Cover Letter

Thank you for scheduling your appointment, procedures and care at Rejuv Medical. We look forward to serving you with the highest level of professionalism while providing exceptional patient outcomes.

Dr. Joel Baumgartner M.D., a board certified medical physician specializing in non-surgical orthopedic and sports medicine, designed this medical center with a mission to reverse the impact of disease and degeneration through evidence-based treatments. Rejuv is a state licensed Medicare certified medical practice. Rejuv is committed to meeting the needs of those we serve, and our goal is to afford the community access to quality health care in a comfortable and cost-effective environment.

To ensure the best possible visit it is important that all paper work and necessary requested medical information be provided during your visit. Below is a check list of the needed paperwork and records to make the most of your time and the physicians. If you do not have the paperwork completed, please arrive 30 minutes before your appointment.

What to Bring to Your Appointment:

_____ Medical History

_____ Lab work completed within the last year

_____ Imaging (X-rays, MRI, or other imaging) completed within the last year

_____ Demographics

_____ Insurance & Financials Policies

_____ Privacy Notices

_____ Release of Information

_____ How Did You Hear About Us?

Name _____ Date of Birth _____
Primary Care Provider _____
Referring Provider _____

New Patient Intake Paperwork

Your completed intake paperwork helps our providers get to know you and your medical history. We know this is a lengthy form but we rely on its accuracy and completeness to provide you with the best possible care and a successful first visit. If you have any questions about completing the forms please contact us at FrontDesk@RejuvMedical.com or by phone at (320) 217-8480.

Treatments Coordinated by Rejuv Medical

What types of treatments might you be interested in?

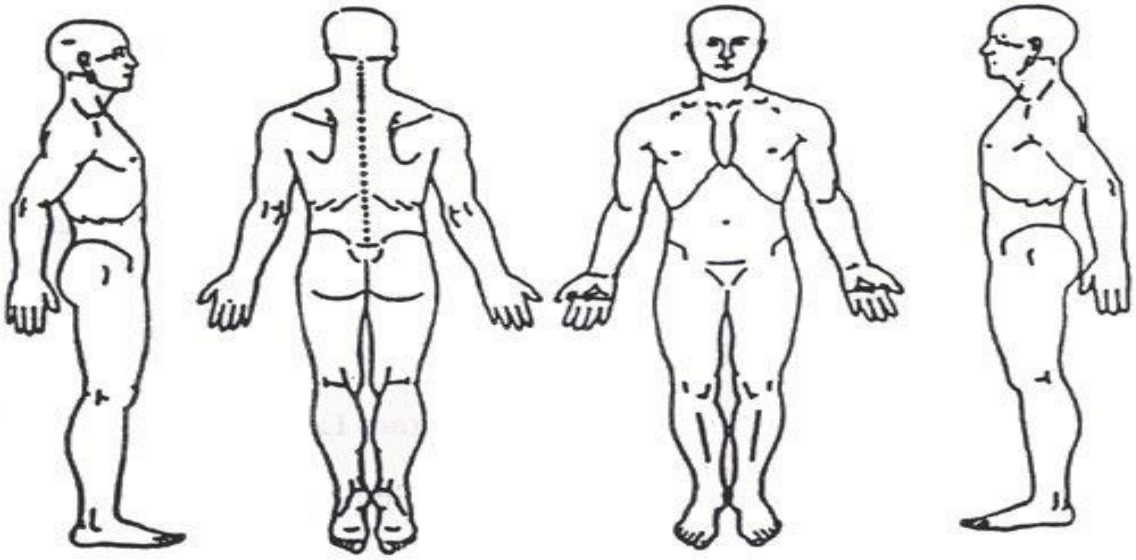
☐Regenerative Therapy (Stem Cell, PRP, Prolotherapy)
☐Medical Fitness/ Exercise
☐Functional Medicine
☐Food Sensitivity Testing
☐ Hormone Evaluation
☐Weight Loss/ Health Restoration
☐Dietary Supplements
☐Allergy Testing
☐Physical Therapy
☐Joint Injections
☐IV Therapy
☐Hair Restoration
☐Regenerative Esthetics
☐Primary Care

