BIOCELLULAR THERAPIES
Patient Registration Form

*****PLEASE, SIGN AND DATE ON THE BOTTOM OF EACH FOLLOWING PAGE*****

Patient LEGAL Name:_____
(Last Name) (First Name) (Middle Initial)

Address: _____ City: _____ State/ZIP: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____Age:_____ Sex: M / F Social Security #:_____

DATE OF ACCIDENT: _____ HEIGHT: _____WEIGHT:_____

OCCUPATION: _____

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

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific □ Other Race □ White

Language: □ English □ Spanish □ Other_____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Email: _____

Communication Preference (choose one): [ ] Phone [ ] Cell Phone [ ] Email

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Advanced Directive (Living Will)? Check yes only if you can provide us a copy today [ ] Yes / [ ] No

Is any Doctor treating you right now? Please write Dr.'s Name: _____

Primary Care Physician's Name: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Full Address: _____

_____ _____

Patient/Guardian Signature **Date**

Is this complaint related to a:

Workers' Compensation? [ ] No [ ] Yes, **Date of injury**: _____

Motor Vehicle Accident? [ ] No [ ] Yes, **Date of Injury**: _____

Personal Injury? [ ] No [ ] Yes, **Date of injury**: _____

Auto Insurance Name: _____

Claim No.:_____

Is there an attorney involved? [ ] No [ ] Not yet [ ] Yes

Name of attorney: _____

Adjuster / Case Manager's Name: _____ Phone: _____

CHIEF COMPLAINT: (*Give a brief description of the nature of your visit – for example, left knee pain)*

_____

_____

Please describe how your injury occurred: _____

_____

_____

_____

_____

Have you ever had this problem in the past? [ ] No [ ] Yes

Have you had prior CAT Scan / X-Ray / Bone Scan / MRI / EMG diagnostic studies for your complaint?

If yes, please provide when and where last scan was done:

_____

The above information is true to my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize BioCellular Therapies and/or insurance company to release my information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

REVIEW OF SYSTEMS

****PLEASE **ONLY** MARK **YES** TO PROBLEMS YOU ARE **CURRENTLY** HAVING****

CARDIOVASCULAR
- ☐ Bleeding Problems
- ☐ Chest Pain
- ☐ Circulation Problems
- ☐ Palpitations
- ☐ Other: _____

CONSTITUTIONAL
- ☐ Fatigue/Weakness
- ☐ Itching
- ☐ Skin Problems
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other: _____

E.N.T.
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Nosebleeds
- ☐ Runny Nose
- ☐ Sore Throat
- ☐ Other:

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Fatigue
- ☐ Heat Intolerance
- ☐ Hot Flashes
- ☐ Other: _____

EYES
- ☐ Blurred Vision
- ☐ Eye Pain
- ☐ Failing Vision
- ☐ Vision Loss
- ☐ Other: _____

GASTROINTESTINAL
- ☐ Abdominal
- ☐ Appetite Loss
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ GI Bleed
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Other: _____

GENITOURINARY
- ☐ Difficult Urination
- ☐ Excess Urination
- ☐ Frequent Urination
- ☐ Leakage of Urine
- ☐ Painful Urination
- ☐ Passing Stones
- ☐ Pregnancy
- ☐ Retention of Urine
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Ankle Swelling
- ☐ Disturbance in Walking
- ☐ Extremity Numbness
- ☐ Extremity Pain
- ☐ Extremity Weakness
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Numbness
- ☐ Stiffness
- ☐ Tingling Sensation
- ☐ Other: _____

NEUROLOGICAL
- ☐ Difficulty Walking
- ☐ Dizzy Spells
- ☐ Memory Loss
- ☐ Severe Headaches
- ☐ Weakness
- ☐ Other: _____

PSYCHIATRIC
- ☐ Anxious
- ☐ Depressive state
- ☐ Memory Loss
- ☐ Other: _____

RESPIRATORY
- ☐ Chest Pain
- ☐ Chronic Coughing
- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Other:_____

ALLERGIES TO MEDICATIONS / FOODS

☐ **NONE**

Name of Medication/Food	**Reaction (circle one)**
1._____	Chest pain / Breathing Difficulties / Headaches / Hives / Itching / Nausea Throat tightness / Muscle, Joint Pain Other _____
2._____	Chest pain / Breathing Difficulties / Headaches / Hives / Itching / Nausea Throat tightness / Muscle, Joint Pain Other _____
3._____	Chest pain / Breathing Difficulties / Headaches / Hives / Itching / Nausea Throat tightness / Muscle, Joint Pain Other _____
4._____	Chest pain / Breathing Difficulties / Headaches / Hives / Itching / Nausea Throat tightness / Muscle, Joint Pain Other _____
5._____	Chest pain / Breathing Difficulties / Headaches / Hives / Itching / Nausea Throat tightness / Muscle, Joint Pain Other _____
6._____	Chest pain / Breathing Difficulties / Headaches / Hives / Itching / Nausea Throat tightness / Muscle, Joint Pain Other _____
7._____	Chest pain / Breathing Difficulties / Headaches / Hives / Itching / Nausea Throat tightness / Muscle, Joint Pain Other _____

_____ _____

Patient/Guardian Signature **Date**

FAMILY MEDICAL HISTORY

(Check problem and indicate who was diagnosed: Mother= M, Father = F, Sibling = S, Grandparent = G)

☐ Adopted

Disorder	Who			
Alcohol Liver Disease	☐ M	☐ F	☐ S	☐ G
Bleeding Disorder	☐ M	☐ F	☐ S	☐ G
Mental Disorder	☐ M	☐ F	☐ S	☐ G
Diabetes 1 2	☐ M	☐ F	☐ S	☐ G
GERD	☐ M	☐ F	☐ S	☐ G
Heart Disease	☐ M	☐ F	☐ S	☐ G
Stroke	☐ M	☐ F	☐ S	☐ G
Anesthetic Complications	☐ M	☐ F	☐ S	☐ G
Rheumatoid Arthritis	☐ M	☐ F	☐ S	☐ G
Osteoarthritis	☐ M	☐ F	☐ S	☐ G

☐ Cancer

Type: _____	☐ M	☐ F	☐ S	☐ G
Type: _____	☐ M	☐ F	☐ S	☐ G
Type: _____	☐ M	☐ F	☐ S	☐ G
Type: _____	☐ M	☐ F	☐ S	☐ G
Type: _____	☐ M	☐ F	☐ S	☐ G

PAST SURGICAL HISTORY (*Please print*)

☐ **NO SURGERIES**

General Surgery

- ☐ AAA Repair (year:_____)
- ☐ AICD (year:_____)
- ☐ Appendectomy (year:_____)
- ☐ Breast Surgery (year:_____)
- ☐ CABG (year:_____)
- ☐ Caesarean Section (year:_____)
- ☐ Carotid Endarterectomy (year:_____)
- ☐ Cataract Extraction (year:_____)
- ☐ Cholecystectomy (year:_____)
- ☐ Colon Resection (year: _____)
- ☐ Defibrillator Implant (year:_____)
- ☐ Fundoplication (year:_____)
- ☐ Gall Bladder (year:_____)
- ☐ Gastric Bypass (year:_____)
- ☐ Heart Procedure/Surgery (year: _____)
- ☐ Hernia (year:_____)
- ☐ Hysterectomy (year:_____)
- ☐ Lung Surgery (year:_____)
- ☐ Pacemaker (year:_____)
- ☐ Prostate Surgery (year:_____)
- ☐ Tonsillectomy (year:_____)
- ☐ Tubal Ligation (year:_____)
- ☐ Other: _____
  _____

Orthopedic Surgery

Arthroscopy Year: _____

☐ Ankle	☐ Lt	☐ Rt	(year:_____)	☐ Ankle Replacement	☐ Lt	☐ Rt
☐ Elbow	☐ Lt	☐ Rt	(year:_____)	☐ Carpal Tunnel	☐ Lt	☐ Rt
☐ Hand	☐ Lt	☐ Rt	(year:_____)	☐ Hip Replacement	☐ Lt	☐ Rt
☐ Fingers	☐ Lt	☐ Rt	(year:_____)	☐ Knee Replacement	☐ Lt	☐ Rt
☐ Hip	☐ Lt	☐ Rt	(year:_____)	☐ Shoulder Replace	☐ Lt	☐ Rt
☐ Knee	☐ Lt	☐ Rt	(year:_____)	☐ Back Surgery		
☐ Shoulder	☐ Lt	☐ Rt	(year:_____)	☐ Implant/Hardware which body part:		
☐ Wrist	☐ Lt	☐ Rt	(year:_____)			

_____ _____

Patient/Guardian Signature **Date**

PAST MEDICAL HISTORY

Abdominal Problems:
- Gastritis
- Gallstones
- Hernia
- GERD/Acid reflux/Heartburn
- Diverticulosis
- Irritable Bowel Synd.
- Colitis
- Colostomy / Ileostomy
- Obesity

- **Anesthesia Complication**
- **Blood Bourne Pathogen Exposure**
- **Blood Disorders:**
  - Sickle Cell Anemia
  - Anemia
  - Polycythemia
- **Cancer:** (describe)

  _____
  - Chemo
  - Radiation
  - Surgery
- **Circulation / Vascular Problems:**
  - Blood Clots/DVT
  - Peripheral Artery Disease
  - Varicose Veins
  - Stroke/ TIA
  - Phlebitis
  - Aneurysm
- Diabetes: [ ] Type 1, [ ] Type 2
- **Ear / Nose / Throat Problems:**
  - Deafness / Hearing Problems
  - Meniere Disease
  - Deviated Septum
  - Sinus infections
  - TMJ Problems
  - Thyroid High Low
  - _____
- **Edema**
- **Eye**
  - Cataracts
  - Glaucoma
  - Blindness
  - Poor / Failing Vision
  - Macular Degeneration
- **Gout**
- **Heart Disease:**

Cardiologist:
DR._____

- MI / Heart Attack
- Coronary Artery Disease
- Arrhythmia
- Pacemaker / Defibrillator
- Murmur
- CHF / Congestive Hear Failure
- Congenital Disease

- **Hypertension – High blood pressure**
- **Hypercholesterolemia**
- **Infections**:
  - Bone / Joint
  - MRSA / Staph.
  - HIV – AIDS
  - Herpes
  - TB (Tuberculosis)
  - Lyme Disease
  - Rheumatic Fever
- **Insomnia**
- **Kidney / Urinary / Reproductive:**
  - Stones
  - Failure: [ ] Dialysis [ ] No
  - Currently Pregnant
  - Prostate [ ] Cancer [ ] Enlargement
  - Renal Transplant
  - Liver Disease:
  - Hepatitis [ ]A [ ]B [ ] C
  - Jaundice
  - Cirrhosis
  - Liver Transplant
- **Lung Disease:**
  - Asthma
  - COPD
  - Emphysema
  - Sleep Apnea: CPAP [ ] Yes [ ] No
  - Doesn't use
  - TB exposure
- **Lupus**
- **Neuro / Spine Problems**
  - Degenerative Disc Disease
    - Cervical
    - Lumbar
    - Thoracic
  - Spinal Stenosis
  - Scoliosis
  - Herniated Disc
  - Coccydynia (Tailbone Pain)
  - Neuropathy
  - MS (Multiple Sclerosis)
  - Parkinson's
  - Seizures
  - Myasthenia Gravis
  - Headaches
  - Vertigo
- **Orthopedic / Arthritis / Rheumatology**
  - Fractures:

    _____
  - Laceration:_____
  - Upper Extremity Diagnosis:
    - Carpal tunnel syndrome
    - Impingement
    - Tendon / Ligament Tear
    - Sprain / Strains

