STELMACK PINPOINT HEALTH CARE
THE OFFICE OF DR. ZACHARY STELMACK, D.C.

# Patient Health Summary

**Patient Name: _____ Birthdate: _____/_____/_____ Sex: M F**

**Address: _____ City:_____ State:_____ Zip:_____**

**CIRCLE which telephone # to leave appointment reminders or health related messages:**
**Home: _____ Work: _____ Cell: _____**

**Do you give permission to: _____ Leave Health Related Messages? _____ Send Text Messages?**

**___Married ___Single ___Partner ___Widow/Widower Number of kids _____**

**Email Address: _____**

**Parent/Guardian/Caregiver Name (for minor patient):_____ Phone: _____**

**Insurance Carrier(s):_____ Policyholder's Employer:_____**

**Policyholder's Name:_____ Policyholder's Birthdate:_____**

**Emergency Contact Name: _____ Phone Number:_____**

**Primary Care Physician: _____ PCP Phone: _____**

**Have you had chiropractic care before? Yes___ No___ If yes, for what issue? _____**
**_____**
**_____**

**Whom can we thank for referring you to this office? _____**

**Date Symptoms Began: _____ Describe your current problem and how it began: _____**
**_____**

**Do you perform any repetitive movement in your work, sports, or hobby? ___Yes ___No**
**If yes, please describe_____**

**Is Your Current Problem? : ___Work Related ___Auto Accident Related ___Personal Injury ___None**

**Current Pain Level TODAY** (0 = No Pain and 10 = Unbearable Pain):_____

**In the past week, how much has your pain interfered with your daily activities** (work, social activities, household chores)? (0= No interference to 10 = unable to carry on any activities):_____

**Do you exercise? ___Yes ___No What & How Much? _____**

**Do you drink Alcohol? ___Yes ___No How many per day? _____ How many ounces of water do you drink per day? _____ Do you drink Caffeinated Beverages? ___Yes ___No How many per day? _____**
**Family History:** ___Cancer ___Diabetes ___High Blood Pressure ___Heart/Stroke ___Rheumatoid Arthritis
Other: _____

**Signature:_____ Date:____/____/_____**

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**Please list ALL MAJOR past illness/injuries** (concussions, head injuries, cancer, broken bones, high blood pressure, car accidents, work related, etc.) **you have had which did or did not require hospitalization, please include dates:**

_____
_____
_____
_____
_____

**Please list ALL major surgeries/operations.** List when and where done and the name of the surgeon and if you have any remaining problems associated with these procedures.

_____
_____
_____
_____
_____

**Please list ALL medications & nutritional supplements** (including birth control pills, aspirin, vitamins, minerals) **even if only occasionally**. Include how often, dosage and how long you have been taking it.

_____
_____
_____
_____
_____

**Please check any condition listed that applies to you: ___Contagious Skin Condition ___Open Sores/Wounds ___Easy Bruising ___Decreased Sensation ___Phlebitis ___Blood Clots ___Headaches/Migraines ___Sprains/Strains ___Swollen Glands ___Osteoarthritis ___Tendonitis ___Varicose Veins ___Fibromyalgia ___Fever ___Atherosclerosis**
**Are you allergic to anything** (medications, food, oil, lotion, etc.)? Yes____ No____ If yes, what?
_____
_____

**Do you smoke?** Yes_____ **How much? _____ How Long? _____** No _____

**Women only:**
Are you pregnant or think you might be pregnant? _____
Date of last menstrual period: _____
Do you or have you suffered from any menstrual disorders? ___Yes ___ No
If yes, please describe:
_____

**Signature:_____ Date:____/____/_____**

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# Notice of Privacy Practices (HIPAA) and Release Authorization

We would like to make you aware of how your Patient Health Information (PHI) is going to be used in this office, and your rights concerning that information and your health records. A full and complete Notice of Privacy Practices is posted on our practice website or can be requested from the office.

1) You, the patient, agree to allow our office to use your PHI for the purposes of treatment, payment, healthcare operations, and coordination of care. Examples include but are not limited to submission of PHI to third party insurance payers, and referring physicians. Our office will limit the release of all PHI to the minimum required information necessary.

2) You, the patient, have the right to examine and obtain a copy of your own health record at any time and request corrections. You may request to know what disclosures have been made and submit in writing any restrictions on the use of your PHI. Our office is not obligated to agree to those restrictions.

3) Your, the patient's, written request shall only need to be obtained one time for all subsequent care given from this date forward in this office.

4) You, the patient, may provide a written request to revoke consent at any time during care. This would be applicable from the date the request was received forward, but not to dates prior.

5) All staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce these procedures in the office. We have taken all precaution to insure your records are not readily available to those who do not need them.

6) You, the patient, have a right to file a formal complaint with Stelmack Pinpoint Health Care about any possible violations of these policies and procedures.

7) If you, the patient, refuse to sign this consent for the purposes of treatment, payment and healthcare office operations, our office has the right to refuse care.

## Authorization to Release Information:

**I authorize Stelmack Pinpoint Health Care to release any information including diagnosis and records of examination or treatment rendered to me to third party payers and/or health practitioners.**

**Stelmack pinpoint Health Care and/or members of the staff may contact me regarding appointments reminders, information regarding treatment alternatives, or other health related information. If contact is made by telephone, a message may be left on the voice mail or answering machine.**

**I authorize and request my insurance carrier to pay directly to the chiropractor any insurance benefits otherwise payable to me unless other arrangements have been made with the doctor or staff (i.e. Medicare patients). I agree to be responsible for payment of all services rendered to me (or my dependent).**

**I certify that I have read and understand the above information and agree to these policies and procedures.**

| _____ | _____ | _____/_____/_____ |
|---|---|---|
| **Signature** | **Relationship to Patient** | **Date** |

STELMACK PINPOINT HEALTH CARE
THE OFFICE OF DR. ZACHARY STELMACK, D.C.

600 Hillgrove Ave Suite # 3
Western Springs, IL 60558
T: 708.246.6611
F: 708.246.6689

# FINANCIAL POLICY

Thank you for choosing Stelmack Pinpoint Health Care as your chiropractic physician office. We are committed to providing you and your family with the best chiropractic care. In our ongoing process to make sure that all your needs are met, our billing department will be available to discuss fees and this policy with you.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard and Discover. As a courtesy to you, it is our policy to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

**(Please initial the following)**

___ 1. Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges. As your medical provider, we will only supply factual information to facilitate claim processing.

___ 2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time service. Returned checks and unpaid balances may be subject to collection placement and collections fees.

___ 3. All charges are your responsibility whether your insurance carrier pays or does not pay. If your insurance does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Stelmack Pinpoint Health Care, you recognize the obligation to promptly remit payment to this office.

___ 4. You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney, you will be responsible for all the costs of collecting monies owed, including court costs, collection fees and attorney fees.

___ 5. The above does not apply for those patients that are considered Workers' Compensation or Auto Accident claims. However, be advised that as a compensation or MVA patient, you may be held responsible for charges in the event that your claim is controverted.

___ 6. We ask that you provide us with 24 hour notice of cancelled appointments, failure to do so will result in a $25 fee. **You acknowledge this $25 fee will be incurred if you miss an appointment and do not provide 24 hour notice.**

We understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing.

I have read and understand the above information and will be responsible for the patient listed below.

