STELMACK PINPOINT HEALTH CARE LLC

Date:_____/_____/_____

PATIENT INFORMATION

Name:_____ Date of Birth:_____/_____/_____
(Last) (First) (MI)

Responsible Party(If Different): _____ SSN: _____/_____/_____

Address:_____ Gender: M / F

City:_____ State:_____ Zip Code:_____

Primary Contact Number: (_____)_____-_____ Other: (_____)_____-_____

Email Address:_____

Emergency Contact (Name):_____ Relationship:_____

Emergency Contact Phone Number: (____)_____-_____

How did you hear about us? / Referral Name:_____

How would you like to receive appointment reminders? Home Cell Email Text

We are in network with: Blue Cross Blue Shield and Medicare. All other insurances will be processed as "out of network" and payment is expected at the time services are rendered.

Insurance Information

Company:_____ Effective Date:_____/_____/_____

Member ID#:_____ Group #:_____

Policy Holder's Name:_____ Policy Holder's Birthdate:____/____/____

Relationship to Insured:_____ Policy Holder's SSN: _____/_____/_____

DEMOGRAPHIC INFORMATION

Are you of Hispanic, Latino, or Spanish origin? (Mark ONE box.)

- ☐ Yes
- ☐ No, not of Hispanic, Latino, or Spanish origin

What is your race? (Mark one or more boxes.)

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other:_____
- ☐ Prefer not to answer

What is your preferred language?

- ☐ English
- ☐ Spanish
- ☐ Other:_____

Which of the following best describes you?

- ☐ Student
- ☐ Employed (full time / part time)
- ☐ Retired
- ☐ Other:_____

For Office Use Only: Assigned Patient Number:_____

Patient Policies: Doctor-Patient Agreements

Welcome to Stelmack Pinpoint Health Care, LLC

The purpose of these agreements are to allow us to serve you completely, getting the best results in the shortest amount of time. Experience has taught us that patients who adhere to agreements get the best results.

APPOINTMENTS/TREATMENTS/RECOMMENDATIONS/COMMUNICATION

MISSING OR CHANGING APPOINTMENTS

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required for us to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day, at the very least within a week so your treatment plan does not suffer severe interruption.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, progress evaluations and check-ups may take place. The fees for these services should be paid for according to the payment agreement which is in the Financial Agreements.

DIET AND FOOD SUPPLEMENTS

Diets should be followed and food supplements taken if recommended. Any problems you may have with these recommendations should be communicated.

UPSETS

We are here to serve you. Please speak with the doctor about any upsetting matter. We see your comments as helping us to help you and others.

HOURS

The doctors have specific office hours, the receptionist will schedule your appointments accordingly.

FINANCIAL AGREEMENTS

NOTE: IT IS OUR POLICY TO COLLECT CHARGES FOR SERVICES AS THEY ARE RENDERED

Goal: To assist our patients in the health care insurance process because your insurance policies are an arrangement between you and your insurance carrier and we want to facilitate that arrangement.

HEALTH INSURANCE OPTIONS/POLICIES –Check what option applies to you

(These are the options used on your account specific to the insurance information you provided)

_____Blue Cross/Blue Shield PPO – Stelmack Pinpoint Health Care, LLC is a network provider and will bill BCBS directly for services rendered in a timely manner. When benefits are determined, the patient will receive a statement from this office/clinic for the balance due on the account.

_____Medicare – Stelmack Pinpoint Health Care, LLC is a contracted Medicare provider. We will bill Medicare directly. Medicare only pays for chiropractic adjustments once the yearly deductible has been met.

_____Other Health Insurance – We are also in network with United Health Care, Aetna, Optum, Cigna, and a few others. Stelmack Pinpoint Health, LLC will bill your insurance for you, however, deductibles, coinsurance, and co-pays are collected at the time you receive treatment.

_____Private Pay – If you do not have insurance, you are responsible for all treatment/health care costs.

AUTHORIZATION FOR PAYMENT STATEMENT

_____I hereby assign the eligible benefits for my treatment/care to Stelmack Pinpoint Health Care, LLC

DATE_____ Patient Signature(Parent/Guardian)_____

Printed Name of Patient/Parent/Guardian:_____

STELMACK PINPOINT HEALTH CARE, LLC

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health, history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as**:**

1. A basis for planning my care and treatment
2. A means of communication among the many health professionals who contribute to my care.
3. A source of information for applying my diagnosis and surgical information to my bill.
4. A means by which a third party payer can verify that services billed were actually provided.
5. And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have a right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I many evoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

In consideration of your undertaking to treat me, I agree to the above authorization to release any information you deem appropriate concerning my physical condition for treatment, payment or healthcare operations.

STATEMENT OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO TREAT:

I understand that I am financially responsible for all services rendered to me, or my dependent, at Stelmack Pinpoint Health Care LLC. I hereby authorize Stelmack Pinpoint Health Care LLC or its successors to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf I understand that I am financially responsible for any remaining balance.

