Nathan Newman M.D.
Innovator of the Stem Cell Lift™

PATIENT INFORMATION

Name: Mr. Ms. Mrs. Dr. _____
First Middle Last

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Date of birth: ____/____/____ **Age**: _____
Month Day Year

Address: _____

City: _____ **State**: _____ **Zip code**: _____

Cell phone: _____ **E-mail:** _____

Home phone: _____ Work phone: _____

What is the best way to contact you? ☐ Cell phone ☐ E-mail ☐ Home phone ☐ Work phone

Occupation: _____ **Employer**: _____

EMERGENCY CONTACT INFORMATION:

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

E-mail: _____ **Phone**: _____

Allergies: ☐ None _____

Reason for visit: _____

How did you hear about us?

☐ Friend ☐ Physician Please specify: _____

☐ Google ☐ Youtube ☐ Instagram ☐ Facebook ☐ Yelp

☐ Other, please specify: _____

What did you search? _____

Office use only

Today's Date: _____

☐ Self ☐ Insurance

☐ Input Date: _____ Initials: _____

☐ Input Update: _____ Initials: _____

PATIENT HEALTH QUESTIONNAIRE

Please take the time to accurately complete the questions below as it will assist us in providing you with the best medical care. Your medical history is very important, as it helps to alert us of any potential problems that might interfere with your surgery.

HAVE YOU EVER OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS?

	YES	NO
Asthma / Shortness of breath		
Diabetes		
High blood pressure		
Heart problems / Chest pain		
Rheumatic fever		
Tuberculosis		
Severe headaches / Migraines		
Seizures		
Recurrent severe dizziness		
Eye or vision problems		
Recurrent abdominal problems		
Kidney or bladder problems		
Bleeding disorder/easy bruising		
Varicose leg veins		
Venereal disease (STD's)		
Hepatitis A B C		
HIV		
Cancer		
Periodontal disease		

	YES	NO
Do you smoke		
Do you use recreational drugs		
Problems with anesthesia		
Have any **blood relatives** ever had any problems with anesthesia		
Complications after surgery		
Do you wish correction of past surgical results		
Chronic skin condition		
Do you have any implants (pin, screw, plate)		
Problems with bones or joints		
Psychiatric treatment		
Have you ever had a colonoscopy		
Frequent urinary tract infections		
FEMALE ONLY		
Pregnant or trying to become pregnant		
Breast feeding		
Heavy periods/irregular menstrual cycle		
Have you ever had a mammogram		
When was your last PAP smear?		

Vaccinations for Covid-19 may impact services provided. Please state:

Brand of Vaccination	Date of 1st Shot	Date of 2nd Shot

Other medical history: _____

Past surgical history: _____

_____

Medications: _____

_____

Supplements: _____

_____ _____

Patient signature **Date**

PATIENT AGREEMENT & AUTHORIZATION
ASSIGNMENT OF BENEFITS

I hereby assign to American Advanced Medical Corporation and Dr. Nathan Newman all insurance benefits otherwise payable to me for treatment. I acknowledge that I am financially responsible for paying American Advanced Medical Corporation and Dr. Nathan Newman for services rendered to the extent the relevant insurer, plan or payer does not pay American Advanced Medical Corporation and Dr. Nathan Newman for such services in full. I authorize payment of benefits to American Advanced Medical Corporation and Dr. Nathan Newman for services named on claim. I understand that I am responsible for annual deductable, non-covered services, non-covered pre-existing conditions, co-payments, and all services categorized as "not medically necessary", "cosmetic" or "denied" for any reason by my insurance company.

This assignment of benefits is irrevocable with respect to any services performed by American Advanced Medical Corporation and Dr. Nathan Newman before I have given written notice of my decision to rescind this agreement. I understand that billing by your office will be done as a courtesy and every effort will be made to collect benefits from my insurance carrier(s). If after 30 days, my carrier has not responded, payment is due in full and I will be liable for all uncollected services.

In the event that insurance payment for services rendered to American Advanced Medical Corporation and Dr. Nathan Newman comes directly to me, I agree to pay such monies, by endorsing the insurance check, to American Advanced Medical Corporation and Dr. Nathan Newman within seven (7) days from the date I received payment. I further agree to provide to American Advanced Medical Corporation and Dr. Nathan Newman with a copy of the insurer's Explanation of Benefits form along with the payment rendered from the insurer. I understand that all delinquent accounts shall bear interest at the legal interest rate and that I will be responsible for all administrative, legal, and/or collection agency fees involved recouping any and all outstanding payments due.

I recognize that the physicians, furnishing services, including surgeons, pathologists, anesthesiologist, and the like, are independent contractors and are not employees or agents of American Advanced Medical Corporation and Dr. Nathan Newman and that as a result, the services provided will be billed by each of them independent of the surgery center. In addition, ancillary services, such as laboratory procedures and medications will also be billed by each such service independently.

RELEASE OF MEDICAL RECORDS

I hereby authorize American Advanced Medical Corporation and Dr. Nathan Newman to release to my insurance carrier(s) any information required to process my claims.

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I have received a copy of the Notice of Privacy Practices for Nathan Newman, MD and American Advanced Medical Corporation.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name of Patient/Guardian

AGREEMENT AS TO RESOLUTION OF CONCERNS

I, the "Patient/Guardian" named below, understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician. Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Academy of Dermatology and American Academy of Cosmetic Surgery. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Academy of Dermatology and American Academy of Cosmetic Surgery.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations. Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents. Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery. Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Should my account be referred to an attorney, or collection agency, I will be required to pay reasonable attorney's fees and all collection expenses. All delinquent accounts shall bear interest at the legal interest rate.

The undersigned certifies that he/she has read and understands the foregoing and accepts the terms.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name of Patient/Guardian

Communication by Email & Text Message

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with American Advanced Medical Corporation and/or the Orchid Outpatient Surgical & Medical Center, Inc. there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow American Advanced Medical Corporation and/or the Orchid Outpatient Surgical & Medical Center, Inc. to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient Signature _____ Date _____