IOWA WELLNESS
CENTER

Preparing for Your Injection

You have been scheduled on _____ at _____ AM/PM for your injection to be performed at the office of Iowa Wellness Center, 1395 Jordan st, Suite C, North Liberty, IA 52317

In preparation for your procedure, we ask that you do the following:

- Stop NSAI S (aleve, naproxen, ibup rofen, advil, motrin, voltaren, diclofenac, Celebrex, Mobic, meloxicam) for at least 2 weeks (longer if possible) prior to your injection.
- If you are on any blood thinning medications except aspirin (Eloquis, Plavix, Coumadin/Warafin, Pradaxa, Lovenox, Heparin, Pletal, Aggrenox, Persantine, Ticlid) – please inform us prior to your appointment. We will also need the name and phone number of the prescribing doctor of the blood thinning medication.
- Wear loose-fitting clothing to allow us easy access to the injection site.
- If you have any bracing for area (ex. Knee brace) at home, bring with you to your appointment.
- You can eat and drink as your normal routine prior to this procedure.

_____

Signature

If you have any questions, please feel free to call us at 319-289-0666

PLEASE COMPLETE FORMS BEFORE APPT.

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Other) _____

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Emergency contact:Name: _____ Relation: _____ Phone #: _____

Phone #:(H) _____(W) _____

How did you hear about our practice? _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Superior Healthcare, LLC (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages via text, email, and/or phone (with or without voicemail). I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
Signature of Patient/Guardian Date

NAME:_____DOB:_____ Age:_____ Date of Exam:_____

Please tell us what brings you in today?_____

Please check to indicate if you are currently or have ever experienced any of the following conditions:

Medical
- ❑ Alcoholism
- ❑ Allergies
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Diabetes
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Hepatitis
- ❑ Kidney Disease
- ❑ Loss of Memory
- ❑ Measles
- ❑ Mononucleosis
- ❑ Nausea
- ❑ Pneumonia
- ❑ Polio
- ❑ Psychiatric Care
- ❑ Sinus
- ❑ Skin Rashes
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Diabetes

Please list all medical conditions NOT Listed elsewhere on this form:

_____

_____

_____

_____

_____

_____

Metabolic/Nutritional
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Cold Sores
- ❑ Bleeding Disorders
- ❑ Constipation
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Bulimia
- ❑ Cold Feet/Hands
- ❑ Dizziness
- ❑ Fatigue
- ❑ Goiter
- ❑ Weight gain
- ❑ Gout
- ❑ Hair Loss
- ❑ Headaches
- ❑ Insomnia
- ❑ Liver Disease
- ❑ Light Bothers Eyes
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Sleeping Difficulties
- ❑ Stomach Problems
- ❑ Sudden Weight Loss
- ❑ Ulcers
- ❑ Food cravings
- ❑ Vitamin D deficiency
- ❑ Abdominal Pain

Physical
- ❑ Arthritis
- ❑ Neck Pain/Stiffness
- ❑ Mid Back pain/stiffness
- ❑ Low Back pain/stiffness
- ❑ Sciatica
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot pain
- ❑ Numbness/tingling
- ❑ Wrist pain
- ❑ Shoulder pain

Hormonal
- ❑ Depression
- ❑ Low Body Temp
- ❑ Migraines
- ❑ Miscarriage
- ❑ Nervousness
- ❑ Osteoporosis
- ❑ Prostate Problems
- ❑ Breast Lump
- ❑ Suicide Attempt
- ❑ Vaginal Infections
- ❑ Low libido
- ❑ Oral contraceptive use
- ❑ Thyroid Problems

Cardiology
- ❑ Ankle Swelling
- ❑ Arm/Hand Pain
- ❑ Cold Sweats
- ❑ Chest Pain
- ❑ Fainting
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Pacemaker
- ❑ Varicose Veins
- ❑ Carotid artery blockage
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Low magnesium
- ❑ Low potassium
- ❑ Stroke
- ❑ Anemia

- ❑ Diabetes
- ❑ PCOS
- ❑ Fibroids
- ❑ Breast Cancer
- ❑ Prostate cancer
- ❑ Triglycerides >300

INITIAL INTAKE

NAME:_____

Are you currently under drug and/or medical care? ☐ Yes ☐ No Who is your primary care Dr? _____

Please all medications: (Be sure to include dosage and frequency)_____

_____

Are you on any anti-inflammatory meds? (Aleve, Naproxen, Motrin, Ibuprofen, Celebrex, Meloxicam, Mobic, Voltaren, Diclofenac)

Other:_____Do you take blood thinners (Coumadin, Plavix, Asprin, Xarelto, Eliquis, Pradaxa)?_____

Supplements (vitamins/herbs/minerals): _____

Allergies: _____

WOMEN ONLY: Date of LMP:_____ *Any possibility of pregnancy: YES or NO*

Surgical History: (Please note ALL joint replacement surgeries!)

