Sampson Regen
REGENERATIVE MEDICAL CENTER

## Patient Demographics

Name: _____DOB:_____Today's Date: _____

Address:

_____

_____

**Email: _____ Phone Number: _____**
**Leave Message okay:** ☐ Yes ☐ No Text Reminders Okay: ☐ Yes ☐ No
Marial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Prefer not to answer
Occupation: _____

Emergency Contact Name: _____ Phone Number: _____
Email: _____Relationship to you: _____

Primary Care Physician: _____Phone Number: _____

Pharmacy Name: _____ Phone Number: _____
Pharmacy location: _____

How did you hear about us?
☐ Referred by provider
Provider Name: _____
☐ Referred by a friend or family member
Name: _____
☐ Google search ☐ AI Search ☐ Instagram ☐ Facebook
☐ LinkedIn ☐ Community event/seminar ☐ Podcast ☐ Existing patient
☐ Other_____

☐ By checking this box, I consent to receive practice-related emails from Sampson Regen, including appointment reminders, practice updates, and other important information, and I understand that I can opt out at any time.

## Patient Insurance

Insurance Name: _____

Member ID: _____ Group Number: _____

Effective Date: _____

Relationship to Insured: _____

## Medical History

**Medication**
Please list all prescription medications, over-the-counter medications, vitamins, supplements, and herbal products you are currently taking.
Medication Names and dose

_____

_____

**How would you rate your overall health** ☐ Excellent ☐ Good ☐ Fair ☐ Bad
**Weight:** **Height:**
**Do you currently use tobacco or nicotine products?**
☐ Yes ☐ No
How many per day? _____ For how many years? _____
Former smoker: ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
If yes: ☐ Occasionally ☐ Weekly ☐ Daily

**Allergies**
**Do you have any allergies?**
☐ Yes ☐ No
If yes, please check all that apply:
☐ Medications ☐ Latex ☐ Iodine/contrast Dye ☐ Adhesive Tape ☐ Food
☐ Environmental ☐ Other
Reaction: _____

**Previous Surgeries**
☐ Yes ☐ No
If yes, please list:

_____

_____

_____

**Family Medical History**
Has any immediate family member (parents, siblings, children) been diagnosed with any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Heart disease | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No |
| High blood pressure | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Autoimmune Disease | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No |

Other: _____

**Pregnancy (If Applicable)**
Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure ☐ Not Applicable
Are you currently breastfeeding? ☐ Yes ☐ No

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## Tell Us Your Story

**What brings you in today?**

**Which area is bothering you?** ☐ Right ☐ Left

☐ Neck ☐ Wrist ☐ Low back ☐ Ankle/foot
☐ Shoulder ☐ Upper back ☐ Hip ☐ Other_____
☐ Elbow ☐ Mid back ☐ Knee

**When did your symptoms begin?**

☐ Less than 1 week ago ☐1-6 weeks ago ☐ 3-6 months ago
☐ More than 6 months ago ☐ More than 1 year ago ☐ 4 – 10 years ago

**How did it start?**

☐ Sports injury ☐ Exercise ☐ Work injury
☐ Motor vehicle accident ☐ Fall ☐ Overuse injury
☐ No known injury ☐ Other_____

**Since it began...**

☐ Getting worse ☐ Unchanged ☐ Improving

**Tell us about your typical pain… 0 is no pain and 10 is the worst pain imaginable**

Average Pain 0–10:

**My pain is:**

☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Throbbing ☐ Stabbing ☐ Electric ☐ Tightness
☐ Pressure ☐ Clicking ☐ Catching ☐ Locking
☐ Popping ☐ Instability ☐ Weakness ☐ Numbness
☐ Tingling

My symptoms are

☐ Constant ☐ Intermittent

My pain travels to:

What makes it worse?

What makes it better?

**How Is This Affecting Your Life?**

Because of this condition I have difficulty with:

☐ Walking ☐ Running ☐ Sitting ☐ Standing
☐ Sleeping ☐ Driving ☐ Lifting ☐ Exercise
☐ Work ☐ Household chores ☐ Caring for family ☐ Sports
☐ Stairs ☐ Other_____

The activity I miss the most is:

My biggest goal is:

☐ Return to work ☐ Return to sports ☐ Return to the gym
☐ Play with my children ☐ Pick up my grandchildren ☐ Sleep comfortably
☐ Improve Mobility ☐ Avoid surgery ☐ Reduce pain medication
☐ Other _____

**Activity & Sports**

Do you regularly exercise? ☐ Yes ☐ No

How many days a week do you exercise? _____

Activities you participate in:

☐ Walking ☐ Running ☐ Hiking ☐ Weight lifting
☐ CrossFit ☐ Cycling ☐ Swimming ☐ Yoga
☐ Pilates ☐ Golf ☐ Tennis ☐ Pickleball
☐ Basketball ☐ Soccer ☐ Other _____

**Upcoming Plans**

Do you have any upcoming travel plans? ☐ Yes ☐ No

Destination (optional): _____Travel Dates: From _____ To _____

## Previous Treatment

**What have you tried?**

☐ Rest ☐ Ice ☐ Heat ☐ NSAIDs ☐ Tylenol
☐ Physical Therapy ☐ Home Exercises ☐ Chiropractic ☐ Massage
☐ Acupuncture ☐ Cortisone Injection ☐ PRP ☐ Bone Marrow Concentrate
☐ Shockwave ☐ Surgery ☐ Bracing ☐ Other_____

Which treatment helped the most?

