Advanced Rejuvenation
2033 Wood Street, Suite 210 Sarasota, FL 34237
Phone: 941-330-8553 Fax: 941-330-9853

Jeffrey Sack MD Ronald Bramson DPM, PA-C John Lieurance DC Beth Moran ARNP

CONFIDENTIAL PATIENT HEALTH INFORMATION

Today's Date: ___/___/_____

First:_____ Last:_____ Middle initial_____

Date of Birth: ___/___/_____ Age: _____ Social Security: _____/____/_____ ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address:_____Apt#:_____

City:_____State:_____Zip:_____County:_____

Home Phone:_____ Work Phone:_____ Ext: _____

Email:_____ Do you wish to receive our newsletter? ☐ Y ☐ N

EMERGENCY CONTACT

First:_____ Last:_____ Middle initial_____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other (please explain) _____

Cell/Home Phone:_____Work:_____

EMPLOYMENT INFORMATION

Business Name: _____ Phone:_____

Occupation/Job Title: _____

HOW DID YOU HEAR ABOUT US?

☐ Family _____ ☐ Friend/Co-Worker _____

☐ Practitioner Referral _____ ☐ Sign ☐ Internet ☐ Other _____

I acknowledge that I have received the Notice of Privacy Practices for protected health information

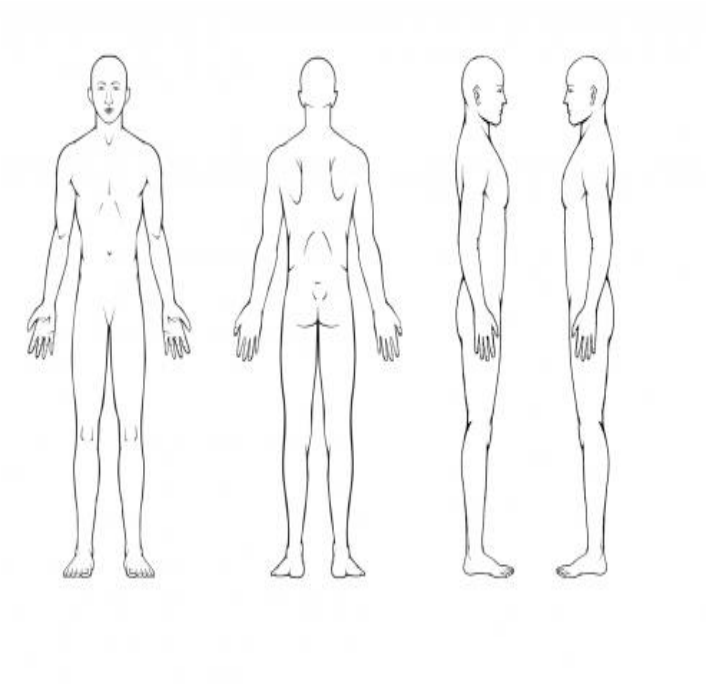
Patient Signature: _____

Parent or Guardian Signature: _____

CURRENT HEALTH CONDITION

1. Using the letters in the key below, please label on the diagram, the area(s) of discomfort.

   Key: A=Ache B=Burning N=Numbness
   P=Pins and needles S=Stabbing



2. When did this condition begin? ___/___/_____
3. Has it ever occurred before? □ Yes □ No
   When?_____
4. Is this condition related to:

   ☐ Auto Accident ☐ Job ☐ Slip or Fall

   ☐ Lifting ☐ Slept wrong ☐ Unknown cause

   ☐ Other Explain:_____
   _____
5. What percentage of the time do you experience your symptoms?

   ☐ Constantly (76-100%) ☐ Frequently (51-75%)

   ☐ Occasionally (26-50%) ☐ Intermittently (1-25%
6. How would you describe the type of pain (check all that apply)

   ☐ Sharp ☐ Stiff ☐ Numb ☐ Stabbing with motion ☐ Electric like with motion ☐ Dull ☐ Achy ☐ Tingly

   ☐ Shooting ☐ Diffused ☐ Burning ☐ Sharp with motion ☐ Shooting with motion ☐ Other._____
7. How are your symptoms changing with time?

   ☐ Getting Worse ☐ Staying the Same ☐ Getting Better
8. Using a scale from 0-10 (10 being the worst), how would you rate your condition?

   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
9. How much has your condition interfered with your work?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely debilitating
10. How much has your condition interfered with your social activities?

    ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely debilitating
11. Who else have you seen for your condition?

    ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician ☐ Orthopedist

    ☐ Massage Therapist ☐ Physical Therapist ☐ No one ☐Other: _____
12. Have you had an X-Ray or MRI? ☐ Yes ☐ No By Whom?_____Date:_____
13. Have you taken anti-inflammatory medications? Please list:_____
14. Have you had cortisone injections? ☐ Yes ☐ No If so When?_____By Whom?_____
15. Have you had Physical Therapy? ☐ Yes ☐ No If so When?_____By Whom?_____
16. What aggravates your condition? _____
17. How would you rate your overall health?

    ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
18. What type of exercise do you do?

    ☐ Strenuous ☐ Moderate ☐ Light ☐ None

FAMILY HISTORY

Has anyone in your immediate family had any of the following?

☐ Rheumatoid ☐ Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problems ☐ Cancer ☐ ALS

Which family member experienced and of the conditioners above?

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandfather ☐ Grandmother

PAST AND/OR PRESENT CONDITIONS

For each condition listed below, place a check in the past column if you have had the condition previously. If you presently have the conditions place a check in the present column.

Past / Present		**Past / Present**		**Past / Present**	
□	□ Headaches	□	□ High Blood Pressure	□	□ Chronic Sinusitis
□	□ Neck Pain	□	□ Heart Attack	□	□ Liver Gall Bladder Disorder
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Fatigue
□	□ Mid Back Pain	□	□ Stroke	□	□ Muscular Incoordination
□	□ Low Back Pain	□	□ Angina	□	□ Visual Disturbances
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Dizziness
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Diabetes
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Excessive Thirst
□	□ Hand Pain	□	□ Painful Urination	□	□ Frequent Urination
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Smoking/Tobacco Use
□	□ Upper Leg pain	□	□ Allergies	□	□ Drug/Alcohol Dependence
□	□ Knee Pain	□	□ Epilepsy	□	□ Depression
□	□ Ankle/Foot Pain	□	□ Prostate Problems	□	□ Systemic Lupus
□	□ Jaw Pain	□	□ Loss of Appetite	□	□ Dermatitis/Eczema/Rash
□	□ Joint Pain/Stiffness	□	□ Abnormal Weight Gain/Loss	□	□ HIV/AIDS
□	□ Arthritis	□	□ Abdominal Pain	□	□ Pace Maker/CID
□	□ Rheumatoid Arthritis	□	□ Ulcer	**For Females Only**	
□	□ Cancer	□	□ Asthma	□	□ Birth Control Pills
□	□ Tumor	□	□ Hepatitis	□	□ Hormone Replacement
□	□ Other _____			□	□ Pregnancy

CURRENT MEDICATIONS

List all current prescription medications:_____

List all over-the-counter medication:_____

Allergies: _____

HOSPITALIZATIONS SURGICAL PROCEDURES AND/OR TRAUMA

List all surgical procedures:_____

List all hospitalizations:_____

List any significant past trauma:_____

ACTIVITIES

What activities do you do outside of work? _____

What activities do you do at work?

□ **Sit**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Stand**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Computer work**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Phone use**	□ Most of the day	□ Half of the day	□ A little of the day

List any additional information you would like to discuss today:_____

_____

Patient Signature:_____Date:_____

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

Note to patient: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Jeff Sack, MD, Ronald Bramson, DPM, PA-C, and such physicians, associates, assistants and other personnel of the medical facility chosen by him or her to perform the following Stem Cell, PRP, or other regenerative injection procedure:

PROLOTHERAPY (SCLEROTHERAPY ALSO KNOWN AS RECONSTRUCTIVE THERAPY)

► LOCAL ANESTHETIC BLOCK ► FACET BLOCKS ► NERVE BLOCK
► INTRA ARTICULAR INJECTIONS ► PROLOTHERAPY ► PRP
► BONE MARROW ► FAT GRAFT ► STEM CELL

In common terms known as: _____

INJECTION OF AN IRRITATING SOLUTION INTO THE LIGAMENTS AROUND A JOINT:

►TRIGGER POINT INJECTIONS ►INJECTIONS INTO THE JOINT

And/or any other procedures that in their judgment may be advisable to my well-being, including such procedures that are considered medically advisable to remedy conditions discovered during the above procedure.

GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment or procedure that are described generally on the sheet attached to this consent form. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.

SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this procedure and/or treatment including (doctor will describe specific risks where applicable.)

►ALLERGY OR ADVERSE REACTION TO ANY COMPONENT OF THE INJECTION
►IRRITATION OF SURROUNDING STRUCTURES (INCLUDING POSSIBLE NEURALGIA)
►PNEUMOTHORAX (PUNCTURED LUNG)
►ECCHYMOSIS (BRUISING) ►EPIDURAL INFILTRATION
►SWELLING ►HYPERTENSION
►DIZZINESS ►HEADACHE
►NAUSEA ►PAIN AROUND THE INJECTION SITE AND/OR JOINT

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of alternative procedures and/or treatments and their possible benefits and risks including (doctor will describe specific alternative procedures and complications where applicable).