Surgeries and/or hospitalizations (type & date): _____

_____

Family History: Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

☐ Heart Disease _____ ☐ Diabetes _____
☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

Social History:
Intake of following: Cigarettes ___ packs/day Alcohol _____drinks/week Caffeine _____ cups/day

Exercise frequency: ☐Never ☐Daily ☐ Weekly ☐Walks ☐Runs ☐Swims

Informed Consent to Care

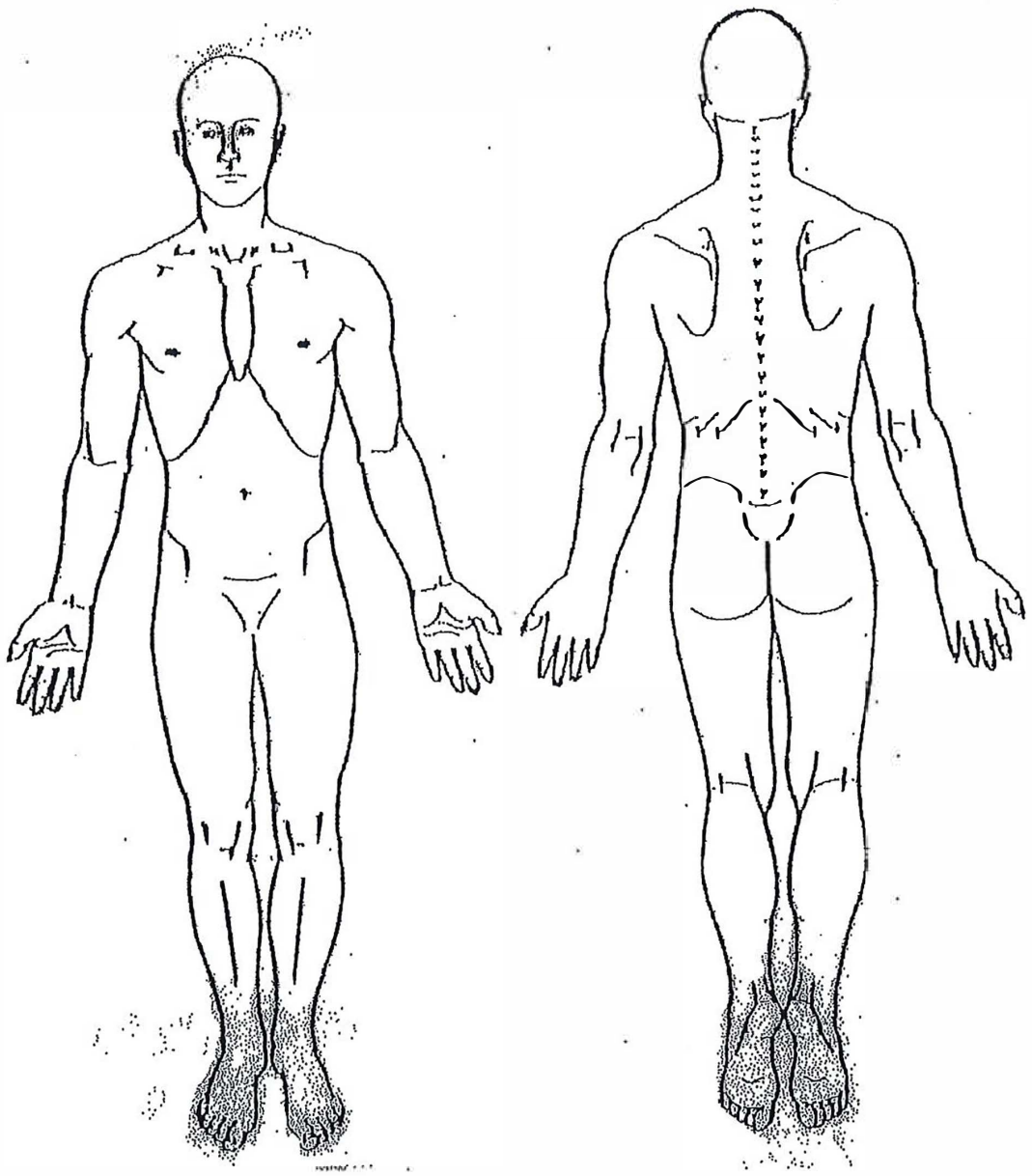
A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____ I have read and understand the above consent form.

Name : _____ **Date** _____



XXXX = TRIGGER POINT LOCATION

---→-----→ = RADIATING PAIN

◯ = JOINT PAIN

H/A = HEADACHE

//// (NN & TT) = NUMBNESS AND TINGLING

▦ = BURNING

A.Notifier. Regenerative Medicine of MS. 398 N. Eason Blvd Tupelo, MS 38804
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Service(s) below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Service(s) below.

D. Service(s)	E. Reason Medicare May Not Pay:	F. Estimated Cost
o Human AminoAllograft Injecrtion	Non-covered service	$
o Spinal rehab therapy	Non-covered – no PT on staff	$
o Cervical Traction	Non-covered service for patient's dx	$
o TENS therapy	Non-covered service for patient's dx	$
o Spinal Decompression therapy	Non-covered service	$
o Platelet Rich Plasma therapy	Non-covered service	$

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the **D.** Service(s) listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐**OPTION 1.** I want the **D.** Service(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

X OPTION 2. I want the **D.** Service(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐**OPTION 3.** I don't want the **D.** Service(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: