HIPAA Information and Consent Form
International Stem Cell Institute

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to communicate with patients via telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the International Stem Cell Institute.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Confidential Medical History Form

Today's Date: ____/____/_____

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: ____/____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Mobile Number: _____

Fax Number: _____ Email: _____

Marital Status: _____ Occupation: _____

Referred By: _____

PARENT / GUARDIAN INFORMATION

Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Mobile Number: _____

Email_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone Number: _____ Mobile Number: _____

TREATMENT REQUIREMENTS

Please confirm you have read and understand the requirements below to receive treatment:

☐ **I understand this is a Patient Funded Treatment**

This is a patient funded treatment and unfortunately cannot be covered by any insurance providers, which will require the patient to pay for the cost of the treatment. The cost will vary depending on the type of treatment, patient's condition(s) and delivery method needed.

☐ **I am able and willing to travel to receive treatment** *(please select all that apply)*

☐ I am able to travel within my state

☐ I am able to travel to surrounding states

☐ I am able to travel inside the U.S.

☐ I am able to travel outside of the U.S.

Last Name: _____ First Name: _____ M.I. _____

PAST MEDICAL HISTORY

Primary condition you are seeking treatment for: _____

Date of diagnosis: ____/____/_____

Describe all symptoms, dates of onset and any other pertinent information:

Confidential Medical History Form

Last Name: _____ First Name: _____ M.I. _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check the appropriate boxes):

- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Diabetes ☐ Hypoglycemia
- ☐ Asthma
- ☐ Emphysema
- ☐ Pulmonary Fibrosis
- ☐ Chronic bronchitis
- ☐ Seasonal allergies
- ☐ Glaucoma
- ☐ Seizures ☐ Stroke ☐ Migraines
- ☐ Depression
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Arthritis
- ☐ Thyroid problems
- ☐ Prostate problems

Have you ever been diagnosed with any form of cancer? ☐ Yes ☐ No

Type: _____ Date of Diagnosis: ____/____/_____

Status: _____

Please describe any current or past medical condition that is not included in the list above:

_____

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, what for? _____

_____

Please list all past surgeries:

Procedure: _____ Date: ____/____/_____

Procedure: _____ Date: ____/____/_____

Procedure: _____ Date: ____/____/_____

Procedure: _____ Date: ____/____/_____

Last Name: _____ First Name: _____ M.I. _____

Have you ever received a blood transfusion? ☐ Yes ☐ No | Date: ____/____/_____

ALLERGIES AND ADVERSE DRUG REACTIONS

Are you allergic to penicillin or any other drug? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Please list your current medications: _____

_____

_____

Nutritional supplements / Herbal Preparations: _____

_____

_____

SOCIAL AND PREVENTATIVE HISTORY

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

If yes, how many packs per… (fill out one) Day: _____ **or** Week: _____ **or** Month: _____

If No, Have you in the past? ☐ Yes ☐ No

If yes, how many packs per… (fill out one) Day: _____ **or** Week: _____ **or** Month: _____

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No

If yes, how many drinks per… (fill out one) Day: _____ **or** Week: _____ **or** Month: _____

If No, Have you in the past? ☐ Yes ☐ No

If yes, how many drinks per… (fill out one) Day: _____ **or** Week: _____ **or** Month: _____

Age: _____ Height: _____ Weight: _____ Sex: _____

Date of your last medical check-up: ____/____/_____

Physician: _____ Telephone: _____

Results of your last medical check-up: _____

_____

_____

Last Name: _____ First Name: _____ M.I. _____

FAMILY HISTORY

Has any member of your family had any of the following illnesses? If yes, please place an "X" in the appropriate boxes to identify all illnesses/conditions of your blood relatives.

	Mother	Father	Brother	Sister	Grandparents	Other
Breast Cancer						
Colon Cancer						
Other Cancer						
Heart Disease						
High Blood Pressure						
Diabetes						
Liver Disease						
Depression						
Psychiatric Illness						
Other (Please Specify)						

Females History

Date of Last Mammogram: ____/____/_____ Mammogram Results: _____

Have you ever had a breast biopsy? ☐ Yes ☐ No

Biopsy results: _____

Males History

Date of Last PSA: ____/____/_____ Result: _____

Last Name: _____ First Name: _____ M.I. _____

REVIEW OF SYMPTOMS
Do you currently have any of the following symptoms? Please check all appropriate boxes:

Eyes, ears, nose, throat

- ☐ Blurred vision
- ☐ Other change in vision
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Hoarseness
- ☐ Nose bleeds

Pulmonary

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Wheezing

Cardiovascular

- ☐ Chest pain
- ☐ Irregular beat / Tachycardia
- ☐ History of poor circulation
- ☐ History of Angina or heart attack

Gastrointestinal

- ☐ Poor appetite
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Trouble swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Nausea or vomiting
- ☐ Rectal bleeding or blood in stools
- ☐ Weight gain/loss of 10+ lbs during last 6 months

Muscle / joint / bone

- ☐ Swelling of ankles or legs
- ☐ Weakness or numbness in:
  - ☐ Arms or hands
  - ☐ Hips
  - ☐ Legs or feet
- ☐ Muscle pain
  - ☐ Neck or shoulders
  - ☐ Back pain
- ☐ Joint pain

Neurological

- ☐ Blackouts or loss of consciousness
- ☐ Poor sleep
- ☐ Headaches
- ☐ Dizziness
- ☐ Loss of memory
- ☐ Speech problems

Genitourinary

- ☐ Frequent or painful urination
- ☐ Blood in urine
- ☐ Incontinence

Skin

- ☐ Itching
- ☐ Easy bruising

Endocrine

- ☐ Change in tolerance to hot or cold temperatures
- ☐ Excessive thirst
- ☐ Hot flashes

Last Name: _____ First Name: _____ M.I. _____

Do you need assistance when walking? ☐ Yes ☐ No

Do you require a wheel chair? ☐ Yes ☐ No

Other requirements? _____

Have you received a stem cell treatment before? ☐ Yes ☐ No

Date of last treatment: ____/____/_____ If yes, please describe: _____

_____

_____

What do you intend to accomplish with the treatment you are seeking? _____

_____

_____

By signing and dating below, I do hereby certify that to the best of my knowledge all the above information on this form that I have supplied is complete and true.

_____ Date: ____/____/_____

Patient / Legal Guardian Signature