►OPEN SURGICAL REPAIR OF LIGAMENTS
►CHRONIC MEDICATION FOR THE RELIEF OF PAIN
►EXTERNAL AND INTERNAL SUPPORTS (FUSION) OF THE AFFECTED JOINT
►DO NOTHING

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes and/or risks if no treatment is rendered.

SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedures

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT: I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

OTHER SERVICES: I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital and medical family practice.

PHOTOGRAPHY: I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.

NO GUARANTEES: I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result

OTHER QUESTIONS: I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read the above consent and have been given a copy.

Signature of Patient, Parent or Legal Guardian:_____Date:_____

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Office Financial Policy

BASIC POLICY
Payment for service is due in full at the time service is provided in our office.

MISSED APPOINTMENTS
In fairness to other patients and our practitioners, we require at least a 24-hour notification of an appointment cancellation or we will charge $95.00 for an abandoned office visit.

I have read, understand and agree to the above financial policies for payment of professional fees.

Signature: _____Date: _____
Responsible Party

Print Name: _____

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Health Insurance Portability and Accountability Act (HIPAA)

We collect information from you and store it in a medical record as well as on a computer. All such information saved on the computer is password protected. Passwords are only afforded to the appropriate personnel. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations. Within our office we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers, and for health care operations.

Outside of our office, we restrict the disclosure of this information to those people, entities, and agencies for whom you authorize disclosure such as other health care providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Specialized government functions (military, inmates)
- Workers compensation
- Disaster Relief and Fund Raising

We will not use or disclose your medical information for any purpose note listed without specific written authorization. Any specific written authorization you provide may be revoked at any time by your written request.

Patient Privacy Rights

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and receive a copy of your record. There will be a copy fee to provide this service to you. We must respond within (30) days if the record is readily available and within (60) days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request, directed to our office, to amend your chart. We must respond within (60) days.
- Receive an accounting of any disclosures made from your record over the last six years, beginning April 14th 2003. You can do this with a written request, directed to our office, to amend your chart. We must respond within (60) days.
- Request restrictions as to the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosure noted above. You may revoke or restrict consent.
- Request Confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to our office, and a copy of this notice will be given with all new patient packets.

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change. Copies will be made available. If you have questions or would like to lodge a complaint regarding our privacy policy, you may contact our Privacy Officer at 941-330-8553.

I have received a copy of Advanced Rejuvenation's privacy notice as required by HIPAA

Patient Signature: _____Print Name: _____Date: _____

Witness Signature: _____Print Name: _____Date: _____

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Patient Consent to Treatment

Consent to Medical Treatment: I hereby voluntarily consent to the rendering of medical care, which may include such medical treatment as the attending practitioner or other consulting physicians consider medically necessary. I understand that I must look solely to the attending practitioner for interpretation of the results of any diagnostic procedure or test, and medical treatment. I have a general understanding of the nature and purpose of my medical treatment, and am generally aware that medical complications can occur. I acknowledge that no guarantees have been made as to the result of treatment. I consent to other health care personnel in training being present during treatment, and in some instances, providing supervised treatment. I understand that some treatments occur in areas that may also be occupied by other patients being treated.

Attendance Policy: I understand that it is important to attend all scheduled appointments. I understand it is my responsibility to know my appointment date(s) and time(s). I understand there may be a $95.00 fee charged to my account for failure to give 24 hours' notice of cancellation.

Patient Personal Property and Valuables: Advanced Rejuvenation shall not be liable for the loss or damage to any patient personal property.

Use and/or Disclosure of Patient Information: Advanced Rejuvenation may use and/or disclose information about me, and my treatment for the following reasons

- Purposes of diagnosing and treatment
- Obtaining payment for my care through my insurance
- For conducting health care operations
- If required by law through legal subpoena
- If requested by State or Federal agencies accompanied by a legal subpoena

There are regulations that control how Advanced Rejuvenation my use information regarding me and my health. Advanced Rejuvenation will abide by these regulations. The regulations are explained in more detail in the HIPAA Compliance Notice. I understand I have the right to review the HIPAA Compliance Notice prior to signing and will be given a copy of the signed notice during my first visit. I may also request the most recent version from Advanced Rejuvenation. Advanced Rejuvenation reserves the right to make changes to its HIPAA Compliance Notice as required by law. I have the right to ask Advanced Rejuvenation to restrict who may receive information about me and/or my health care. Advanced Rejuvenation is not required to agree to my request, but if Advanced Rejuvenation does agree, they will honor my request.

