OPTIMAL MEDICAL, PLLC

8906 Kingston Pike
Knoxville, TN 37923
Phone: 865-500-8220
Fax: 865-357-3335

New Patient Intake Form

To provide you with the most appropriate treatment, please complete the following questionnaire. All information is strictly confidential.

First Name: _____ MI: ____ Last Name: _____

Mailing Address:
_____

City: _____ State: _____ Zip Code: _____

Phone: (H)_____
(C)_____

Email Address: _____ Date of Birth: _____

Sex: M / F SSN: _____ Marital Status: Single / Married / Widowed

Race: Caucasian / African American / Asian / Native American / Latin American / Other

Occupation: _____ Employer: _____
Employer Phone: _____ Can we call you at work? YES / NO
Insurance Company: _____
How did you hear about our practice? _____

Emergency Contact:
Name: _____ Relationship: _____ Phone: _____

Accident Information:
Is this visit due to an accident? Yes / No If yes, what type? Auto / Work / Other
Has it been reported? Yes / N If yes, to whom? _____

Signature: _____ Date: _____

Health History:

Please check to indicate you have previously been diagnosed with any of the following:

___ Aids/HIV ___ Alcoholism ___ Allergies ___ Anemia ___ Anorexia/Bulimia ___ Anxiety ___ Asthma ___ Bleeding Disorder ___ Breast Lumps ___ Cancer ___ Chemical Dependency ___ Chicken Pox/Shingles ___ COPD ___ Deep Vein Thrombosis ___ Depression ___ Diabetes ___ Eczema/Dermatitis ___ Epilepsy ___ Glaucoma	___ Gonorrhea ___ Gout ___ Heart Disease ___ Hernia ___ High Cholesterol ___ Hypertension ___ Irritable Bowel ___ Syndrome ___ Kidney Disease ___ Liver Disease ___ Migraines/Headaches ___ Multiple Sclerosis ___ Ovarian Cysts ___ Pacemaker ___ Parkinson's Disease ___ Pinched Nerve ___ Plantar Fasciitis ___ Polio ___ Prostate Cancer ___ Pulmonary Embolism ___ Rheumatoid Arthritis	___ Stroke/TIA ___ Stomach Ulcers ___ Thyroid Problems ___ Tuberculosis ___ Uterine Fibrosis Other: _____ _____ _____ _____ _____ _____ _____

Orthopedic History:

____Osteoporosis ____Arthritis ____Degenerative Joint ____Disease ____Bulging Disc	____ Herniated Disc ____ Degenerative Disc ____ Disease ____ Carpal Tunnel ____ Scoliosis	____ Broken Bones/ Fractures: _____ _____ _____ _____

Surgical History:

____ Appendectomy ____ Gallbladder Removal ____ Coronary Bypass	____ Hysterectomy ____ Carpal Tunnel Surgery ____ Fusion: _____	____ Laminectomy ____ Discectomy ____ Other: _____ _____ _____ _____ _____

Medications:

Are you on any blood thinners including Coumadin (warfarin), Pradaxa, Xarelto? YES / NO Please list below any medications or supplements that you are taking (include dose/frequency):

_____

Who is your family / primary physician? _____

What Pharmacy do you use? _____

Social History: What is your occupation? _____

Approximate your intake of the following: Alcohol _____ drinks/week Cigarettes: _____ packs/day

Signature: _____ Date: _____

Could Stem Cell Therapy Be Right for You?

If you're struggling with joint pain, arthritis, a lingering injury, or reduced mobility — and you're looking for a way to avoid surgery or long-term medication — you're not alone. Many patients are exploring advanced treatment options that support the body's natural ability to heal.

One of the most promising options is stem cell therapy. This form of regenerative medicine uses special cells with the ability to repair damaged tissues, reduce inflammation, and support healing at the source. While not a fit for every condition, it has helped many people improve mobility, reduce discomfort, and get back to doing what they love — naturally, without invasive procedures and minimal downtime.

If you're curious about whether stem cell therapy may be a good option for you, please take a moment to complete this brief questionnaire:

First Name: _____ **Last Name**: _____

1. Have you heard of stem cell therapy before?
☐ Yes
☐ No

2. How familiar are you with stem cell therapy as a treatment option?
☐ Very familiar – I've researched or considered it before
☐ Somewhat familiar – I've heard about it but don't know much
☐ Not familiar at all

3. What are you hoping to improve or address with your care?
☐ Chronic joint pain (knee, hip, shoulder, etc.)
☐ Degenerative conditions (arthritis, tendon injuries, etc.)
☐ Post-surgical recovery or injury healing
☐ General wellness or anti-aging
☐ Other: _____

4. Have you tried any of the following for your condition? (Check all that apply)
☐ Physical therapy
☐ Surgery or have been advised to consider surgery
☐ Cortisone/steroid injections
☐ PRP (Platelet-Rich Plasma) therapy
☐ None of the above

5. Are you interested in learning more about whether stem cell therapy may be right for you?
☐ Yes – please provide more information
☐ Maybe – I'd like to talk to a provider first
☐ No – not interested at this time

6. If you answered "Yes" or "Maybe," what would you like to get out of stem cell therapy?
☐ Pain relief
☐ Avoiding surgery
☐ Faster healing
☐ Improved function or mobility
☐ Natural/non-invasive treatment options
☐ Other: _____

Thank you! Your responses will help us personalize your care plan and explore options that best match your goals.