What are your health care goals? _____

What is your primary area of pain? _____

Any other concerns you would like addressed? _____

Please mark the location of your pain:



Name_____ Date of Birth _____

Current Medications

☐ I am not taking any medications

Drug name	Dose per pill	Taken daily?	Time of day	How many pills at a time?	How many times per day?	Who prescribes this?
Example: Simvastatin	20mg	Yes	At bedtime	1	Once	Dr. X

Nutritional Supplements

☐ I am not taking any supplements

Name & Brand	Dose per pill	Taken daily?	For how long?	How many pills at a time?	How many times per day?	Who prescribes this?
Example: Nature's Made Vitamin E	400IU	Yes	6 months	1-2	2	Dr. X

Name_____ Date of Birth _____

Past Medical History

Mark the following conditions/ diseases that you currently have or have been treated for in the past:

General/Infection Disease

☐Cancer: _____
☐Tuberculosis
☐Lyme Disease
☐MRSA
☐HIV / AIDS

Head/ Eyes/ Ears/ Nose/ Throat

☐Headaches
☐Migraines
☐Head Injury
☐Glaucoma

Musculoskeletal

☐Carpal Tunnel Syndrome
☐Chronic Low Back Pain
☐Chronic Neck Pain
☐Chronic Joint Pain
☐Fibromyalgia
☐Osteoporosis
☐Osteoarthritis
☐Rheumatoid Arthritis

Respiratory

☐Asthma
☐Bronchitis
☐Emphysema/ COPD
☐Obstructive Sleep Apnea
☐Seasonal Allergies

Genitourinary/ Nephrology

☐Bladder Infection(s)
☐Dialysis
☐Kidney Infection(s)
☐Kidney Stones
☐Urinary Incontinence
☐Prostate Issues

Gastrointestinal

☐Bowel Incontinence
☐GERD (Acid Reflux)
☐Gastrointestinal Bleeding
☐Constipation
☐Ulcer
☐Gallbladder Disease
☐Fatty Liver
☐Liver Disease

Endocrine

☐Diabetes Type:_____
☐Hyperthyroid
☐Hypothyroid
☐Vitamin D Deficiency
☐Vitamin B12 Deficiency
☐Low Testosterone
☐Menstrual Disorder
☐ Polycystic Ovarian Syndrome
☐Post Menopause

Cardiovascular/ Hematologic

☐Anemia
☐Bleeding Disorder
☐Heart Attack
☐High Blood Pressure
☐High Cholesterol
☐Valve Disorder
☐Murmur
☐Phlebitis
☐Poor Circulation
☐Stroke
☐Coronary Artery Disease
☐Blood Clot
☐Peripheral Vascular Disease
☐Congestive Heart Failure

Neuro- Psychosocial

☐Alcohol Abuse
☐Prescription Drug Abuse
☐Alzheimer Disease
☐Depression
☐Anxiety
☐Bipolar Disorder
☐Schizophrenia
☐Seizures
☐Multiple Sclerosis
☐Paralysis
☐Peripheral Neuropathy
☐Reflex Sympathetic Dystrophy/ CRPS
☐Restless Leg Syndrome

Other medical conditions:

_____

_____

_____

_____

_____

Name_____ Date of Birth_____

Allergies to Medications & Foods

☐ I do not have any known drug allergies

Food or Drug Name	Reaction

Topical Allergies: ☐ Iodine ☐ Latex ☐ Tape Are you allergic to shellfish? ☐ Yes ☐ No

Surgical History

Spine **Levels** **Date**

☐Discectomy _____
☐Laminectomy _____
☐Spinal Fusion _____
☐Spinal Cord Stimulator _____
☐Other _____

Heart **Date**

☐Valve Replacement _____
☐Aneurysm Repair _____
☐Stent Placement _____
☐Vascular Surgery _____
☐Other _____

Joint **Type** **Left/Right** **Date**

☐Ankle/ Foot _____
☐Knee _____
☐Hip _____
☐Shoulder _____
☐Wrist/ Hand _____
☐Other _____

