Consent for Purposes of Treatment, Payment and Healthcare Operations

Consultations: I understand that the Consultation is complimentary. I agree to provide all the information needed to evaluate my health concern. I understand if there is any treatment, procedures or services provided that go beyond evaluating if I am a candidate, I will be charged for a new patient appointment.

Financial Agreement: I understand that I am financially responsible to Regenerative Medicine Clinic of Wilmington for all charges. I understand payment is due at the time of service.

Financial Policy: I agree to abide by Regenerative Medicine Clinic of Wilmington's financial policy. I understand to schedule a procedure 50% down payment is required; the remaining balance is due 2 weeks prior to the date of service, if not received the procedure may be cancelled. I understand all new patients are billed for an office visit ($250) and there may be additional fees for services and follow up appointments. *We accept all major credit cards, cash, check and Care Credit.

Insurance: I understand Regenerative Medicine Clinic of Wilmington is not associated with any insurance plans including Medicare/ Medicaid. I understand Regenerative Medicine Clinic does not file any insurance claims. I the undersigned patient agree to **not** file any Medicaid/ Medicare insurance claims for procedures or treatments performed by Regenerative Medicine Clinic of Wilmington. Additional claims may be submitted on behalf of Dr. Yeargan by the rendering provider (labs, radiology, and physical therapy). ***Insurance is a contract between you and your insurance company. We are not a party to this contract. We cannot become involved in disagreements between you and your insurance.***
*If you have insurance that is not Medicare/ Medicaid you may submit a Member Claim to your insurance company. The claim may be considered out-of-network. We will be happy to assist you in this matter.

Consent for Disclosure: I agree that Regenerative Medicine Clinic of Wilmington may leave messages and/ or release medical information to the following individuals.
Name: _____Telephone: _____
Name: _____Telephone: _____

HIPPA Notice of Privacy Practices: I acknowledge that I have received or have been offered a copy of Regenerative Medicine Clinic of Wilmington PLLC, HIPAA Notice of Privacy Practices, effective January 1, 2016, which provides information about how my personal health information (PHI) is used and disclosed.
A current Notice of Privacy Practices for Regenerative Medicine Clinic of Wilmington PLLC, is available at the front desk

Consent for Treatment: I hereby authorize Dr. Yeargan and appointed staff to perform any evaluation or treatment as is necessary, and to perform services and or procedures with my consent. I hereby certify that no guarantee or assurance has been made as to the results that may be obtained from examination or treatment. I have been informed of the patient's rights and responsibilities.

I also understand that if I am candidate for Stem Cell Therapy and/ or Platelet Rich Plasma Treatment, it is not covered by insurance.

Acknowledgment: I have read, understand and agree with the foregoing statements. I acknowledge all questions or concerns have been addressed.

_____ _____
Patient Signature Date

_____ _____
Guardian/ Representative Signature Relationship

Patient Acknowledgment of Receipt of
HIPPA Notice of Privacy Practices

I acknowledge that I have received or have been offered a copy of Regenerative Medicine Clinic of Wilmington PLLC, HIPAA Notice of Privacy Practices, effective January 1, 2016.

_____(Initial)

A current Notice of Privacy Practices for Regenerative Medicine Clinic of Wilmington PLLC, is available in our lobby and the front desk

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of there protected health information (PHI). The individual is also provided the rights to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Individuals that you will allow us to leave messages and/ or release medical information to.

Name: _____Telephone: _____

Name: _____Telephone: _____

_____ _____

Patients Printed Name **Date**

_____ _____

Signature (Patient or Representative) Relationship of Representative/
Authority to act on behalf of the patient

Regenerative Medicine Clinic of Wilmington Staff Use Only

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patients' representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

_____

_____