PAIN ARTHRITIS RELIEF CENTER
REGENERATIVE ORTHOPEDICS

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Phone: _____ Alt. Phone: _____ Email: _____

How did you hear about our office? _____

WELCOME

Welcome to the Pain Arthritis Relief Center. We commend you for taking the first steps in feeling better and getting well. We commit to providing you with the best in Regenerative Medicine and Rehabilitation.

Regenerative Orthopedics specifically uses your own body's healing ability combined with our own proprietary system of cutting edge science. Today's visit focuses on determining whether you qualify as a candidate for Regenerative Orthopedics.

FREE CONSULTATION

You will meet with one of our specialists to discuss your current condition, how your pain is affecting your life and your general health. We will also provide an overview of our program. Should we feel you are a viable candidate and you choose to move forward, we will proceed with your physical examination today.

PAID ORTHOPEDIC EXAMINATION

The overall goal of your physical examination is to arrive at an accurate diagnosis by a board certified orthopedic surgeon, Dr. Michael S. Propper FACS. Your examination will include orthopedic and neurological testing to pinpoint your condition. Once Dr. Propper , determines your diagnosis, he will sit with you to discuss treatment options and your plan of action.

QUALIFICATION, SCHEDULING AND FINANCES

At this point of your visit, if you qualify for one of our Regenerative Orthopedic procedures, we will discuss the details of your specific special procedure and your financial obligation. Before leaving, we will also set up another appointment to review specific instructions and schedule accordingly.

I verify that all the above information is correct and that I have read the document in its entirety and understand its content.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Name: _____ **Date:**_____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general health coverage is an arrangement between my insurance carrier and myself. I understand that if this office chooses to bill any services to my insurance carrier they are performing these services strictly as a convenience to me. Pain & Arthritis Relief Center will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid claims or balances.

I understand that there may be some services that my insurance company will not cover. If my insurance company notifies me that they are refusing payment for any services I have received, I will contact Pain & Arthritis Relief Center immediately to notify them of the nonpayment/rejection notice. I authorize the assignment of all insurance benefits to be directed to Advanced Wellness Systems, LLC (d/b/a Pain & Arthritis Relief Center) for services rendered.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

Patient's Signature_____ Date_____

Parent/Guardian's Signature _____ Date_____

Name of Insurance Co. _____ Policy #_____

Policyholder information (if different from patient)

Insured's Name_____ Insured's Birth Date _____/_____/_____

Patient's Relationship to Insured _____ Insured's SS # (optional) _____

Do you have a secondary or supplemental insurance policy? ☐ Yes ☐ No

Secondary Insurance Co. _____ Policy #_____

CARE AUTHORIZATION

I hereby authorize Pain Arthritis Relief Center (PARC) and its licensed doctors/specialists, based on my complaints and the history I have provided, to undertake an examination and provide treatment which may include chiropractic adjustments, manual therapies, modalities and other tests and procedures considered therapeutically appropriate. I also wish to rely on PARC doctors/specialists to make those decisions about my care, based on the facts then known, that they believe are in my best interest. The specifics of the provider's recommended treatment plan will be further explained during a Report of Findings following the examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

The health care providers will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural or extremity conditions diagnosed at this clinic.

By signing below I acknowledge my consent to be examined and allow PARC, as deemed appropriate by the examining physician, to take radiographs (x-rays) of my spine and/or extremities. I affirm that to my knowledge that I am not pregnant. _____ **(Initial)**

Patient's Signature_____ Date_____

I hereby authorize PARC to administer care as deemed necessary to my child or dependent, a minor under the age of 18 years old.

Parent/Guardian's Signature _____ Date_____