Female Surgeries **Date**

☐Cesarean Section _____
☐Hysterectomy _____
☐Laparoscopy _____
☐Ovarian _____
☐Other _____

Abdominal **Date**

☐Gallbladder _____
☐Appendectomy _____
☐Gastric Bypass _____
☐Other _____

Other Surgeries **Date**

☐Thyroidectomy _____
☐Hemorrhoid surgery _____
☐Hernia Repair _____

Any other surgeries, dates and details: _____

_____

_____

Name_____ Date of Birth_____

Family History

Please indicate family medical problems and the family members that they pertain to:

Family Member:	Diabetes (Type)	High Blood Pressure	Heart Disease	Stroke	High Cholesterol	Hypothyroid	Cancer (Type)	DVT	Status (Living/ Deceased)	Age
Mother										
Father										
Sibling(s)										
Son(s)										
Daughter(s)										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Maternal Aunt(s)										
Paternal Aunt(s)										
Maternal Uncle(s)										
Paternal Uncle(s)										

Other family medical problems: _____

_____

☐ No significant family medical history ☐ Adopted (No family history available)

Name_____ Date of Birth _____

Social History

Tobacco Use

☐ Never used tobacco

☐ Current Smoker

Do you smoke every day? ☐ Yes ☐ No

How many cigarettes per day do you smoke? ☐ <5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ >31

How soon after waking do you have your first cigarette? ☐ Within 5 minutes
☐ Within 30 minutes ☐ Within an hour ☐ After an hour or more

Are you interested in quitting? ☐ Yes ☐ No ☐ Thinking about it

☐ Former smoker

How long has it been since you last smoked? ☐ < 1 month ☐ 1-3 months
☐ 3-6 months ☐ 6-12 months ☐ 1-5 years ☐ 5-10 years ☐ > 10 year

Other

☐ Smokeless/ Chewing Tobacco ☐ Electronic Cigarette ☐ Second hand smoke exposure

Alcohol Use

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No ☐ Active in AA

If Yes:

- How often did you have a drink containing alcohol? ☐ Monthly or less
  ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week
- How many drinks did you have on a typical day that you were drinking? ☐ 1-2 ☐ 3-4
  ☐ 5-6 ☐ 7-9 ☐ >10
- How often did you have 6 or more drinks on one occasion? ☐ Never ☐ Monthly or less
  ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Illegal Drug Use

Have you ever used illegal drugs? ☐ Never ☐ Former ☐ Current ☐ Active in NA

If 'Former', which? _____ If 'Current', which? _____

Have you ever used someone else's prescription? ☐ No ☐ Yes, which? _____

Have you ever abused narcotic or prescription medications? ☐ No ☐ Yes, which? _____

Genetic/ Ethnic Background/Ancestry: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Highest level of education: ☐ Grammar School ☐ High School ☐ College ☐ Post-Graduate

Are you working? ☐ Yes ☐ No ☐ Retired If 'Yes', Employer: _____

Job Description: _____ If 'Retired', what type of work did you do? _____

Are you on Disability? ☐ Yes ☐ No If so, why and since when? _____

Are you capable of becoming pregnant? ☐ Yes ☐ No If so, are you currently pregnant? ☐ Yes ☐ No

Do you have any history of physical, sexual, or emotional abuse? ☐ Yes ☐ No

If you feel comfortable doing so, please explain _____

Name_____ Date of Birth_____

Lifestyle Questions

Height _____ Weight _____

Diet

Do you feel you eat a healthy diet on a daily basis? ☐ Yes ☐ No

Do you follow a specific dietary lifestyle? ☐ Vegan ☐ Vegetarian ☐ Paleo ☐ Keto ☐ South Beach ☐ Mediterranean ☐ Intermittent Fasting ☐ Atkins ☐ No specific dietary approach

