MAUI REGENERATIVE MEDICINE

2310 Umi Place Haiku Hawaii 96708
Office: 808-575-2328
www.mauiregenerativemedicine.com

Patient History Information

Name: _____ Date: _____
Address: _____ State/Zipcode: _____
Phone Home: _____ Cell:_____ SSN#_____
Age:_____ Date of Birth:_____ Sex: M F
Occupation:_____Employer:_____
Marital Status: S M W D No. of Children:____ Spouse Name:_____

Emergency Contact Name and Phone: _____
Email: _____
How did you find out about our office? _____
How do you prefer we contact you: _____
What is the reason for this visit?_____

Is this condition due to: Auto accident Work Injury Other accident Illness Other

Are symptoms: Improving Getting worse About the same Intermittent
Date symptoms appeared: _____ Have you ever had these symptoms before? Yes No
Have you seen any of the following doctors for this? MD Naturopathic Dr
Chiropractor Acupuncturist Other: _____
Therapy Received:_____Dates treated:_____
Diagnosis: _____
Reason for termination of treatment: _____
Medications Prescribed:_____
Doctors Name:_____

I understand that a 24 hour advance notification is required for scheduling or cancelling of appointments to avoid a charge. I understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patients Signature: Date

Please apply check to boxes below: C =currently P =previously N= never

GENERAL SYMPTOMS

C	P	N	
			HEADACHE
			FEVER
			CHILLS
			NIGHT SWEATS
			DIZZINESS
			CONVULSIONS
			LOSS OF SLEEP
			FATIGUE
			NERVOUSNESS
			Loss of Weight
			Numbness in extremeties
			Wheezing

MUSCLE & JOINTS

			Weakness
			Twitching
			Stiff Neck
			Bachache
			Swollen joints
			Tremors
			Painful Tailbone
			Foot trouble
			Hernia
			Pain in btwn Shoulders
			Spinal Curvature

SKIN/ALLERGIES

			Skin eruptions
			Itching
			Brusing Easily
			Dryness
			Boils
			Sensitive skin
			Hives
			Eczema
			Psoriasis

HABITS

			Smoking
			Alcohol
			Coffee

RESPIRATORY

			Chronic Cough
			Spitting Blood
			Spitting Phlegm
			Chest Pain
			Difficult breathing

GASTRO-INTESTINAL

			Poor Appetite
			Poor Digestion
			Excessive Hunger
			Belching/Gas
			Nausea
			Vomiting
			Vomiting blood
			Pain over stomach
			Constipation
			Diarrhea
			Colon trouble
			Hemorrhoid
			Liver toruble
			Jaundice
			Gall bladder trouble

CARDIO-VASCULAR

			Rapid heart
			Slow heart
			High Blood pressure
			Low Blood pressure
			Pace Maker
			Pain over heart
			Prev. Heart trouble
			Swelling ankles
			Poor circulation
			Varicose veins
			Strokes

EYE-EAR-NOSE-THROAT

C	P	N	
			Poor vision
			Crossed eyes
			Pain in eyes
			Deafness
			Earache
			Ear Noises
			Ear Discharge
			Nasal Obstruction
			Nose Bleeds
			Sore throat
			Hoarseness
			Hay Fever
			Asthma
			Frequent colds
			Enlarged thyroid
			Tonsillitis
			Sinus trouble

GENITO-URINARY

			Freq. urination
			Painful urination
			Blood in urine
			Kidney Infection
			Bedwetting
			Incontinence
			Prostrate trouble

WOMEN ONLY

			Painful periods
			Excessive flow
			Irregular cycles
			Hot Flashes
			Cramps or Backaches
			Miscarriage
			Vaginal Discharge
			Pregnant at this time
			Abnormal Pap

	Arthritis
	Epilepsy
	Mental Disorder
	Lumbago
	Eczema

Have you had any of the following:

	Appendicitis
	Pneumonia
	Rheumatic Fever
	Polio
	Tuberculosis
	Whooping Cough
	Anemia
	Measles
	Mumps

	Chicken Pox
	Diabetes
	Cancer
	Heart Disease
	Goiter
	Influenza
	Pleurisy
	Alcoholism
	Venereal Disease

Family History/List Member:

Diabetes _____

Heart _____

Kidney _____

Cancer _____

_____

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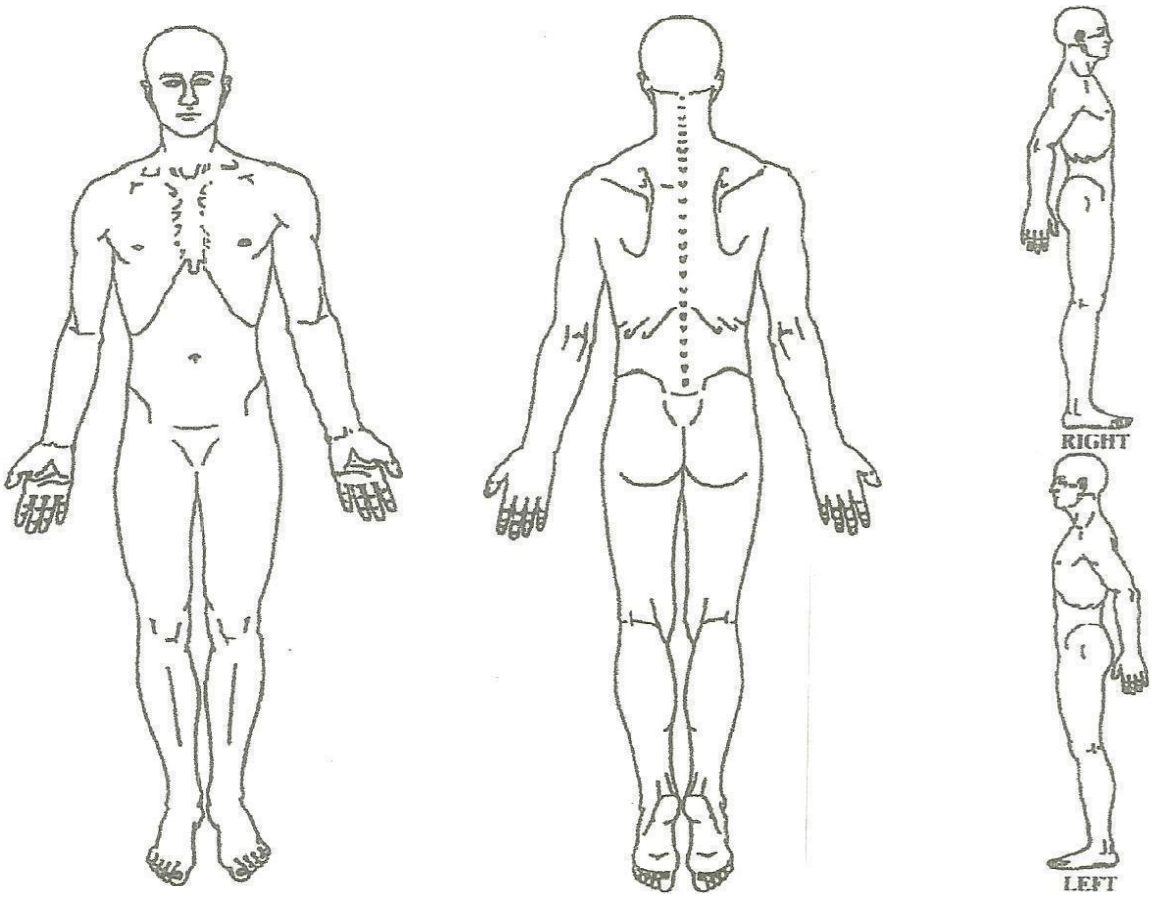
Name: (please print)_____ Date: _____

Use the letters below to indicate the type and location of your sensations right now.

Key: S = Stiffness B = Burning N = Numbness
P = Sharp Pain T = Tingling D = Dull Pain



FINANCIAL POLICIES

Please take time to read and sign this financial responsibility statement before your first visit.

PAYMENT POLICY:

All account balances are due at the time of service. We reserve the right to not extend credit, as this is not a service we guarantee. We accept cash, checks, MasterCard, and Visa.

INSURANCE POLICY:

We do not accept insurance at this time. We do not offer billing services for insurance companies.

INTEREST FEES: There is no interest or finance charge on current accounts. After 60 days, all accounts are subject to a monthly finance charge of 2.0% of the unpaid balance, which is an annual percentage rate of 24% (or a minimum charge of $1.00).

MISSED / LATE CANCELLATION APPOINTMENT FEES:

We require 24 hours notice for rescheduling or canceling patient appointments.