Optimal Medical, PLLC

Informed Consent to Care

A patient coming to the doctor gives his or her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from such as latent pathological defects, illness, or deformities, which would otherwise not come to the attention of the physician.

The patient agrees to settle any claim/dispute he/she may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitrations under the current malpractice terms which can be obtained with written request.

All forms of health care, while offering considerable benefit may also provide some level of risk. Prior to receiving medical care, it may be necessary to perform a health history and physical examination. These procedures are performed to assess the patient's specific conditions and overall health. These procedures will assist Optimal Medical in determining if medical care is needed or if any further examinations or studies are needed. In addition, they will help Optimal Medical determine if there is any reason to modify the patient's care or provide the patient with a referral to another health care provider. All relevant findings will be reported to the patient, along with a care plan before beginning care. Patients understand and accept that there are risks associated with medical care and give consent to the examination that the doctor deems necessary and to the medical services, as reported following the assessment.

This notice is effective as of (today's date) _____ and will expire 7 years after the date on which you last received services from Optimal Medical.

Patient Signature: _____ Date: _____

To Our Patients

Regarding patient rights to make advanced healthcare decisions.

Federal law requires that Optimal Medical gives the patient's information about their rights to make advanced health care decisions. The patient may make healthcare decisions for themselves, but if they cannot, advance directions are required. If the patient becomes unable to do so, the patient appoints another person to accept or refuse treatment on their behalf.

The patient may leave advance directions about withdrawal of life support executing a "Living Will." A Living Will authorizes the patients' healthcare provider and family to withdraw or withhold medical care which artificially prolongs life, in the event Optimal Medical determines the patient to have a terminal condition from which there is no reasonable expectation of recovery.

> It is Optimal Medical's policy to honor the patient's healthcare decisions to the full extent required or allowed by law. The patient is NOT required to give advance healthcare directions to receive care at this facility.

Do you have a Living Will? YES / NO

Do you have a Durable Power of Attorney for healthcare? YES / NO

If you answered YES to either question, we must put a copy of the document in your medical chart to ensure your wishes are honored.

Patient Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date: _____

I acknowledge that I have received the Notice of Privacy Practices of Optimal Medical, PLLC. I acknowledge that it is the policy of Optimal Medical, PLLC to send a text message or leave reminder messages on my answering machine or with another person in my home. I will make a request for an alternative means of communication (within reason) in writing. I acknowledge that I should have a problem or question regarding my rights, I may speak with a privacy officer about my concerns.

Patient Signature: _____ Date: _____

X-Ray Questionnaire for Women

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we want to confirm that you are not pregnant now.

Name: _____

___There is a possibility that I may be pregnant at this time
___Yes, I am pregnant
___No, I am not pregnant
___I request that x-rays not be taken because:
_____
_____

Date of last menstrual cycle: _____

Patient Signature: _____ Date: _____

Assignment of Health Plan Benefits and Right as Well As An Appointment and/or Designation as My Personal Representative and an ERISA/PPACA Representative and Beneficiary

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Optimal Medical PLLC, as well as all employees, employers, representatives, and agents, thereof, (herein collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medication provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms, or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan including ERISA (Employee Retirement Income Security Act).

Governed plan/insurance contract, PPACA (Patient Protection and Affordable Care Act governed plan/insurance contract) rights that I (or my child or spouse or dependent) may have under my/our applicable health plan(s) or health insurance policy (ices). I also hereby appoint and designate that

Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file or pursue appeals and/or legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is considered valid and enforceable as the original.

Signed this _____ day of _____, 20_____

_____ _____

Patient Signature or Signature of Guardian if Minor Date

_____

Please Print Name

Optimal Medical, PLLC

Authorization to Treat Specific and Irrevocable Assignment of Benefits and Healthcare Lien

Date of Injury (if applicable):_____

Liable Party:_____

Secord Party (if applicable):_____

Second Insurance Company:_____

To Optimal Medical, PLLC here forward known as *Providers*.