Have you ever had an eating disorder? ☐ No ☐ Yes, Type: _____

How much water do you consume daily? ☐ < 64 ounces ☐ > 64 ounces

Do you consume less than 5 servings of fruits and vegetables per day? ☐ Yes ☐ No

Do you consume caffeinated beverages? ☐ Yes ☐ No If so, how many per day? ☐ 1-2 ☐ 3-4 ☐ 5-7

Do you eat at restaurants frequently? ☐ Yes ☐No Do you eat fast food frequently? ☐ Yes ☐ No

Do you consume any foods with artificial colors, sweeteners, or preservatives? ☐ Yes ☐ No

Exercise

Do you exercise? ☐ Yes ☐ No If so, how many days per week? ☐ 1-2 ☐ 3-4 ☐5-7

What type of exercise do you enjoy? _____

How much time do you exercise on the days you do exercise? ☐15-30 min ☐ 30-60 min ☐ >60 min

Explain your exercise goals: _____

Involved in any sports or hobbies? ☐Yes ☐No If so, please list _____

Fatigue

Are you tired or fatigued? ☐Yes ☐No How long have you been fatigued?_____

Average daily energy level? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What time of day do you have the most energy?_____

What time of day to you have the least amount of energy?_____

Sleep

How many hours do you sleep on average each night? ☐<5 ☐ 6 ☐ 7 ☐ 8 ☐>8

Do you wake feeling refreshed? ☐Yes ☐No Do you snore? ☐Yes ☐No

Have you ever had a sleep study? ☐Yes ☐No If so, when and what were the results?_____

Stress

Do you have a lot of stress in your life currently? ☐Yes ☐No

If so, what is the usual source of the stress?_____

What is your typical daily stress level? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Are you easily upset or irritated? ☐Yes ☐No Are you constantly keyed up or jittery? ☐Yes ☐No

What is your current outlet or strategy to deal with stress?_____

Name_____ Date of Birth_____

Review of Systems

Mark any that have occurred in the LAST MONTH:

General:

- ☐ Change of appetite
- ☐ Chills
- ☐ Intolerant of cold
- ☐ Swelling
- ☐ Weight loss
- ☐ Always tired
- ☐ Puffiness
- ☐ Frequent infections
- ☐ Weight gain
- ☐ Night sweats
- ☐ Lack of libido
- ☐ Belts fit differently
- ☐ Excessive thirst
- ☐ Hot flashes
- ☐ Fever

Head/Eyes/Ears/Nose/Throat:

- ☐ Sinus pain
- ☐ Change in vision
- ☐ Bleeding gums
- ☐ Allergies (seasonal)
- ☐ Ear pain
- ☐ Hoarseness
- ☐ Nasal discharge
- ☐ Ear discharge
- ☐ Trouble swallowing
- ☐ Sore throat
- ☐ Nasal congestion
- ☐ Hearing loss
- ☐ Tooth pain

Respiratory:

- ☐ Cough
- ☐ Shortness of breath
- ☐ Blood sputum
- ☐ Wheezing
- ☐ Snoring
- ☐ Breathing discomfort
- ☐ Sleep apnea

Cardiovascular:

- ☐ Bleeding disorder
- ☐ Swelling in hands or feet
- ☐ Shortness of breath during sleep
- ☐ Chest Pain
- ☐ High blood pressure
- ☐ Fainting
- ☐ Deep vein thrombosis
- ☐ Calf or leg pain
- ☐ Irregular heartbeat
- ☐ Lightheadedness

Gastrointestinal:

- ☐ Excess gas
- ☐ Diarrhea
- ☐ Rectal Pain
- ☐ Nausea
- ☐ Heartburn
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Vomiting/ dry heaves
- ☐ Dark/ tarry stools
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Bloody stools
- ☐ Abdominal cramps

Genitourinary:

- ☐ Urinary Urgency
- ☐ Waking at night to urinate
- ☐ Weak stream
- ☐ Foul urine odor
- ☐ Loss of urine
- ☐ Increased frequency
- ☐ Painful urination
- ☐ Difficulty starting stream

Skin:

- ☐ Changes in hair, skin or nails
- ☐ Rash
- ☐ Tattoos
- ☐ Discoloring
- ☐ New moles

Lymphatic/ Hematologic:

- ☐ Frequent infections
- ☐ Swollen glands
- ☐ Easily bruised
- ☐ Unexplained bruising

Name_____ Date of Birth _____

Mental Health:
☐ Frequent awakenings
☐ Sense of hopelessness
☐ Difficulty organizing thought
☐ Depression
☐ Suicidal thoughts
☐ Changes in behavior
☐ Difficulty sleeping
☐ Loss of interest in hobbies or activities
☐ Difficulty concentrating
☐ Hallucinations
☐ Poor impulse control

Men Only:
☐ Dribbling after urination
☐ Penile discharge
☐ Scrotal pain
☐ Swelling in scrotum
☐ Erectile dysfunction

Women Only:
☐ New breast lump(s)
☐ Frequent yeast infections
☐ Vaginal dryness
☐ Irregular periods
☐ Breast discharge
☐ No menstrual bleeding
☐ Post menstrual
☐ Breast pain
☐ Pelvis Pain
Last menstrual period:
_____

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.
I authorize Rejuv Medical and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.
I give my consent for Rejuv Medical to retrieve and review my medication history. I understand that this will become part of my medical record.
I acknowledge that I have had the opportunity to review Rejuv Medical Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.
I authorize the Rejuv Medical to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Rejuv Medical to release any information required in obtaining procedure authorization or the processing of any insurance claims.
I understand that Rejuv Medical will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked.

Signed: _____ Date: _____

Parent/Guardian Name (if under 18) : _____

Demographics

First Name	M.I.	Last Name	DOB	Gender

Address	City	State	Zip

Home Phone Number	Mobile Phone Number	Social Security Number

Email (We do not sell, rent or distribute your email address per HIPAA Law)	If Patient is a Minor; Name of Responsible Party	DOB of Responsible Party

Preferred Method for Appointment Confirmation: ☐ Text ☐ Phone ☐ Email ☐ I do not want appointment confirmation

Occupation	Employer	Work Phone Number

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Disabled ☐ Not Employed / N/A

Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Widowed ☐ Other _____

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other: _____ ☐ Prefer not to say

Preferred Language: ☐ English ☐ Spanish ☐ Somali ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to say

Emergency Contact Person	Relationship	Emergency Contact Phone Number

Primary Insurance Carrier	ID Number	Group Number	
Primary Insurance Carrier Address	City	State	Zip
Name of insured/ Policy Holder	Relationship to insured	DOB	Gender

Secondary Insurance Carrier	ID Number	Group Number	
Secondary Insurance Carrier Address	City	State	Zip
Name of insured/ Policy Holder	Relationship to insured	DOB	Gender

Demographics

Please initial the following and sign below:

_____ Rejuv Medical cannot guarantee insurance coverage by your insurance carrier. The information you provide will assist us in determining if some of the expenses are reimbursable by your HMO or insurance.

_____ I certify that the information I am providing is true & correct. That I (or my dependent) have insurance coverage and assign directly to Rejuv Medical all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment that may not be covered.

_____ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

_____ I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Patient/Responsible Party Signature	**Relationship**	**Date**

Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Rejuv Medical's health care operations. The Notice of Privacy Practices also describes my rights and Rejuv Medical's duties with respect to my protected health information. The Notice of Privacy Practices is available from your therapist.

Rejuv Medical reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Name of Patient or Personal Representative

_____	_____
Signature of Patient or Personal Representative	Date

_____
Description of Personal Representative's Authority

Insurance & Financial Policies

INSURANCE

If you have insurance, we will do our best to help you receive your maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. We will file insurance claims with insurance carrier(s) if you provide us with all of the necessary information. Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered v. non-covered charges, secondary insurance, "usual and customary" charges, procedures they consider experimental, etc., other than supply factual information as necessary. You are responsible for the items listed above as well as any services considered "not medically necessary" by your insurance company.

In-Network vs. Out-of-Network

Rejuv Medical is **IN-network** with MOST of the following carriers: BCBS, Health Partners, Preferred One, Tricare, Medicare, Ucare, Medicaid, Medica & Humana Medicare and others.
Rejuv Medical is **OUT-of-network** with PrimeWest and United Health Care.