    _____
  - Lower Extremity Diagnosis
    - Meniscal Tear
    - Bursitis
    - Sprains / Strains

    _____
  - Osteoarthritis
  - Rheumatoid Arthritis
  - Degenerative Joint Disease
  - Polymyalgia
  - Fibromyalgia
- **Osteoporosis / Osteopenia**
- **Pyschiatric:**
  - Depression
  - Anxiety
  - Bi-Polar
  - ADD / ADHD
  - Panic Attacks
  - Claustrophobia
  - Schizophrenia
  - PTSD
- **Skin Disorders:**
  - Acne
  - Psoriasis
  - Rosacea
  - Vitiligo

_____ _____

Patient/Guardian Signature **Date**

CURRENT MEDICATIONS

(Including over-the-counter medications)

(*Please print*)

☐ **NOT CURRENTLY TAKING ANY MEDICATIONS**

	Name of Drug	Dosage	Frequency and For how long	This Medication has helped: *A lot*	*Some*	*None*
1.				☐	☐	☐
2.				☐	☐	☐
3.				☐	☐	☐
4.				☐	☐	☐
5.				☐	☐	☐
6.				☐	☐	☐
7.				☐	☐	☐
8.				☐	☐	☐
9.				☐	☐	☐
10.				☐	☐	☐
11.				☐	☐	☐
12.				☐	☐	☐
13.				☐	☐	☐
14.				☐	☐	☐
15.				☐	☐	☐

SOCIAL HISTORY

Do you smoke? Yes [ ] No [ ] If the answer is yes of quit,
When did you quit? _____
Maximum number of packs per day? _____
Total number of years? _____

Do you chew tobacco? Yes [ ] No [ ] If the answer is yes of quit,
When did you quit? _____
Maximum number of packs per day? _____
Total number of years? _____

Do you drink Alcohol (including beer or wine)? Yes [ ] No [ ]
Number of drinks per week _____
Type of alcohol? _____

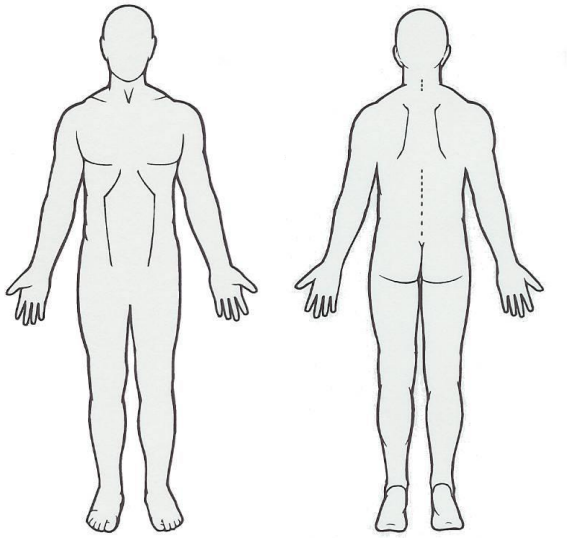
Are you a recovering alcoholic? Yes [ ] No [ ]

_____ _____

Patient/Guardian Signature **Date**

Using the diagram below, mark your area (s) of pain:

RIGHT **LEFT** **LEFT** **RIGHT**



FRONT **BACK**

DESBRIBE YOUR PAIN:

Severity:	Mild	Moderate	Severe	
Quality:	Dull	Sharp	Aching	Throbbing
Duration:	Intermittent	Constant	Night	Day

Made better by: _____

Made worse by: _____

DAILY ACTIVITIES

Activity	Able	Not Able	Explanation
Dressing Self			
Personal Hygiene			
Household Cleaning			
Grocery Shopping			
Read			
Manage Own Money			
Laundry			
Eating			
Cooking			
Driving			
Watching Television			
Use Computer			
Part-Time Work			

I HAVE:

- ☐ Neck Pain
- ☐ Neck Pain and Arm Pain
- ☐ Upper Back Pain (Thoracic)
- ☐ Low Back Pain Only
- ☐ Low Back and Leg Pain
- ☐ Scoliosis

I HAVE HAD THIS PROBLEM FOR:

_____ Days
_____ Weeks
_____ Months
_____ Years

_____ _____

Patient/Guardian Signature **Date**

AUTO PATIENTS

PLEASE ANSWER THE QUESTIONS BELOW

Do you own a Vehicle? Yes / No If you do not own a vehicle, do you reside with a blood relative? **Yes / No**

At the time of the accident you were the **[ ] DRIVER [ ] PASSENGER [ ] PEDESTRIAN**

WAS THERE ANYONE ELSE IN THE CAR WITH YOU? [ ] Yes / **[ ]** No

WHERE DID YOU GO AFTER THE ACCIDENT? HOME / WORK / HOSPITAL
If hospital, which hospital? _____

How did you get there? [ ] Drove self [ ] Someone else [ ] Police [ ] Ambulance

What was your vehicle doing at time of accident: [ ]Stopped at intersection [ ]Stopped in traffic [ ] Parking [ ]Stopped at light [ ]Proceeding along [ ]Making right hand turn [ ]Making left hand turn [ ] Slowing down [ ] Accelerating [ ]Other_____

Who hit who: [ ] You hit other vehicle [ ] Other vehicle hit you [ ] You hit...(object)_____

Road Conditions: [ ]Icy [ ]Wet [ ]Dry & Clean [ ]Sandy [ ]Dark [ ]Other_____

Point of Impact: [ ] Head-on [ ] Rear-end [ ] Left front [ ] Left rear
[ ] Right front [ ] Right rear [ ]Other_____

Did you see the accident coming? [ ] Yes [ ]No **Did you brace for the impact?** [ ] Yes [ ] No

Did you have a seat belt on? [ ] Yes [ ] No **Did airbags deploy?** [ ] Yes [ ] No

Direction of your head at impact: [ ] Facing forward [ ] Turned to the right [ ] Turned to the left

Did your body strike the inside of the vehicle? [ ] Yes [ ] No Describe_____

Did you lose consciousness during accident? [ ] Yes [ ] No

Was an accident report filled out by police? [ ] Yes [ ] No

Check off any and all symptoms immediately & days following accident:
[ ] Neck stiffness [ ] Mid back pain [ ]Neck pain [ ]Low back pain [ ]Headache [ ]Ringing in ears [ ]Loss of taste /smell [ ] Dizziness [ ] Fainting [ ] Diarrhea [ ]Fatigue [ ]Nausea [ ]Chest Pain [ ]Irritability [ ]Shortness of breath [ ] Confusion [ ] Tension [ ]Anxious **/**Nervousness [ ]Toe numbness [ ]Pain in eyes [ ]Depression [ ] Constipation [ ] Sleeping problems [ ]Shoulder pain R **/** L [ ]Knee pain R **/** L [ ]Wrist pain R/L [ ] Ankle pain R**/** L [ ]Hip pain R **/** L [ ] Elbow pain R / L [ ]Other_____

PRIOR SYMPTOMS HISTORY
[ ] I have **NOT** had any prior symptoms similar to my current complaints
[ ] My current complaint **DID** exist before, but they have not been bothering me
[ ] My current complaint **ALREADY** existed and was **WORSENED** by this accident

_____ _____
Patient/Guardian Signature **Date**

2290 W. Eau Gallie Blvd Suite 210B, Melbourne FL 32935
Phone: (321)435-1505 Fax: (321) 426-7446

MEDICAL RECORDS / RELEASE FORM

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PERSON / OFFICE AUTHORIZED TO DISCLOSE INFORMATION

Information listed below will be disclosed by: _____

Patient Name: _____ DOB: _____

I hereby request and authorize the following medical documents / records to be released to the above listed office (BioCellular Therapies)

_____ Reports
_____ Complete Medical file
_____ Medical Records
_____ Daily Notes
_____ Images
_____ Including HIV/AIDs

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patients personal representative.

