Stiso Chiropractic, Acupuncture & Massage **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 :_____ Age:___

Address: _____ City:_____ State:___ Zip___

Date of birth:___/___/___ Soc.Sec.#___-___-___ Email:_____

Height___ Weight:___ Marital Status: S / M Phone #(___)_____ Cell# (___)_____

Employer:_____ Occupation/Job duties:_____

Emergency Contact Name:_____ Tel (___)_____

Appointment reminders via text message: ☐Yes ☐No. Mobile Carrier: _____

How did you hear about our office? ☐ Referred by PCP ☐ Insurance Provider List ☐Google ☐ Newspaper/TV
☐ Referred by a friend (name)_____ ☐Other _____

What is your major complaint? (**DETAILED description**) _____

_____

_____

Date Symptoms began: _____ How did it occur? _____

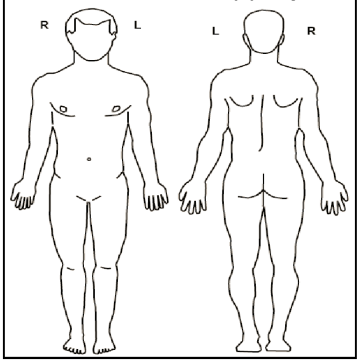
_____

Other Dr.'s seen for this condition:_____

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

_____

Place an X over area(s) of pain



Rate your pain 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** or **No** Any unexplained weight loss/gain? **Yes** or **No** Dizziness/ fainting? **Yes** or **No**

Check those that best describe your condition:

☐ Dull	☐ Burning	☐ Pins/Needles
☐ Sharp	☐ Migraine	☐ Electric Shock-like
☐ Achy	☐ Cramping	☐ Pulsating
☐ Stiff	☐ Knifelike	☐ Muscle Weakness
☐ Pinching	☐ Shooting	☐ Numb

Worse after: ☐Standing ☐Sitting ☐Rising from chair
☐Activity ☐Resting ☐Lifting ☐Bending ☐Reaching
Symptoms are: ☐Constant ☐Comes & Goes

Your past medical history. Mark all that apply:

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

Tobacco Use ☐ Yes ☐ No ☐ Quit _____(date)

Alcohol Use: ☐ Never ☐ Occassionally ☐ Daily

Other:_____

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

Past major surgeries, broken bones, illnesses etc: _____

_____

Previous Chiropractor Name & Town: _____

Current medication(s): _____

FEMALE PATIENTS ONLY: Are you currently or do you have any reason to believe you are PREGNANT? **Yes** or **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**. Labor complications? _____

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? _____

PATIENT RESPONSIBILTY, INSURANCE & OFFICE POLICIES

Patients are responsible for checking their insurance coverage and obtaining a referral (if needed) before treatment begins. Our staff will also call your carrier to verify coverage. However, verification of coverage is not a guarantee of payment. If you, or our staff, receive inaccurate coverage details, or if your coverage changes or is canceled during the course of your treatment, you, the patient, are still financially responsible for ALL charges.

Insurance companies contractually forbid the waiving of deductibles, co-payments and/or co-insurance by healthcare providers. **Co-Payments are due at the time services are rendered.** Patients with high deductible policies are subject to a minimum payment of $75 on the initial visit and $40 each additional, at the time of service.

Appointment cancellations require prior notice, by phone, or a $30 "no show" charge will apply for the time reserved.

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, traction…etc. The fact Medicare will not pay for these services does not mean they are unnecessary. By signing this case history, you affirm you have been made aware of the cost and accept financial responsibility for any non-covered services rendered.

ASSIGNMENT OF BENEFITS: I understand that health and auto accident policies are an arrangement between my 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, I am authorizing Dr. Stiso to proceed with any standard treatment that may be necessary. 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 practitioner. Conditions include, but are not limited to: latent pathology, defects, skin damage, illnesses, implants, deformities or pregnancy.

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

Patient Name (print):_____

Patient or Guardian's Signature:_____ Date:_____

BELOW IS FOR OFFICE USE ONLY

CPT CODES

99201	99202	99203	99204
72040	72070	72100	72114
98940	98941	98942	98943
97032	97140	97012	G0283
97026	97110	97039	97032

TX: ____x/wk. _____ wks

ICD 10 REFERENCE

M99.01	M99.02	M99.03	M99.04	M99.05	M99.06	M99.07
M54.13*(723.3)*	M54.6*(724.1)*	M54.5*(724.2)*	M53.2X7*(724.6)*	M46.1*(unsp)*	M25.561*(R)*	M25.511*(right)*
M50.220*(722.0)*	M51.24*(722.11)*	M51.26*(722.10)*	Q76.2*(756.12)*		M25.562*(L)*	M25.512*(left)*
G44.52*(307.81)*	M51.34*(722.51)*	M51.37*(722.52)*	M54.17*(radic)*			M26.60(TMJ)
G24.3*(torticollis)*	M54.13(723.4)	M54.32*(724.3L)*				**M99.08**
S13.4XXA*(S/S)*	M54.31*(724.3R)*	S33.5XXA*(S/S)*		M62.830(728.85)		G55*(353.8)*
	G54.0 *(TOS)*					

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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

1903 Atlantic Avenue, Bldg B Stuite 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: _____

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

Relationship: _____

Date Signed: _____ Witness: _____