Out of Network Insurance

Although Rejuv Medical is not a participating provider with your insurance plan, please be assured that you will not incur any additional costs or penalties from using our facilities beyond your In-Network clinics as long as your financial position would be hindered by additional costs. Though we do not know how much of the billed charge your health plan will pay. We will only charge you for any remaining deductible to the extent your health plan will give you the credit for satisfying your In-network deductible requirement, the additional amount we charge is calculated such that it will not exceed what you would pay as the copayment or coinsurance pursuant to your In-network benefit. We must have a copy of a recent pay stub or W-2 and a signed note stating that the financial difference would prevent you from being able to use our services. We look forward to assisting you in this process to determine if you qualify by calling the billing office and supplying appropriate information.
It is the policy of Rejuv Medical to ensure that none of our patients pay more than they would have had they gone to an In-network facility so long as there is financial hardship if you were to have to pay a higher than In-network deductible. Someone from our staff will be calling you to discuss payments once the insurance has processed the visit and procedure. Please understand that co-pays will be billed separately.
It is possible that your insurance payment for your visit to Rejuv Medical will be sent directly to you. We ask that you please endorse the check over to Rejuv Medical, and mail it, along with your Explanation of Benefits. By sending such payment you receive directly to the center you avoid the possibility of additional costs for using our facility. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and to make any unnecessary adjustment.
If you have any questions or concerns, please do not hesitate to contact our billing office at 320-217-8480 ext. 2 between the hours of 8:00 a.m. - 4:00 p.m. Monday through Friday.

Covered vs. Paid

Covered: This means that there is coverage for this service/procedure; however, this is subject to copay, co-insurance, and/or deductible. This means you may be financially liable and have out of pocket expenses.
Paid: The carrier pays all expenses and you have no out of pocket expense.
*Note: Very few carriers pay at 100%. Please contact your carrier for clarification of your copay, co-insurance, and/or deductible.

Referrals / Pre-authorizations

If your insurance requires a referral and/or pre-authorization for services, you are responsible for obtaining it. Failure to obtain a referral or pre-authorization may result in a lower or no payment from your insurance company. Know your insurance benefits. **You are financially responsible for any unpaid balances on your account**.

Worker's Compensation (WC)

We require written approval or authorization by your worker's compensation carrier prior to your initial visit. All necessary information must be provided to file your claim. Our office will not become involved in disputes arising from Worker's Compensation claims. **If your WC carrier denies your claim, we will bill your personal health insurance carrier(s) as outlined above**. If you have no health insurance coverage, you are responsible for payment in full. All bills will be sent directly to you and it is your responsibility to forward the bills to your attorney if you wish.

Personal Injury

If you are being treated as part of a personal injury lawsuit or claim, we require that you allow us to bill your health insurance carrier pending settlement of your case. In the absence of personal health insurance, other financial arrangements may be made. Payment of your bill remains your responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. If you do involve an attorney you will be required to obtain a Letter of Protection before any other services are rendered.

Responsible Parties of Minors

The parent or legal guardian who signs the "Financially Responsible Party" is responsible for payment of services rendered.

Transferring of Records

If you want copies of your records transferred to another doctor, you must make the request in writing. We reserve the right to charge reasonable copying fees.

Payments and Financial Details

Payments Due at Time of Service: As a result of the contracts we have with our in-network carries, we are required to collect copays and part of the deductible at the time of service. We cannot habitually bill you for your copays they are designated to be collected at time of service.

Statements

Insurance payments on your account are generally received within 14-30 business days after your clinic visit. Once we receive payment from your insurance, a statement will be sent to you if there is a remaining unpaid balance on your account. Your unpaid balance is due upon receipt of your statement, unless other arrangements have been approved by us. Payments may be made by cash, check or credit/debit card. We do except Care Credit. Statements will be sent to the address listed on your registration form. Please notify our office if you want your statements to go to an alternate address.

Returned Check Fee

There is a $25.00 fee for returned checks.

