person(s) authorized to make requested disclosure)

To release protected health information to **Wellward Regenerative Medicine**

INFORMATION TO BE RELEASED:

________ History & Physical	________ Surgical Reports	________ ER Records
________ Progress Reports	________ Laboratory Reports	________ Radiology Reports
________ Mental Health	________ Entire Record	________ Other (specify:

REASON FOR DISCLOSURE:

________ Additional Medical Care	________ Physician Change	________ Personal
________ Insurance Eligibility/Benefits	________ Legal Proceedings	________ Other

If the person(s) and/or organizations(s) listed above are not health care providers, health plans, or healthcare clearinghouses, who must follow the Federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards and your health information may be re-disclosed without obtaining your authorization.

YOUR RIGHTS AND OBLIGATIONS WITH RESPECT TO THIS FORM:
You are under no obligation to sign this form. You may withdraw this authorization by written notification. If you agree by signing this authorization, you must be provided a signed copy of this form if so requested.

I have had an opportunity to review the contents of this authorization and my rights in relation to this form. By signing below, I am certifying my agreement with the statements made in this form and agreeing to the release of my protected health information as indicated by this form.

______________________________	______________________________	_________________
Patient Printed Name	Patient Signature	Date
______________________________	______________________________	_________________
Witness Printed Name	Witness Signature	Date

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HIPPA Information Release Form

Name: ______________________________________ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize Wellward Regenerative Medicine to release information including the diagnosis, records of examination rendered to me, appointments, and claims information. This information may be released to:

[ ] Spouse____
If yes, please list Full Name

[ ] Child(ren)____
If yes, please list Full Name(s)

[ ] Other____
If yes, please list Full Name(s) & Relationship(s)

[ ] Information is not to be released to anyone but myself.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

[ ] my home ____________________ [ ] my work ____________________ [ ] my cell __________________
Please List Number Please List Number Please List Number

If unable to reach me:

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call.

[ ] ____

Signed: ____ Date: ___/____/_____

Witness Signature:_________________________________ Date: ___/____/_____

Witness Print:_____________________________________ Date:___/___/______