We may charge for missed appointments, or appointments not canceled or rescheduled within the 24 hour time frame as stated above a fee of $100.00.

ACKNOWLEDGMENT:

I have read this financial policy statement and understand its terms. I understand that delinquent accounts may be assigned to a credit reporting collections service. If it becomes necessary to pursue collections of any amount owed, I agree to pay for all costs and expenses, including reasonable attorney fees. There will be a $50.00 fee added to any accounts referred to collections. I hereby authorize the Maui Regenerative Medicine to release any information necessary to secure payment.

Print Patient's Name:_____
D.O.B._____

Responsible Party Relationship to patient_____SSN# : _____

Signature of responsible party_____ _____Date_____

Dr.Kevin Davison N.D.,L.Ac
Patient Conditions of Treatment and Informed Consent to Treat

This document is a binding agreement (the "Agreement") between Maui Regenerative Medicine LLC. ("We" "Us" "Our") and the individual patient whose name and signature appears below ("You" "Yours"). In consideration of the health care service which may be provided to You by Us at the present and at all times in the future. You agree as follows (Your agreement indicated by placing Your initials on the line following each section and by signing in the space provided):

1.

Consent For Treatment. You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize Us to provide You with health care treatment which, depending on Your health conditions, may include without limitation one or more of the following procedures: naturopathic medicine, dietary, herbal, medical, pharmaceutical and anesthetic treatment, Minor Surgery, Gynecology, Radiofrequency procedures, Acupuncture, prolotherapy and/or Platelet Rich Plasma injections, Stem Cell injections, Intravenous Micronutrient and Botanical Therapy and Heavy Metal Chelation. (together the "Treatments") administered by Us, or physicians, assistants, consultants and staff. You acknowledge the We have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatments. (Initials)___

2.

Experimental Nature of Treatment. Y ou acknowledge and agree that the Treatments may consist in whole or part of experimental procedure and methods, including without limit Acupuncture, Intravenous Micronutrient Therapy, Minor Surgery, Prolotherapy and Platelet Rich Plasma therapy, Stem Cell Therapy, on which no governmental (including the U.S. Drug Administration ("FDA"), scientific or medical authority has confirmed the safety or efficacy therefore, You acknowledge that the safety and efficacy record of the Treatment is based only on empirical and anecdotal evidence, which only shows that the Treatment appear to be relatively safe and effective. We have informed you that the Treatments MAY alter, address or decrease Your pain, symptoms or complaints, but also may have no effect. (Initials) ___

3.

Minor Surgery, Prolotherapy, Injection Therapy Risk, Side Effects, Complications. We hereby inform you that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation swelling; increased pain; bleeding; dizziness, numbness; scarring; scar or keloid formation; asymmetry; allergic reaction; discoloration; soreness, itching, a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments;, all of which may be permanent. Treatment may very rarely cause infection; injury to nerves, temporary or permanent alteration in sensation; the need for additional surgery or hospitalization; spinal cord injuries. Pneumothorax (temporary lung collapse), paralysis, or other serious or debilitating injuries or death. (Initials) ___

4.

Description of Treatment. T he exact procedure, , as well as the recommended sequence of Treatment, will be explained to You when We actually administer the Treatment. You acknowledge that any of the Treatments may involve insertion of needles into Your skin and veins and injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicines and FDA approved prescription medicines, chelating agents, local anesthetic (procaine, Bupivacaine, Lidocaine) concentrated sugar water or dextrose, concentrates or Your own blood (platelet Rich Plasma, Bone Marrow Stem Cells, Fat Derived Stem Cells) and, on occasion, other substances and local subcutaneous anesthetic infiltration (with or without epinephrine)which will be explained to you before injection. (Initials) ___

5.
Medical Staff. You are aware that among those attend You on Our behalf are medical, nursing and other health care personnel employed by Us or in training, who unless requested otherwise, may participate in Your patient care. (Initials) ___

6.
Information You Provide Us. Y ou have provided Us with complete list of all prescription and nonprescription medications and dietary supplements You are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medications, dietary supplements or medical treatments of any kind. You agree to update Us periodically should the list change. (Initials) ___

7.
Assumption of Risk. You hereby acknowledge after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this agreement or the Treatments that You have, You are willing to assume any and all risk associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatment can ever fully explain every possible risk, side effect or complication that may/or could arise from the treatment, but that by initialing and signing this Agreement, You nevertheless acknowledge Your willingness to assume such risk and that You consent to the Treatment is willing, voluntary and informed. (Initials) ___

8.
Alternatives. You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. (Initials) ___

9.
Miscellaneous. You agree that this Agreement constitutes the entire agreement between You and Us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by You. This Agreement shall be binding on You and Your successors, heirs, legal representatives and assigns. In case any one of the provisions of this Agreement is held invalid or illegal, such provisions shall be curtailed, limited or served only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the State of Hawaii without regard to any adjudicated in state or federal court in Maui County, Hawaii and You Submit to the jurisdiction of any such court. (Initials) ___

BY SIGNING THIS AGREEMENT, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, YOU HAVE RECEIVED A COPY OF THIS AGREEMENT, AND THAT YOU ARE THE PATIENT, GUARANTOR, THE PARENT' S LEGAL REPRESENTATIVE OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

Patient Legal Guardian/Proxy/Representative

_____	_____	_____	_____
Signature	Date	Signature	Date
_____		_____	
Printed Name		Printed Name of person signing	

Physicians Certification I hereby certify that one of my associates or I have explained to the patient or authorized person that the nature of the proposed treatments, the medically significant alternatives, and inlay terms the purpose, likelihood of success, benefits, and reasonably foreseeable risk, complications, and consequences of treatment. The patient or person authorized has had the opportunity to ask questions and has stated that no further explanation was desired.

Physicians Signature _____Date_____

MAUI REGENERATIVE MEDICINE

Notice of Privacy Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to this information. Please review it carefully.

Protected Health Information (PHI) is defined as any information whether oral or recorded, in any form or medium that is created or received by a healthcare provider that connects the patient's name to any treatment, financial status or health status in the past, present or future. PHI is generally used when we send and receive information to / from doctors, lawyers, pharmacies and insurance companies. If PHI is requested by another office or by the patient, we request the patient sign a release form before any information can be shared or released. There is an understanding that we may send PHI if requested by your insurance company in order to secure payment for you. Only the minimum information necessary will be shared, as a rule.

Disclosure of PHI in the following cases do not require patient consent: If the disclosure is required by law, if the request is from the public health authority, if the request involves child abuse, neglect, domestic violence, in judicial and administrative proceedings, requests from law enforcement, requests for cadaveric organ, eye or tissue donation purposes, food and drug administration requests, in cases of communicable diseases, to avert a serious and imminent threat to health and safety, or workers compensation.

Patients have the right to receive a copy of this Notice of Privacy Practices. They have the right to access their own PHI and to request amendments and restrictions. Patients have the right to not be intimidated or threatened when making these requests. We may not require them to sign a waiver, relinquishing these rights, in order to receive treatment. Patient's names will not be used in any fundraiser or venture without prior authorization, except for our mailing list. Patients can be removed from this list by request. Unless we are otherwise directed, PHI will only be released to friends and / or family if the patient is incapacitated or it is an emergency and ONLY if the doctor decides that the is in the best interests of the patient. If you have family members who you would like to authorize access to your PHI, please add their name(s) to the bottom of this form. Custodial parents have access to their children's PHI if they are minors unless another agreement has been made or the doctor believes there is a possibility of child abuse / neglect.

If a patient requests an amendment of, or access to their PHI, depending on the situation, the doctor may or may not comply. If access or amendments are denied, the patient will be provided with a statement that includes the reasons for that denial. Our office has 30 days to respond to any request for information. If the requested information is kept offsite, our office has 60 days to respond. If the patient does not agree with the doctor's decision, there is an appeals process that will be explained to the patient at that time. Our staff are trained in privacy and security procedures. The front staff members have limited access to all active patient files and also to existing archived files dating back to 1978. (MRM routinely destroys files after10years of inactivity). They do not have authority to review and / or release test results, or to access any

PHI without appropriate reasons. The practitioners in the office have access to their patients' PHI only, unless the on call doctor needs to access the PH Ito assist the patient. If the patient sees more than one doctor, information may be shared between doctors .

I have read the above notice.

Sign Name_____ Date_____

Print name_____

Please do not include my name on your newsletter mailing list_____

I would like a copy of this notice_____

I authorize MRM to share my PHI with:_____

Relationship_____

We have a copy of our complete Privacy Policy available in the waiting room.