Stiso Chiropractic & Acupuncture **Frank R. Stiso, DC, LLC**
1903 Atlantic Avenue, Wall NJ 08736 Confidential Case History

BE AS DETAILED AS POSSIBLE. DO NOT LEAVE BLANK ANSWERS. WRITE N/A OR DON"T KNOW

Date:___/___/___ Name _____ Address _____

City_____ State___ Zip_____ Soc.Sec.#___-_____-_____ Birthday: ___/___/___ Age:_____

Marital Status: S or M Spouse's Name:_____ Spouse/Emergency Contact#: (___)_____

Height:_____ Weight:_____ Occupation:_____ Job duties:_____

Employer (name/ address): _____ Work Telephone #: (___)_____

Home Phone (___)_____ Cell (___)_____ Email:_____

Allow Appointment Reminders via Test Message ☐Yes ☐No Cell Phone Carrier: _____

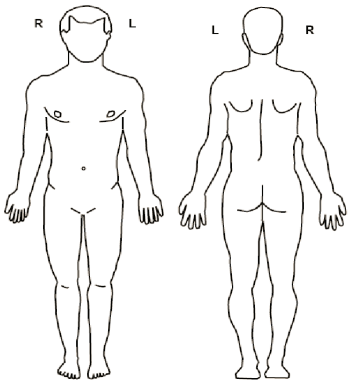
How did you hear about our office? ☐ Referred by another physician ☐ Insurance "Find a Provider" ☐Google
☐ Social Media ☐Friend (name) _____ ☐ Other _____

DETAILED description of symptoms: _____

_____

_____

Place an X over area(s) of pain →



How did it occur? _____

How long has this been going on? _____

Other Dr.'s seen for this condition:_____

Is this a ☐work or ☐automobile related injury? If so, EXPLAIN: (date & place..etc)

_____

Rate your pain on a scale from 1-10 (Circle One) **10 = Most Painful** **1 2 3 4 5 6 7 8 9 10**

Pain wakes you up at night? **Yes No** Any unexplained weight loss/gain? **Yes No** Dizziness/ fainting? **Yes No**

Check those that best describe your condition:

☐ Dull	☐ Burning	☐ Pins/Needles
☐ Sharp	☐ Cold	☐ Electric Shock-like
☐ Achy	☐ Cramping	☐ Pulsating
☐ Stiff	☐ Knifelike	☐ Constant
☐ Tight	☐ Shooting	☐ Comes & Goes
☐ Numb	☐ Pinching	☐ Occasional
☐ Weak	☐ Migraine	☐ No Pattern

Your past medical history. Mark all that apply:

☐ Cancer	☐ HIV / AIDS
☐ Diabetes	☐ Heart disease / Stroke
☐ Kidney disease	☐ Hypertension
☐ Musculoskeletal disorders	☐ Do you smoke tobacco
☐ **Pace Maker**	☐ **Spinal surgery**
☐ Implant:_____	☐ Other:_____

☐ Alcohol Use: ☐rarely ☐occassionally ☐daily

* Primary Care Doctor Name & Address: (REQUIRED)_____

Past major surgeries, broken bones, illnesses etc: _____

_____

Previous Chiropractor: (Name, Town & State):_____

Current medication(s): _____

FEMALE PATIENTS ONLY: Are you currently or do you have any reason to believe you are pregnant? **Yes No** Has it been more than 10 days since the start of your last menstrual cycle? **Yes No** How many children have you birthed_____? Did you receive an epidural? **Yes No** Were there any complications? **Yes No** If yes please explain:_____

HEALTH INSURANCE INFORMATION:

Primary Insurance Name:_____ Policy #:_____

Name of insured & date of birth?_____ Relationship to insured?_____

Secondary Insurance Name:_____ Policy #: _____

Name of insured & date of birth?_____ Relationship to insured?_____

CHIROPRACTIC COVERAGE RESPONSIBILTY & REFERRALS:

You the patient are responsible for checking with your insurance company to verify chiropractic coverage before treatment begins. Our staff will also call your carrier to verifying coverage. However verification of coverage is not a guarantee of payment. **If you, or our staff, receive inaccurate coverage details from your insurance carrier you the patient are still financially responsible for ALL services rendered.** In addition, patients are responsible for obtaining all referrals (if needed). Referrals must be presented to the front desk before you are seen by the doctor. DO NOT expect your primary care physician to "back-date" your referral. If treatment is not covered by your insurance because a referral was not obtained, you the patient will be responsible for payment.

Co-Payments are due at the time chiropractic services are rendered. Insurance companies forbid the waiving of deductibles or co-payments by healthcare providers. Co-Insurance must be paid in full.

MEDICARE PATIENTS: ADVANCED BENEFICIARY NOTICE (ABN)

Medicare only pays for the chiropractic adjustment. **Medicare does NOT pay for chiropractic physical examinations, X-rays or adjunctive physiotherapies** such as, but not limited to, electric muscle stimulation, ultrasound, cold laser therapy, traction… etc. The fact that Medicare will not pay for certain services does not mean that you should not receive them. By signing this case history, you accept financial responsibility for any non-covered services rendered by Dr. Stiso.

ASSIGNMENT OF BENEFITS: I understand that health and auto accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me and/or my attorney (if applicable, charges may apply). In making collection or settlement from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I irrevocably authorize, direct and instruct my attorney (if applicable) to make payment to Dr. Stiso from my settlement, fees due, to his office as mandated within the PIP fee schedule. Furthermore I authorize assignment of benefits to this office and allow Dr. Stiso and staff the right to appeal any claim denials from my insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am ultimately responsible for payment.

Furthermore, I understand that if I am accepted as a patient at the Stiso Chiropractic Center, I am authorizing Dr. Stiso to proceed with any standard treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request. I am aware it is my responsibility to make it known, or to learn through health care procedures, the existence of underlying conditions that would otherwise not come to the attention of the treating chiropractor. Conditions include, but are not limited to: latent pathological defects, skin damage, illnesses or deformities.

I hereby attest all information given is true and agree to all office policies listed above.

Patient's Signature_____ Date: _____

Guardian's or Spouse's Signature:_____ Soc. Sec. #:_____

BELOW IS FOR OFFICE USE ONLY

ICD Codes 9:

_____
_____
_____
_____
_____

ICD Codes 10:

_____
_____
_____
_____
_____

Exam: 99201 99202 99203 99204
X-ray: 72040 72070 72100 72114

Manip: 98940 98941 98942 98943
Modal: G0283 97032 97140 97012
97026 97110 97039 97032

_____
_____
_____
_____
_____
_____

Frank R. Stiso, DC, LLC & BrainCore of Manasquan LLC

1903 Atlantic Avenue, Bldg B Suite 2, Manasquan NJ 08736

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The *Notice of Privacy Practices* has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for Frank R Stiso DC LLC and/or BrainCore of Manasquan LLC to provide treatment to me, and also for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.

2. Frank R. Stiso, DC, LLC and/or BrainCore of Manasquan LLC reserves the right to change its privacy practices that are described in its *Notice of Privacy Practices*, in accordance with applicable laws.

3. I understand that, and consent to, the following appointment reminders and/or birthday cards that will be used by the Practice: a) a postcard mailed to me at the address provided by me, and b) telephoning, texting or emailing me at any of the contact numbers supplied to Dr. Stiso by me as well as leaving a message on my answering machine/voice mail or with any individual answering the phone that may or may not include personal and/or medical information.

4. I authorize this office to receive, use and/or disclose my PHI and all insurance information in order for Frank R. Stiso, DC, LLC and/or BrainCore of Manasquan LLC to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations. My PHI may be viewed and shared by all of the doctors practicing here at this office as well as Dr. Stiso's Colonia office (Frank A. Stiso, DC, PA).

5. I understand that I have a right to request that Frank R. Stiso, DC, LLC and/or BrainCore of Manasquan LLC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the *NOTICE OF PRIVACY PRACTICES*, then Dr. Stiso will not treat me.

I have read and understand the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

Print Name: _____

Signature: _____ Date Signed: _____

Signature of Legal Representative (Parent, Guardian, etc.): _____