Collections

If your account becomes past due, we will take necessary steps to collect your debt. You will be responsible for all fees associated with debt collection attempts, including but not limited to collection agency and legal fees. If we refer your debt to a collection agency, you will be required to pre-pay for your next visit(s) until the debt is paid.

Patient Balance and Service Payment Policy

All cash balances need to be paid at time of service. If balance is not able to be paid at the time of service a payment Electronic Funds Transfer (EFT or ACH) arrangement may be made with the billing department.

Payments may be made with cash, personal check, credit card (VISA, MC, AmEx, and Discover), Care Credit, or (EFT/ACH).

If payment cannot be arranged, a non-emergency service would need to be rescheduled, as well as future appointments will have to wait until a payment is received or payment plan is implemented.

Payment plan policy options as follows:

Balance Range	Payment Plan Duration	Minimum Payment
$5 to $499.99	NA	5% or $25 whichever is greater
$500 and above	10 months (Sup approval for extended)	10% of current balance

If you are unable to keep your scheduled appointment, please call us at least 24 hours in advance to reschedule/cancel your appointment.
In the case of multiple cancelled or no-show appointments, Rejuv Medical reserves the right to require a $25.00 hold fee to schedule any future appointments. Fee will be held until attendance of appointment. If a hold fee is placed on an appointment which results in a cancellation or no-show, the $25.00 hold fee becomes non-refundable.

PLEASE INITIAL THE FOLLOWING:

_____ **Rejuv Medical cannot guarantee insurance coverage by your insurance carrier. The information you provide will assist us in determining if some of the expenses are reimbursable by your HMO or insurance.**

_____ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

SIGNATURE BELOW CONFIRMS THAT YOU HAVE BOTH READ AND UNDERSTAND ALL POLICIES AND CONDITIONS.

_____ _____
Name of Patient or Personal Representative Relationship (if patient is a minor)

_____ _____
Signature of Patient or Personal Representative Date

PERMISSION FOR VERBAL COMMUNICATIONS

_____ _____

(Print name of patient) (Date of Birth)

_____ _____

(Street address) (Phone)

_____

(City, State, Zip)

I permit Rejuv Medical, their physicians, nurses, and other personnel to discuss health information, in person or by telephone, with the following people or organizations involved in my medical care.

This authorization is limited to discussions regarding the following medical condition:

_____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care)

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Release of information under this document is limited to verbal discussions with my health care providers. This document does not permit the release of any written health information to the individuals named above with exception given to other health care providers needing information for continuation of care.

This authorization is valid for 1 year from signing or until: _____

I understand that I may revoke this permission at any time but I must notify Rejuv Medical, who I wish to remove from the list and the date they need to be removed. This may be done either in writing or by talking with the Release of Information/ Business Office.

_____ _____

Patient's Signature Date

If this Release is signed by a representative on behalf of the patient, please complete the following:

Name and Relationship to patient: _____

Reason not signed by the patient: _____

Return completed form to
Rejuv Medical
901 3rd Street North
Waite Park, MN 56387
Attention: Release of Information

How Did You Hear About Us?

Please check all that apply

Your Name: _____ Date: _____

Professional Referral

☐Physician/Nurse ☐Chiropractor ☐Salon/Spa/Massage

☐Work comp Adjuster ☐Sports Team Sponsor ☐Athletic Trainer/Coach

Name of Professional Referral: _____

Radio Advertisement

☐Wild Country 99 ☐Lite 99.9 ☐104.7 KCLD

☐Mix 94.9 ☐AM1240 WJON ☐98.1 Country

☐Spirit 92.9 ☐KFAN ☐Other:_____

Internet Advertisement

☐Google/Search ☐Facebook/Social Site ☐YouTube

Direct Mail Item

☐Postcard/Flyer ☐Promo Pack ☐Coupon Magazine

☐Coupon Book ☐Newcomers Mailing

Other

☐Billboard ☐Newspaper ☐Sports Program

☐Prize Box at a Business ☐Email ☐Expo:_____

☐Friend/Family _____ ☐Networking Group _____