MP Health PC

Regenerative Medicine
Patient Information

Date _____

Name _____
Last First MI

Date of Birth _____ Sex □ Male □ Female Social Security # _____

Email Address _____

Mailing Address _____
City State Zip

Phone Number (H) _____ (W) _____ (Other) _____

Occupation _____ # Hours per week currently working _____

Spouses Name _____ Spouses Date of Birth _____

Spouses Occupation _____ # Hours per week currently working _____

Emergency Information

Emergency Contact Name _____ Relation _____

Emergency Contact Phone Number (H) _____ (W) _____

Accident Information

Is this visit due to an accident □ Yes □ No If yes, what type? □ Auto □ Work □ Other _____

Has it been reported? □ Yes □ No If yes, to whom? _____

Consultation History

Major Complaint _____

Is there any other health problem that concerns you besides your _____ (major complaint)

that you wish you could get rid of? (please explain) _____

Regarding this problem: How long? _____ How often? _____

What hobbies, interests or physical activities do you like to do outside of work? _____

Who's more disappointed? Your family, friends or you about your inability to participate or enjoy these activities? _____

When your problems are at their worst do they prevent you from doing or enjoying these activities? Y ____ N ____

Is there anything else that you would do more of or enjoy more of if it wasn't for these conditions? Y ____ N ____

Please explain: _____

1178 Fremont Ct. Suite B. Elkhart, IN 46516
Phone: (574) 218-6512 • Website: MPHealth.net

MP Health PC

Initial Intake

Are you currently under drug and/or medical care? □ Yes □ No

Who is your primary care doctor? _____

Supplements (vitamins, herbs, minerals) _____

Allergies _____

Women Only: Date of LMP _____ Any possibility of pregnancy? □ Yes □ No

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

□ Heart disease _____ □ Diabetes _____

□ Cancer _____ □ Arthritis _____

□ Other _____

Social History: Intake of any of the following.

□ Cigarettes _____ packs/day □ Alcohol _____ drinks/week □ Caffeine _____ cups/day

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

Previous Tests: (check all that apply)

__ Bone Scan __ CT Scan __ Discogram __ EMG (nerve conduction)
__ MRI __ Myelogram __ Thermography __ X-Ray

Past Medical History (check all that apply)

__ Asthma __ Diabetes __ Hepatitis ABC __ Paralysis
__ Bleeding problems __ Emphysema __ Hiatal Hernia __ Psychiatric disorder
__ Bleeding ulcers __ Epilepsy / seizures __ High blood pressure __ Stroke / CVA
__ Blindness __ Fibromyalgia __ High cholesterol / Lipids __ Substance Abuse (drugs/alcohol)
__ Bowel problems __ Headaches __ HIV / AIDS __ Thyroid disorder
__ Cancer __ Heartburn __ Kidney disorder __ Ulcers (GI tract)
__ Chronic Fatigue Syndrome __ Heartburn __ Liver disorder __ Valve problems
__ Depression __ Heart failure __ Lung disorder

Past Surgical History (check all that apply and include date)

Appendectomy _____ Gallbladder _____ Hip _____ Low Back _____
Carotid _____ Heart _____ Hysterectomy _____ Neck _____
Cataract _____ Hernia _____ Knee _____ Tonsils _____
Other _____

Current Medications _____

Medication Allergies _____

This form has been filled out to the best of my knowledge (signature) X _____

Regenerative Medicine Orders

*If the answer to any of the following questions is **yes**, the patient must see medical before being officially cleared to accept this treatment.*

Is the patient on **any** blood thinners? If yes, which one? _____

Is the patient currently diagnosed and/or being treated for any type of cancer? _____

Does the area being examined have any hardware? _____

MP Health PC

Patient Questionnaire

Please check any of the areas you would like evaluated:

□ Back	□ Foot __ R __ L	□ Elbow __ R __ L	□ Shoulder __ R __ L
□ Hip __ R __ L	□ Wrist __ R __ L	□ Neck	□ Ankle __ R __ L
□ Knee __ R __ L	□ Hand __ R __ L	□ Toe __ R __ L	□ Finger __ R __ L

□ Other (please explain) _____

Which of the above is the worst? _____

What caused your pain (e.g. work related, fall, car accident, spontaneous, etc.)? _____

How often does it occur? _____

What does it feel like (please describe)? _____

What is your pain score on the *BEST* day? _____ / 10 What is your pain score on the *WORST* day? _____ / 10

What have you done that has helped the problem? _____

What activities would you like to do if this was not a problem? _____

Circle your pain score *TODAY*:

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

Medications	Helped:	Little	Some	Much	**Exercise**	Helped:	Little	Some	Much
Physical Therapy	Helped:	Little	Some	Much	**Nutrition**	Helped:	Little	Some	Much
Chiropractic	Helped:	Little	Some	Much	**Stretching**	Helped:	Little	Some	Much

Does this cause you to suffer from:

_____ Moodiness
_____ Being irritable
_____ Interrupted sleep
_____ Restricted daily activities
_____ Reduced decision making
_____ Poor attitude
_____ Decreased productivity
_____ Exhaustion at the end of the day
_____ Being unable to work long hours

Does this affect your life:

_____ Lose patience with spouse, friends or family
_____ Restricted household duties
_____ Hinders ability to exercise or participate in sports
_____ Interferes with ability to participate in hobbies
_____ Other desired activities

Please explain _____

_____

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MP Health P.C.

Review of Systems

Name: _____

Y	N	Neurological
_____	_____	Migraines
_____	_____	Headaches
_____	_____	Slurring of speech
_____	_____	Ringing in ear
		Ear/Nose/Throat
_____	_____	Altered taste/smell
_____	_____	Night blindness
_____	_____	Sore throat
_____	_____	Gingivitis
_____	_____	Nose bleeds
		Cardiovascular
_____	_____	Chest pain
_____	_____	Palpitations-racing heart beat
_____	_____	Swelling in hands/feet
_____	_____	Anemia
		Respiratory
_____	_____	Recurrent respiratory infections
_____	_____	Asthma
_____	_____	Chest congestion
_____	_____	Wheezing
_____	_____	Frequent sneezing
		GI
_____	_____	Stomach pains or cramping
_____	_____	Constipation
_____	_____	Reflux or heartburn
_____	_____	Bloating
_____	_____	Gas
_____	_____	Nausea or vomiting
		Musculoskeletal
_____	_____	Joint pain
_____	_____	Arthritis
_____	_____	Chronic pain
_____	_____	Muscle aches

Y	N	Skin
_____	_____	Eczema
_____	_____	Dermatitis
_____	_____	Excessive sweating
_____	_____	Rashes
_____	_____	Brittle nails
_____	_____	Hair loss
_____	_____	Easy brushing
_____	_____	Increased bleeding
_____	_____	Numbness/tingling
		Genitourinary
_____	_____	Uterine ibroids
_____	_____	Ovarian cysts
_____	_____	Cancer (breast, ovarian, prostate, uterine)
_____	_____	Prostate problems
		Emotional/Mental
_____	_____	Depression
_____	_____	Anxiety
_____	_____	Mood swings
_____	_____	Irritability
_____	_____	Memory loss
_____	_____	Confusion
		Energy
_____	_____	Fatigue
_____	_____	Hyperactivity
_____	_____	Restlessness
_____	_____	Insomnia
_____	_____	Stress
_____	_____	Decreased Libido
		Weight
_____	_____	Decreased appetite
_____	_____	Weight gain
_____	_____	Inability to lose weight
_____	_____	Food cravings
_____	_____	Binge eating
_____	_____	Water retention
_____	_____	Muscle aches

Pleease check ALL options you have previously tried to assist in above symptoms:

_____ Over the counter medications
_____ Prescriptions
_____ Dietary change
_____ Exercise
_____ Consult wiht specialist
_____ Supplements
_____ Alternative medication/treatment therapies

Have you ever had any type of food sensitivity or vitamin/mineral testing done? _____ Yes _____ No

If yes, what? _____

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MP Health P.C.

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific health care, 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, illness, 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 family 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 have 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of MP Health P.C., 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 for an alternative means of communication (within reason) in writing.

X _____ _____

Signature of Patient/Guardian Date

X _____ _____

Witness (Office Staff) Date

1178 Fremont Ct. Suite B
Elkhart, IN 46516
Phone: (574) 218-6512

Consent to use Likeness

I _____, here by give MP Health PC permission to use my likeness in any promotional materials (whether written or electronic) used by MP Health PC. For purposes of this consent "likeness" includes any photographs taken of me, recorded video productions, recorded voice statements, and any written statement made by me.

I further give MP Health PC permission to use, reproduce, distribute and/or publicize by any means and without limit. Publication or use may occur in any media, including newspapers, magazines, television, brochures, pamphlets, internet, web pages and educational material.

I acknowledge and understand that MP Health PC intends to use my likeness for promotional and educational purposes.

This agreement is binding on my successors, assigns and/or heirs.

_____

Name:

Date:_____

MP HEALTH P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEATH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect October 14, 2014, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice affective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new copies of this Notice, please contact us using the information listed in this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while still in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment to your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information this is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour (with a minimum of $20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before October 14, 2014. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative mans or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (E-Mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. CONTACT OFFICER: Dr. Mark Schneider. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

CONTACT OFFICER: Dr. Mark Schneider ADDRESS: 1178 Fremont Court Suite B: Elkhart, IN 46516 TELEPHONE: 574-218-6512