Regenerative Spine & Joint Center

RECOMMENDED TREATMENT PLAN

Patient Name ____ Date ________________

Quantity		Amount	Total	Savings
_____	PRP Treatment (s)	@ ________	_________	_________
_____	Initial Consult	@ ________	_________	_________
_____	Office Visit (s)	@ ________	_________	_________
_____	Stem Cell (s)	@ ________	_________	_________
_____	Nutritional Consult (s)	@ ________	_________	_________
_____	Nerve Block (s)	@ ________	_________	_________
_____	Trigger Point Injection (s)	@ ________	_________	_________
_____	Nutritional Injection (s)	@ ________	_________	_________
_____	Rebuilder	@ ________	_________	_________
_____	B-12 Injections	@ ________	_________	_________

Plan Total _________ *Savings* _______

Prepaid Program __________

Finance Plan

Down Payment __________
Weekly/Monthly Payment __________

Signature __________________________________ Date ________________

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