Right to Terminated or Revoke Authorization You may revoke or terminate this authorization by submitting a written revocation to the above listed offices at BioCellular Therapies. You should contact the Compliance office to terminate the authorization.

Potential for Re-Disclosure Information that is disclosed under this Authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

_____ _____
Patient/Guardian Signature **Date**

Doctor's Lien

Doctor's Name: _____

_____ _____
Attorney(s) Name Date

_____ _____
Attorney(s) Address Attorney(s) Phone

_____ _____
City State Zip Code

_____ _____
Patient Name Date of Birth

I hereby authorize the above doctor to disclose to my attorney(s) a full report of the case history, examination, diagnosis, treatment and prognosis of myself in regard to the accident in which I was involved. The purpose of this disclosure is to permit my attorney to provide me with the legal services.

- This authorization has no expiration date.
- I understand that I have the right to revoke this authorization by sending a written letter to the above- named doctor, except to the extent that the above-named doctor has already taken action in reliance upon this authorization.
- I understand that the information disclosed under this authorization may be re-disclosed by my attorney(s), and that the privacy of my information is no longer protected by the federal privacy rule once it is disclosed to my attorney(s).
- I understand that I may inspect or copy the information to be disclosed, except in those circumstances when the inspection or the copying of my information may be lawfully denied under federal law.
- I also understand that I may refuse to sign this authorization, and that the above-named doctor will not condition treatment on my providing authorization for this disclosure.

I hereby authorize and direct you, my attorney(s) to pay directly to said doctor such sums as may be due and owing the doctor for professional services, supplies, items, reports and proceedings rendered to me or on my behalf both by reason of the aforementioned accident/injury and by reason of any other bills that are due and owing to the doctor and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor.

- I understand that I may be charged a No Show fee of $150.00 per office visit.
- I understand that I am required to give 72 hour notice to cancel any Surgery Center appointment; otherwise I will be charged $5,000.00

I hereby give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney(s) or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by the doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of pending payment

I hereby waive my right to make any objections regarding the enforceability or appropriateness of this agreement. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ _____
Patient/Guardian Signature **Date**

_____ _____
Print Patient/Guardian Name **Relationship to patient**

Assignment of Benefits

I, the undersigned patient/insured, knowingly, voluntarily, and intentionally assign and transfer any and all rights and benefits of my automobile insurance policy (i.e. Personal Injury Protection ("PIP"), Uninsured Motorist and Medical Payments benefits) to the above-stated Health Care Provider(s) with which I have treated. I understand it is the intention of the Health Care Providers to accept this Assignment of Benefits in lieu of demanding payment at the time services are rendered. I understand that this document will allow the Health Care Providers to file suit against the insurer either in my name or the providers' names for payment of the insurance benefits, to obtain an explanation of benefits and to seek attorneys' fees and costs under Fla. Stat. 627.736(8), 627.428 and 57.041 from the insurer. This Assignment of Benefits includes, but is not limited to, the cost of medical care, transportation, medication, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this Assignment of Benefits, then the insurer is instructed to notify the Health Care Providers in writing within five (5) days of receipt of this document advising of its basis for such dispute. Failure to inform the Health Care Providers shall result in a waiver by the insurer to contest the validity of this Assignment of Benefits. The undersigned patient/insured directs the insurer to pay the Health Care Providers the maximum amount of the policy benefits directly to the Health Care Providers without any reductions and without including the undersigned patient's/insured's name on the check. It is the Health Care Providers' contention that the charges are reasonable. This Assignment of Benefits applies to past, present and future medical expenses and is valid even if not dated. A photocopy of this Assignment of Benefits is to be considered as valid as the original. I, the undersigned patient/insured, agree to pay any applicable deductible or co-payments for services rendered, including payment for services after the policy of insurance exhausts and for any other services unrelated to the date of injury. The above-stated Health Care Providers are given Powers of Attorney to: (1) endorse my, the undersigned patient's/insured's, name on any check for services rendered by the above-stated Health Care Provider, (2) to request and obtain copies of any recorded statements or Examinations Under Oath given by me, the undersigned patient/insured, and (3) to request and obtain copies of any Independent Medical Examination report and/or peer review report pertaining to me, the undersigned patient/insured.

