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 list 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) : _____

**fully typed name constitutes my legal signature*

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**

***fully typed name constitutes my legal signature*

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

Date _____

_____
Description of Personal Representative's Authority

_____
*Signature of Patient or Personal Representative

**fully typed name constitutes my legal signature*

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 - **fully typed name constitutes my legal 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

Insurance & Financial Policies

Insurance

Insurance is a contract between you and your insurer. If your insurance company pays only part of your bill or rejects your date of service, you are financially responsible for the balance and are to pay it upon receipt of your statement. Rejuv Medical, PA will not become involved in disputes regarding your co-payments, deductible, covered/non-covered charges, OR procedures that are considered investigational/experimental, and services that are considered "not medically necessary".

Patients without Insurance

Patients without insurance are required to pay for service at the time of check out with a self-pay discount of 40%.

Referrals

Some insurance companies may require a referral to receive care at Rejuv Medical, PA. It is your responsibility to obtain this referral if required. Unauthorized services will be the financial responsibility of the patient. The following insurance plans need referrals to receive care at Rejuv Medical, PA:

Health Partners with a Group Number 3080
Blue Cross Blue Shield with alpha prefix of MNA and JZD.
Veterans Affairs
*** Additional plans may be added as Rejuv works with other insurance companies***

In-Network Vs Out-of-Network

It is the responsibility of the patient to reach out to their insurance to confirm that Rejuv Medical, PA is an In-Network provider. Rejuv Medical, PA is not responsible for any insurance coverage changes throughout the year, and it is the sole responsibility of the ***patient*** to notify Rejuv Medical, PA in a timely manner if changes occur.

Rejuv Medical, PA is **IN-Network** with MOST of the following carriers:

Aetna	Blue Cross Blue Shield	Champ VA	Cigna
Health Partners	Humana	Medica	Medicare
Medical Assistance	Preferred One	Tricare	Ucare
United Health Care			

Rejuv Medical, PA is **Out-of-Network** with the following carriers:

PrimeWest
Itasca Medical
US Department of Labor (Workers Comp)

***A few specific plans **may** consider Rejuv Medical as out-of-network, and charges may be applied to your out-of-network benefits. We are aware of these plans:

Health Partners High Peak Value
Preferred One Preferred Health
United Health Care AARP

*** Additional plans may be added as Rejuv Medical works with other insurance companies***

Worker's Compensation (WC)

We require written approval or authorization by your worker's compensation carrier prior to your initial visit and treatment plan. The following information must be provided to file your claim; 1) Worker's compensation insurance name, 2) claim submission address, 3) claim number, 4) date of injury, 5) body part that was injured, 6) adjuster name, phone, and fax number. If information is not provided the balance will be patient responsibility at the time of check out, as medical insurance typically does not cover injuries sustained at work. Commercial insurance information must also be provided in the event these claims are denied by the Workers Comp insurer.

Motor Vehicle Accident (MVA)

Patients involved in motor vehicle accident and seeking treatment related to injuries sustained need to provide the following to bill your date of service; 1) auto insurance name, 2) claim submission address, 3) claim number, 4) date of accident, 5) injury sustained. If information is not provided the balance will be patient responsibility at the time of check out as medical insurance typically does not cover injuries sustained in a motor vehicle accident until benefits have been exhausted. Commercial insurance information must also be provided in the event these claims are denied by the Auto insurer.

Covered Vs. Covered-in-Full (Paid)

Covered: Benefits are processed according to your insurance plan's rules for cost-sharing. If there is a deductible, you will pay the negotiated rate and it will apply to your deductible and out-of-pocket max. If you have previously met your deductible but not your out-of-pocket max, you might owe a copay or co-insurance. How much you will pay depends on your plan and the services that are received.

Covered-in-full (Paid): Benefit is paid entirely by your insurance plan. An example would be an annual physical that may be performed at Rejuv Medical.

***Very few insurers pay at 100%. Contact your insurance for clarification of your deductible, co-insurance, copay and out of pocket max. ***

Not Covered: Services that are not paid for/covered by your insurance plan. This would include services that aren't medically necessary or investigational/experimental.