1. I hereby testify that my sole purpose for coming to this office is for healthcare.
2. I hereby authorize providers and its staff and doctors to examine and treat my condition.
3. I hereby authorize providers to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster to process claims for reimbursement of charges incurred at the Providers clinic by me.
4. I authorize and assign direct payment to Providers if any sum I now or hereby after owing you by my attorney out of the proceeds of any settlement of my care and by any insurance company obligated to reimburse me for the charges for your service or otherwise obligated to payment to me or you based in whole or part upon the changes made for Providers services.
5. I give assignment and lien against any claim against a third party whose negligence may have caused my injury up to the amount of the bill for treatment.
6. I understand that I am financially responsible for all charges for services rendered by Providers, and you may investigate my credit, employment, income records and credit references.
7. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for Provider services refuses to make such a payment upon demand by you, I hereby assign and transfer to you the cause of action that in my favor against any such company the name (s) of which is believed to be correctly set forth under pertinent data above and authorize you to prosecute said action either in my name or your name as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sum (s) due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amount you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.
8. I waive the statute of limitations regarding Providers' right to recovery.
9. I hereby authorize and direct you, my attorney, to pay directly said Provider(s) such sums as may be due and owing him professional services rendered me both by reasons of this accident and by reasons of any other bill(s) that are due his office and to withhold such sums for any settlement, judgment, or verdict as may be necessary adequately to protect said Providers. I hereby further give a lien on my case to said Provider against all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself because of the injuries for which I have been treated or injuries in connection therewith.

Patient Signature: _____ Date: _____

Attorney Signature: _____ Date: _____

OPTIMAL MEDICAL, PLLC NOTICE OF PRIVACY PRACTICES

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

Optimal Medical, PLLC is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information

Disclosure of Your Healthcare Information:

Treatment:

Our treatment area is an open environment. You may be treated alongside other patients and your health information discussed. In addition, audio and video recording will take place in our office for the purpose of maintaining an elevated level of patient care, integrity, and security.

We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations (example):

"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Optimal Medical, PLLC."

"It is our policy to provide a substitute healthcare provider, authorized by Optimal Medical, PLLC to provide assessment and/or treatment to our patients without advance notice, in the event of your primary health care providers absence due to vacation, sickness, or other emergency."

Payment:

We may disclose your health information to your insurance provider for payment or healthcare operations (example).

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Optimal Medical, PLLC for your healthcare services rendered. If you pay for your healthcare services personally, we will provide an itemized billing statement to your insurance carrier for reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury, and codes which describe the healthcare services received."

Workers' Compensation:

We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Emergencies:

We may disclose your health information to notify or assist in notifying a family member, or another responsible for your care about your medical condition or in the event of an emergency of your health.

Public Health:

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings:

We may disclose your health information during any administrative or judicial proceeding.

Law Enforcement:

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Person:

We may disclose your health information to coroners or medical examiners

Organ Donation:

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs, and tissues.

Research:

We may disclose your health information to researchers conducting research approved by an Institutional Review Board.

Public Safety:

It may be necessary to disclose your health information to appropriate people to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the public.

Specialized Government Agencies:

We may disclose your information for military, national security, prisoner, and government benefit purposes.

Marketing:

We may contact you for marketing purposes or fundraising purposes, as described below:

"As a courtesy to our patients, it is our policy to call your home or send you a text message in the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be discussed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate and or market upcoming events, new services, and charitable events. During these times, we may send you

a letter, email, text message, post card, invitation, or call your home to invite you to participate. We will provide you with information about the type of activity, the dates and times and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Optimal Medical, PLLC sponsored events."

Change of Ownership:
If Optimal Medical, PLLC is old or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Optimal Medical PLLC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to request that Optimal Medical, PLLC amend your protected health information. But Optimal Medical PLLC is not required to agree to amend your health information. If your request to amend your health information has been denied, you will be provided with an explanation of your denial reason(s) and information about how you can disagree with the denial.
    - You have the right to an accounting of disclosures of your protected health information made by Optimal Medical, PLLC.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices:

Optimal Medical PLLC reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such an amendment is made, Optimal Medical, PLLC is required by law to comply with this notice.

Optimal Medical, PLLC is required to maintain the privacy of your health information and to give you notice of its legal duties and privacy practice regarding it. If you have any questions about any part of these notices or if you want more information about your privacy rights, please contact: Request to speak to Compliance Manager by calling 865-690-1455. If they are not available, you may make an appointment for a personal conference in person or by telephone within two working days.

Complaints:

Complaints about your Privacy Rights, or how Optimal Medical, PLLC has handled your health information should be directed to the Compliance Manager by calling 865-690-1455. If they are not available, you may make an appointment for a conference in person or by telephone within two working days.

Office Address:
8906 Kingston Pike
Knoxville, TN 37923

If you are not satisfied with the way this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building Washington, DC 20201

Privacy Practice Acknowledgement of Receipt:

_____ _____

Patient Signature Date