Disputes

The insurer is directed by the Health Care Providers and the undersigned patient/insured not to issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there is a written settlement agreement between the Health Care Providers, specifically the Office Manager, and the insurer as to the amount to be paid by the insurer for the services rendered only to the undersigned patient/insured. The undersigned patient/insured and the Health Care Providers hereby contest and object to any reductions or partial payments made by the insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the Health Care Providers shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the Health Care Providers to accept a reduced amount as payment in full. The insurer is hereby placed on notice that the Health Care Providers reserve the right to seek payment in full for the bills submitted. If the insurer asserts that it can pay claims at 200% of the Medicare Fee Schedule, then the insurer is instructed and directed to provide the Health Care Providers with a copy of the policy of insurance within ten (10) days. Should the insurer and Office Manager of the above-stated Health Care Providers reach an agreement to settle any of the bills submitted at a reduced amount, this agreement shall be reduced to writing and submitted to the attention of the Office Manager for written approval. See Fla. Stat. 673.3111.

Release of Information

I, the undersigned patient/insured, hereby authorize the Health Care Providers to: furnish an insurer, an insurer's intermediary, my other medical providers and my attorney(s) via mail, facsimile or e-mail, with any and all information that may be contained within my medical records to: obtain insurance coverage information (i.e. declarations page and policy of insurance) in writing and telephonically from the insurer, request from any insurer all Explanation of Benefits/Review forms (EOBs) for all of my medical providers, obtain a non-redacted PIP payout sheet, obtain written and verbal statements that I or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including, but not limited to: documents, reports, scans, notes, bills, opinions, x-rays, IMEs, peer reviews and MRIs from any of my medical providers or any insurer. The Health Care Providers are permitted to produce my medical records to its attorney in connection with pursing a legal action. The insurer is directed to keep my, the undersigned patient's/insured's medical records confidential. The insurer is not authorized to provide my, the undersigned patient's/insured's, medical records to anyone without my, the undersigned patient's/insured's and the Health Care Providers' express written permission. **Certification**

I, the undersigned patient/insured, certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care from the above-stated Health Care Provides; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service provided; and I agree that the Health Care Providers' prices for the medical services, treatment and supplies provided are reasonable, usual and customary.

Caution: Please read this document carefully before signing. Please ask to review a copy of the above-stated Health Care Providers' charges. If you do not completely understand this document, please ask the front desk personnel or the medical provider to explain it to you. If you sign below it will be understood that you understand and agree with the contents of this Assignment of Insurance Benefits.

_____ _____

Patient/Guardian Signature **Date**

(Please print) (If patient / insured is a minor, signature of parent/guardian)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execute on of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

_____ _____

Patient/Guardian Signature **Date**

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. **Uses and Disclosures of Protected Health Information**: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. **We may use or disclose your protected health information in the following situations without your authorization:** as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint**. We will not retaliate against you for filing a complaint**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided. **We welcome your comments**: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

_____ _____

Patient/Guardian Signature **Date**

BioCellular Therapies
2290 W. Eau Gallie Blvd Suite 210B
Melbourne FL 32935
PH: (321) 435-1505 Fax (321) 426-7446

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowledgment
( ) An emergency situation prevented us from obtaining acknowledgment
( ) Other (Please specify)
_____
_____
_____

ACKNOWLEDGMENT OF INFORMATION and RECEIPT OF NOTICE OR PRIVACY PRACTICES

I have read and received the phone numbers needed to report abuse and complaints.

I have read the office's Notice of Privacy Practices.

_____ _____
Patient/Guardian Signature **Date**