Patient Billing

Copays: All patients with an insurance co-pay are expected to pay their co-pay in full at check in prior to seeing a provider. Our contract with the insurance company requires that we collect this amount. The patient's agreement with his or her insurance company also requires payment of this fee by the patient at the time of service.

Responsible Parties of Minors: Parents or legal guardian are responsible for the cost associated with the treatment of a minor children. The parent accompanying the minor child to the clinic shall be responsible for any co-pay regardless of the custodial rights.

Statements: Insurance rulings on your claims are generally received within 14-30 business days after submission of your clinic visit. Once we receive this information 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 Rejuv Medical, PA. 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.

Lab Services

Rejuv Medical, PA does not process labs onsite for our providers - all lab processing is done through Quest Diagnostics. Certain insurance companies require labs be billed by the lab actually PROCESSING the sample, so be aware that you may receive a separate bill from Quest Diagnostics. Any questions or concerns regarding that bill would need to be addressed directly with Quest Diagnostics.

Payment Policy

Cash paid balances: All cash paid balances need to be paid at the time of service. This would include:

Orthopedic Sports Medicine:	**Functional Medicine:**	**Esthetics**
Prolotherapy	IV Therapy	Botox
Platelet Rich Plasma (PRP) Treatment	LEANboost	Dysport
Stem Cell Treatment	Food Sensitivity Testing	Fillers
Shockwave	Saliva Testing	Facial & Hair PRP
	Sexual Wellness PRP	

Payment Plan Policy: All billed patients will have the opportunity to contact Rejuv Medical, PA to discuss payment arrangements for their accounts at any time in the billing process. There is a minimum amount of $50.00 per month or 10% of the balance a month, whichever is greater.

If patients are unable to meet the financial obligation, 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 Options: Payments may be made with cash, personal check, credit card (VISA, MC, AMEX, and Discover), or Care Credit.
Returned Check Fee: There is a $25.00 fee for returned checks.

Collections

We kindly ask that payment be made upon receipt of your statement. If an account becomes 30 days past due, Rejuv reserves the right to send a written Final Notice, allowing an additional 30 days to make payment or set up a payment arrangement. If there is still no resolution after this period, the account may then be referred to a third-party collection agency. At that point, all further payment arrangements would be handled directly through them. This reflects the formal collections process Rejuv may follow in the event of an unpaid balance. Whenever possible, our preference is to work with patients to find a resolution before it reaches this stage.

Scheduled Appointments

If you are unable to keep your scheduled appointment, please call us at least 24 hours in advance to reschedule/cancel your appointment. If there are multiple cancelled or no-showed appointments, Rejuv Medical, PA reserves the right to require a $25.00 appointment hold fee to schedule any future appointments and no more than two appointments can be scheduled at a time. Appointment hold fees are non-refundable if scheduled appointment is cancelled or a no showed.

Records Request

If copies of your records are needed or are to be transferred to another facility, you must make the request in writing. We reserve the right to charge reasonable copying fees. Any attorney requesting records needs to send in a medical record request. Rejuv Medical, PA reserves the right to take up to 10 days to process a request.

Legal Claims

If you are being treated due to a motor vehicle accident or workers compensation claim, Rejuv Medical, PA requires that patients allow us to bill your personal health insurance carrier pending settlement of your case. In the absence of personal insurance, the self-pay discount will be applied and need to be paid at the time of check out. Payment of your bill remains your responsibility. When an attorney is involved, you will be required to obtain a Letter of Protection before any other services are rendered.

PLEASE INITIAL THE FOLLOWING:

_____ Rejuv Medical, PA 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 insurance.

_____ I understand that I am financially responsible for all charges whether paid by my insurance carrier.

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

_____ _____

Patient Name - Print First and Last | Relationship (if patient is a minor)

_____ _____

Patient (or responsible party) Signature | Date

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 ☐ YouTube
☐ Linked In ☐ Instagram ☐ TikTok

Printed Materials

☐ Postcard ☐ Flyer ☐ Magazine
☐ Coupon Book ☐ Sports Program ☐ Newspaper

Other

☐ Billboard ☐ Expo _____ ☐ Email

☐ Employee _____ ☐ Friend/Family _____

☐ Networking Group _____