The signature below acknowledges that I have read and understand this document and accept its terms. I also acknowledge that I have been offered a copy of Advanced Rejuvenations HIPAA Compliance Notice.

With my signature below, I acknowledge that I understand and agree with its content and significance.

Patient Signature:_____Date:_____

Parent or Guardian Signature (if applicable): _____Date:_____

Witness Signature:_____Date:_____

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ACTOR RELEASE CONSENT

I hereby grant to Advanced Rejuvenation, the right to photograph video-record, and audio record any performances, poses, actions, plays and appearances, and subsequently use the photographs, silhouette and other reproductions of my physical likeness in connection with the testimonial motion picture or physician training motion picture.

I also grant Advanced Rejuvenation, their successors, assigns, and licensees, the perpetual right to use, as they may desire, all still and motion pictures, audio recordings, and records taken of me. And the right to use my name and/or likeness in or in connection with the exhibition, advertising, exploitation and/or publicizing of the picture including, but not limited to, internet website information, as well as for educational and training purposes. I further grant the rights of reproduce in any manner whatsoever any recordings, including all instrumental, musical or other sound effects produced by me in connection with the production and/or post production of the picture.

I agree that I will not assert or maintain against Advanced Rejuvenation, their successors, assigns, and licensees, any claim, action, suit or demand of any kind or nature whatsoever, including, but not limited to, those grounded upon invasion of privacy, rights of publicity, or other civil rights, or for any reason in connection with their authorized use of my physical likeness and audio in the picture, as herein provided.

My signature signifies that I understand the information above, and do the best of my ability will adhere to the schedule agreed to in this consent. Additionally, I agree to the best of my ability, to make myself available should it be necessary to re-record my voice and/or record voice-overs and otherwise perform any necessary audio work required after the end of filming. Should I not be able to perform said work, I understand that Advanced Rejuvenation may terminate our agreement and seek other persons for perform in my place.

I also acknowledge and agree that my commitments beyond the scope and intent of this release are the sole responsibility of the above named production, or it's duly appointed representative and NOT Advanced Rejuvenation.

I certify and represent that I am over 18 years of age, and have read the foregoing, and fully understand the meaning and effect thereof.

Please check one of the options below

☐ I choose not to give my consent, and do not give my consent to have my image or voice used in any way.

☐ I choose to give my consent freely and without limit as outlined above.

Patient signature:_____Date:_____

Witness signature:_____Date:_____

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Adverse Incident Policy

In accordance with the Agency for Health Care Administration (AHCA) and the State of Florida and in compliance with respect to the same, the above captioned medical practice hereby fully discloses our adverse incident policy.

In the event of an adverse incident or emergency occurs within the facility, Advanced Rejuvenation will immediately call 911 and report the incident to ensure emergency medical care.

The Medical Director of Advanced Rejuvenation will be notified immediately and will report the incident to any and all applicable authorities.

We will also notify the referring physician if applicable.

Should you have an adverse incident after exiting the facility, Advanced Rejuvenation advises that you call 911 immediately and request that emergency services notify our office as soon as possible.

For further information on this or any other policy or procedure, please call our office at 941-330-8553 and leave a request for clarification with our patient relation specialist.

I acknowledge that this policy has been fully explained to me and I have been offered a copy of the same.

Patient signature:_____Date:_____

Family/Primary Physician: _____

EXPLANATION AND CONSENT FOR TREATMENT BY

DR JOHN LIEURANCE, DC, RMA

I understood that Dr. Lieurance, primary license is as a Chiropractic Physician or Doctor of Chiropractic ("D.C."). D.C. is a Doctor of Chiropractic. Chiropractic physicians' licensure do not authorized them to perform intravenous or non-intravenous injections. Administration of medicines as prescribed by the medical staff.

John Lieurance also holds a license as a registered "Medical Assistant" pursuant to Florida Statute Section 458.3485. As a Registered Medical Assistant (RMA), Dr. Lieurance is authorized, per statute to perform, the following treatments:

Performing aseptic procedures, preparing patients for the physician's care, venipunctures and non-intravenous injections, administering medication as directed by the physician, performing laboratory procedures, performing dialysis procedures, including home dialysis.

I confirm I am aware Dr. Lieurance, is licensed as both a Chiropractic Physician and a Registered Medical Assistant (RMA). I acknowledge that Dr. Lieurance treatment may be as a RMA and not a Medical Doctor.

By signing below, I acknowledge Dr. Lieurance's degree, certifications, and accept treatment as provided.

_____ _____

Patient's signature Date