Print Name of Patient: _____ Date of Birth: _____/_____/_____

_____ _____/_____/_____

Signature of Patient or Responsible Party Date

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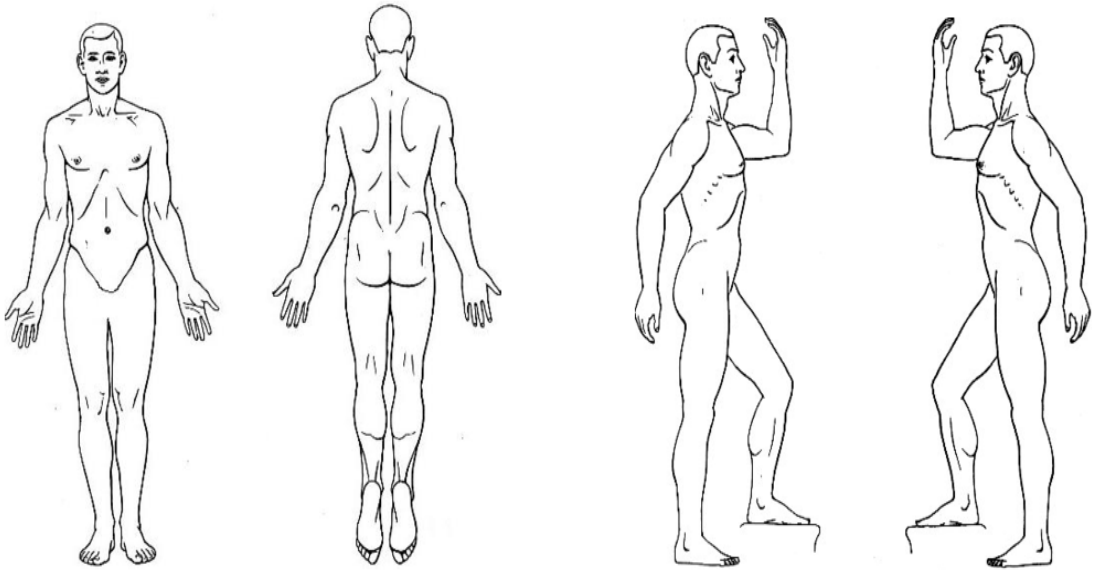
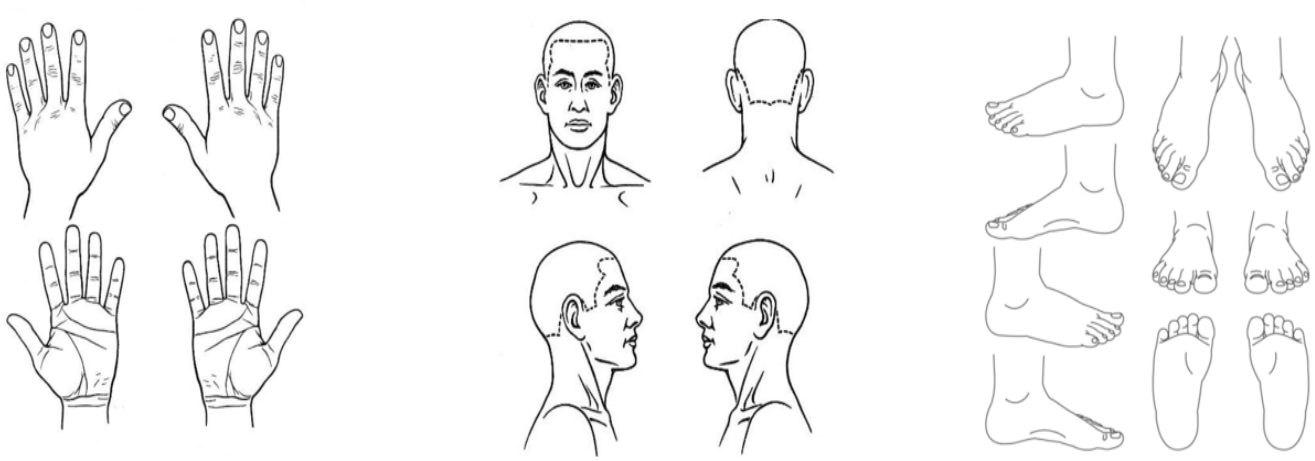
Use the appropriate symbol(s) listed below.

| | | |
|---|---|---|
| ACHING XXXX<br>XXXX | NUMBNESS ====<br>==== | PINS AND 0000<br>NEEDLES 0000 |
| BURNING >>>><br>>>>> | STABBING ////<br>//// | THROBBING ++++<br>++++ |



HEADACHES ↓



**Signature:**_____ **Date:**____/____/_____

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6) You, the patient, have a right to file a formal complaint with Dr. Sarah Kelly about any possible violations of these policies and procedures.

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**I certify that I have read and understand the above information and agree to these policies and procedures.**

_____ _____ _____/_____/_____

**Signature** **Relationship to Patient** **Date**