**Patient Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phones: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Spouse/Legal Guardian (circle one) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married Divorced Separated w/Partner Widow(er)

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your primary care provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Physicians you currently see: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Medical Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please choose Yes or No to the following and initial:**

I authorize employees or agents of Regenerate Integrative Medical Solutions and/or Desert Oasis Wellness to leave a detailed message for me on a voice message device associated with the phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, regarding my:

**Laboratory reports/Protected Health Information:** YES \_\_\_\_\_\_\_\_\_ initials NO \_\_\_\_\_\_\_\_\_ initials

If you answered NO, the physicians and/or staff members will, as necessary, leave a message indicating your need to call us to retrieve any of your health-related information.

Whom can we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any drug allergies and your reaction:**

Informed Consent and Request for Care

**I understand that the evaluation, diagnosis and treatment by the physicians at Regenerate Integrative Medical Solutions may include, but are not limited to:**

* Interview (history taking) and Physical examinations
* Diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva, Pap Smears
* Dietary advice and therapeutic nutrition: the therapeutic use of foods, diet plans, nutritional supplements, intravenous and intramuscular injections
* Acupuncture, Trigger point injections, Prolotherapy and PRP injections
* Botanical medicines and nutraceuticals
* Prescription medications

**I understand and I am informed that there are risks and benefits with evaluation, diagnosis and treatment including, but not limited to the following:**

* **Potential risks**: pain, discomfort, minor bruising from injections; allergic reaction to prescribed herbs, supplements, prescription medications; an aggravation of pre-existing symptoms.
* **Potential benefits**: restoration of the body’s maximal functioning capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
* **Notice to pregnant women**: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

I acknowledge that I have read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment. Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I further acknowledge that I have read and understand Regenerate Integrative Medical Solution’s Privacy Practices and that I may request a printed copy. Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I also understand that a missed appointment fee of $50 will be charged **for ALL no show appointments and cancellations made on the same day of scheduled appointments**.

Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as a patient of Dr. Pettitt, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations Act created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to your privacy**

Dr. Pettitt is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information and we must provide you with the following important information:

**Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

**Your rights regarding your health information**

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Pettitt, 138 South Broad Street, Globe, AZ, 85501. *Note: Dr. Pettitt must respond to this request within 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Pettitt, 138 South Broad Street, Globe, AZ, 85501. You must provide us with a reason that supports your request for amendment. *Note: We must respond within 60 days. The Privacy Officer or the patient’s physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the office of Dr. Pettitt.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice/consultation service or with the Secretary of the Department of Health and Human Services. To file a complaint about our practice/consultation service, contact the office of Dr. Pettitt. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice/consultation service will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Policies

Welcome to Regenerate Integrative Medical Solutions. We look forward to working with you on your healthcare needs. This document contains important policy information that pertains specifically to you. Please read over the entire document, if you have any questions please feel free to ask an agent.

**Appointments**

Your appointments are important for your care and are considered to be an agreement between you and Dr. Pettitt. If you fail to give notice of cancellation of an appointment your physician becomes unable to provide service to another patient during your scheduled time. Should you decide not to keep the appointment, Please give us a **24 hours notice** of cancellation. **Missed appointments and cancellations made on day of appointment will result in a $50 missed appointment fee.** To uphold this policy, we may ask you for a credit card number to have on file at the time that you make your appointment. Your credit card will not be charged unless you miss your appointment without at least a **24 hour cancellation notice**. Please note that insurance companies do not reimburse for missed

Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment**

Payment in full is due at the time service. For your convenience we accept FSA/HSA, Check, Cash, Visa or Mastercard payments. There will be a $35.00 fee for all returned checks or insufficient funds for an automatic membership withdrawal. Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**

Dr. Pettitt is out of network for some insurance companies. Dr. Pettitt does not submit claims to insurance companies on your behalf. We will however, provide you with the information necessary for you to submit your claim to your insurance company. We do not guarantee any coverage from your insurance company.

**Emergencies**

If you have a true medical emergency or serious medical concern you are to call 911 immediately. If you have an urgent medical concern please call the office; if it is after regular business hours (9am to 5pm) please leave a message for your and someone will return your call the next business day, if you feel you cannot wait until the next business day it is your responsibility to seek the appropriate medical care.

**Email, Texting and Facebook**

Email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. There are, however, important differences. E-mail is not the same as calling us; there is no person at the other end of the call – just a computer. You can’t tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message.

**The following are our rules for contacting us using texting, e-mail and Facebook**:

**Texting, Facebook and Instagram are not appropriate means of communication**. Initial: \_\_\_\_\_\_\_\_\_

E-mail and Facebook are never appropriate for urgent or emergency problems. Please call the office or go to the Emergency Department for emergencies.

E-mail is great for asking those little questions that don’t require a lot of discussion or questions you

forgot to ask during the visit. However, it is not an alternate to seeing us. If you think that you may need to be seen, please schedule an appointment.

E-mail messages should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

Emails may become a part of the medical record when we use it; a copy may be printed and placed in your chart. Initial: \_\_\_\_\_\_\_\_\_\_\_

Emails may be forwarded to the staff for handling, if appropriate. Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Inappropriate uses of e-mail, social media and/or text messaging** also include prescription refill requests, referral and appointment scheduling requests and billing/insurance questions. Please call the office or use the patient portal. Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_

Finally, either one of us can revoke permission to use the e-mail system at any time.

I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date