**Imaging**

Have you had imaging?

☐ X-ray ☐ MRI ☐ CT ☐ Ultrasound ☐ EMG

Where?

When?

Do you have the images?

☐ Yes ☐ No

**About Your Visit**

What questions would you like answered today?

Is there anything else you'd like your provider to know before today's visit?

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## Medical Release From

**Authorization to Release Medical Information**

Patient's Name: _____

Date of Birth: _____/_____/_____

I request the following Information:

_____Imaging Diagnostic tests: ☐ MRI ☐ X-ray ☐ EMG ☐ CT

_____History

_____Records

_____Procedure/OP Notes

To be released to: Sampson Regen Regenerative Medical Center
Steven Sampson, D.O.
10780 Santa Monica Blvd Suite 210 Los Angeles, CA 90025
Phone (310)453-5404
FAX (310) 453-2535 ATTN: _____

Patient Signature: _____ Date: _____

Requesting from: _____ (name of Doctor or Facility)

Fax number _____ Phone number_____

## Out of Network Policy

Our practice is not contracted with any insurance companies and is considered an out-of-network provider for all insurance plans.

Payment in full is required at the time services are rendered. We do not bill insurance companies directly or accept assignment of insurance benefits.

As a courtesy, we will provide you with an itemized receipt (superbill) and any necessary documentation that you may submit to your insurance company for possible out-of-network reimbursement. Please note that reimbursement is determined solely by your insurance plan, and we cannot guarantee payment or coverage.

If you have questions regarding your out-of-network benefits, deductible, or reimbursement eligibility, we recommend contacting your insurance carrier prior to your appointment.

By signing below, I acknowledge that I have read and understand the practice's Out-of-Network Insurance Policy and agree to be financially responsible for all charges incurred.

Patient Name: _____ Date: _____

Patient Signature: _____

## HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

**1. Authorization**

I authorize Sampson Regen Regenerative Medical Center (healthcare provider) to use and disclose the protected health information described below to the follow person(s) _____ (individual seeking the information).

**2. Effective Period**

This authorization for release of information covers the period of healthcare from the below dates: _____ to _____ OR o all past, present, and future periods.

**3. Extent of Authorization**

☐ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of
alcohol or drug abuse).

☐ I authorize the release of my complete health record except for the following:

☐ Mental health records

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effective until date listed in item (2) above, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Patient/Guardian | Patient/Guardian Signature | Date |

If all categories declined above, please check below

☐ Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Privacy Practices for Sampson Regen Regenerative Medical Center.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Patient/Guardian | Patient/Guardian Signature | Date |

## AI-Assisted Documentation Consent

1. Purpose of AI-Assisted Documentation

Our practice uses a secure, HIPAA-compliant third-party technology tool (e.g., an AI medical scribe) to assist clinicians with documenting patient visits. This technology may listen to and/or transcribe conversations during your visit to help create accurate medical notes in your health record.

2. How the Technology Works

- The tool may capture audio of your visit and convert it into written clinical notes.
- The information is used solely for documentation and care purposes.
- The AI tool does not make medical decisions; your clinician reviews and finalizes all notes.

3. Privacy and Security

We take your privacy seriously and comply with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) and the California Confidentiality of Medical Information Act (CMIA).

- Any third-party technology we use is required to protect your information and only use it as permitted by law.
- We maintain appropriate agreements with vendors to safeguard your protected health information (PHI).

4. Recording and Consent

Because California is a two-party consent state, we will only use audio recording features with your permission. By signing below:

- You acknowledge that portions of your visit may be recorded and processed for documentation purposes.
- You understand that recordings (if any) are used only to generate clinical notes and are handled securely.

5. Voluntary Participation

Your participation is voluntary.

- You may decline the use of AI-assisted documentation at any time.
- Your decision will not affect your care or access to services.

6. Questions

If you have questions about how your information is used, please ask your provider or our staff.

Patient Acknowledgment and Consent

I have read and understand the information above. I consent to the use of AI-assisted documentation, including audio recording (if applicable), for my medical visit.

Patient Name (print): _____

Signature: _____ Date: _____

If signed by representative:

Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Decline AI-Assisted Documentation

☐ I prefer that AI-assisted documentation not be used during my visit.

## HIPAA 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 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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, 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 physician's practice, 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, 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 a hospital stay may require that your relevant protected health Information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:**

We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities Include, but are not limited to, quality assessment, employee review, training· of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-In sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the wailing room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of Interest to you.

We may use or disclose your protected health Information In the following situations without your authorization. These situations include 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, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, Inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon ·your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements under 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 the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action In reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS**

The following are statements of your rights with respect to your protected health information.

**You have the right to Inspect and copy your protected health Information (fees may apply)** -under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasoable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health lnformat10 restricted by law, information that Is related to medical research In which you have agreed to participate, Information hose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**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 and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications** -You have the right to request confidential communication 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 i.e. electronically.
You have the right to request an amendment to 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** -You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.
You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice, and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

**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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Office of Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza -Room 322
San Francisco, CA 94102

**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. We are also required to abide by the terms of the**

**notice currently in effect. If you have any question in reference to this form, please ask to speak with our HIPAA Compliance Officer In person or by phone at our main phone number.**

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.