I further authorize my insurance company, if applicable, to direct payment to Stelmack Pinpoint Health Care LLC on my behalf.

I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan.

A photocopy of this assignment shall be valid and have the same effect as the original.

Date:_____ Patient's Signature_____

(or parent/guardian signature if applicable)

PATIENT CONFIDENTIAL MEDICAL INFORMATION

Name:_____ Date:_____

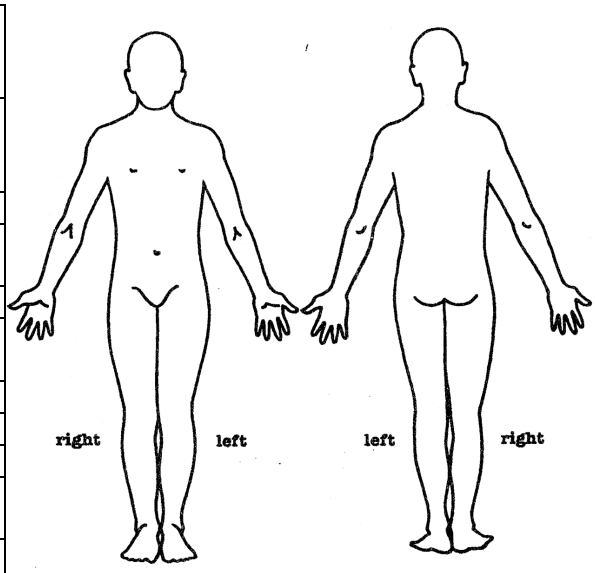
Is the reason you are coming in for treatment today a result of an accident? (work, auto, etc.) YES NO

If you answered YES to the previous question please provide the following information:

ACCIDENT INFORMATION
Date of accident:
Type of accident: [ ] Auto [ ] Work [ ] Home [ ] Other
To whom have you reported the accident to? [ ] Auto ins. [ ] Employer [ ] Worker's Comp. [ ] Other
Attorney Name and Contact Info (If Applicable)
Name/Firm Name:
Address:
City, State Zip:

PATIENT CONDITION

Reason for visit:
When did symptoms appear and how?
Is this condition getting progressively worse? [ ] Y [ ] N [ ] Unknown
Mark an "X" on the picture on the right where you have pain, numbness, or tingling.
Rate the level of pain on a scale from 1(no pain) to 10(severe pain):
Type of pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Aching [ ] Shooting [ ] Burning [ ] Tingling
[ ] Cramps [ ] Stiffness [ ] Swelling [ ] Other:
How often do you experience this pain?
Is it constant , or does it come and go?
Does it interfere with: [ ] Work [ ] Sleep [ ] Daily Activities [ ] Recreation [ ] Usual Sports [ ] Child Care
Activities or movements that are painful to perform: [ ] Sitting [ ] Standing [ ] Walking [ ] Bending [ ] Lying Down



MORE INFORMATION ABOUT CONDITION

What treatment have you already received for this condition? [ ] Medication [ ] Surgery [ ] Physical Therapy
[ ] Chiropractic Services [ ] None [ ] Other:
Name/Contact Information for other doctor(s) who have treated this condition (if applicable):
Name of primary care physician:
Date of Last: Physical Exam: Spinal X-Ray: Blood Test: Spinal Exam:
Chest X-Ray: Urine Test: Dental X-Ray: MRI, CT, Bone Scan:
Pap Smear / GYN: Prostate Exam: Colonoscopy:

SOCIAL HISTORY

Exercise/Type	**Work Activity**	**Sleep**
[ ] None [ ] Cardio [ ] Moderate [ ] Weights [ ] Daily [ ] Aerobic [ ] Heavy [ ] Yoga/Pilates	[ ] Sitting - #Hrs_____ [ ] Standing - #Hrs_____ [ ] Light Labor - #Hrs_____ [ ] Heavy Labor - #Hrs_____	Hours/Night_____ Sleep on: [ ]Back [ ] Side [ ] Stomach How many pillows? Type of Pillows:_____

STELMACK PINPOINT HEALTH CARE LLC

Patient:_____ DOB:_____ DATE:_____ FILE#:_____
Last, First MM/DD/YYYY MM/DD/YYYY

MEDICATION LIST

ALLERGIES:_____
_____

PRESCRIPTION MEDICATIONS

Medication Name	What do you use it for?	Dosage/Amount Taken per Day	Date Started

OVER THE COUNTER MEDICATIONS

Medication Name	What do you use it for?	Dosage/Amount Taken per Day	Date Started

SUPPLEMENTS/VITAMINS

Medication Name	What do you use it for?	Dosage/Amount Taken per Day	Date Started

STELMACK PINPOINT HEALTH CARE LLC

Patient:_____ DOB:_____ DATE:_____ FILE#:_____
Last, First MM/DD/YYYY MM/DD/YYYY

COMPREHENSIVE MEDICAL HISTORY

Name of General Practitioner:_____ Date of Last Examination:_____

Please check if you now, or ever, have experienced the following in each category:

CONSTITUTIONAL
1. ___Cancer
2. ___Allergies
3. ___Fever or Chills
4. ___Weightloss or Gain
5. ___Night Sweats
6. ___Fatigue
7. ___Insomnia/Sleep Changes
8. ___Other

ENDOCRINE
9. ___Diabetes
10. ___Thyroid Disease
11. ___Intolerance to Hot/Cold
12. ___Increased Thirst
13. ___Other

EYE, EAR, NOSE, THROAT
14. ___Glaucoma
15. ___Sinusitis
16. ___Poor Vision
17. ___Pain in Eye(s)
18. ___Deafness/Difficulty Hearing
19. ___Nosebleeds
20. ___Dental Problems
21. ___Hoarseness
22. ___Other

PULMONARY
23. ___Asthma
24. ___COPD
25. ___Tuberculosis
26. ___Pneumonia
27. ___Difficulty Breathing/ Shortness of Breath
28. ___Wheezing
29. ___Chronic Cough/Phlegm
30. ___Coughed Up Blood
31. ___Other

GASTROINTESTINAL
32. ___Appendicitis
33. ___Jaundice, Hepatitis, Cirrhosis
34. ___Ulcer
35. ___Gallbladder Disease
36. ___Colon Polyps
37. ___Hemorrhoids
38. ___Poor Appetite
39. ___Abdominal Pain
40. ___Black/Bloody Stool
41. ___Frequent Nausea/Vomiting
42. ___Frequent Heartburn
43. ___Frequent Bloating/Gas
44. ___Frequent Diarrhea/ Constipation
45. ___Difficulty Swallowing
46. ___Other

CARDIOVASCULAR
47. ___Heart Disease
48. ___High Cholesterol
49. ___High Blood Pressure
50. ___Stroke
51. ___Chest Pain
52. ___Irregular/Rapid Heart Beat
53. ___Fainting/Lightheadedness
54. ___Rheumatic Fever
55. ___Ankle Swelling
56. ___Varicose Veins
57. ___Other

BLOOD/LYMPH
58. ___Anemia
59. ___Bleeding Disorder
60. ___Enlarged Lymph nodes
61. ___Other

SKIN
62. ___Change in Mole
63. ___Itching or Rash
64. ___Other

DOCTOR'S COMMENTS:

Patient:_____ DOB:_____ DATE:_____ FILE#:_____
Last, First MM/DD/YYYY MM/DD/YYYY

COMPREHENSIVE MEDICAL HISTORY

GENITOURINARY
65. ___Kidney Disease/Stones
66. ___Urinary Infection
67. ___Sexually Transmitted Disease
68. ___Sexual Difficulties
69. ___Frequent/Painful Urination
70. ___Bloody/Discolored Urine
71. ___Incontinence
72. ___Other

NEUROLOGIC/PSYCH
73. ___Epilepsy/Seizures
74. ___Headache
75. ___Psychiatric Disorder
76. ___Weakness
77. ___Numbness/Tingling
78. ___Dizziness
79. ___Tremor/Twitching
80. ___Arm/Leg Pain
81. ___Depression/Anxiety
82. ___Other

MUSCULOSKELETAL
83. ___Fracture/Dislocation
84. ___Arthritis
85. ___Scoliosis/Spinal Curvature
86. ___Neck Pain
87. ___Upper Back Pain
88. ___Lower Back Pain
89. ___Swollen/Painful Joints
90. ___Other

MALE SPECIFIC
91. ___Prostate Disease
92. ___Testicular Pain/Swelling
93. ___Impotence/Erectile Dysfunction
94. ___Difficulty Urinating
95. ___Other

FEMALE SPECIFIC
96. Date Last Period Began: _____
97. ___Live Birth(s)
98. ___Miscarriage/Abortion
99. ___Painful Periods
100. ___Irregular/Heavy Periods
101. ___Brest Lump/Pain
102. ___Hot Flashes
103. ___Other

CHILDHOOD DISEASES
104. ___Measles
105. ___Mumps
106. ___Chicken Pox
107. ___Other

TRAUMA
108. ___Motor Vehicle Accident
109. ___Other

HOSPITALIZATION/SURGERIES
110. _____
111. _____

SOCIAL HISTORY
112. ___Smoke/Tobacco Use
113. ___Alcohol Use
114. ___Recreational Drug Use
115. ___Sexually Active With Multiple Partners
116. Married/Partnered?_____
117. Occupation: _____
_____

FAMILY HISTORY
118. ___Kidney Disease
119. ___Heart Disease/Stroke
120. ___High Blood Pressure
121. ___Cancer
122. ___Thyroid Disease
123. ___Diabetes
124. ___Neurological Disease
125. ___Musculoskeletal Disease
126. ___Psychiatric Disease
127. ___Other

DOCTOR'S COMMENTS: