FIRST NAME	MIDDLE INITIAL	LAST NAME		
ADDRESS		CITY	STATE	ZIP
TODAY'S DATE	PHONE NUMBER			
ALTERNATE CONTACT #	MAY WE LEAVE A MESSAGE?			

BIRTH DATE	AGE	# OF CHILDREN	E-MAIL ADDRESS

MARITAL STATUS M☐ S☐ W☐ D☐	SEX M☐ F☐
OCCUPATION	EMPLOYER

EMPLOYER'S ADDRESS	CITY	STATE	ZIP

EMPLOYER'S PHONE NUMBER	YEARS EMPLOYED
SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH
SPOUSE'S EMPLOYER	SPOUSE'S OCCUPATION

PERSON RESPONSIBLE FOR THIS ACCOUNT
HOW DID YOU HEAR ABOUT DR. SCHULTZ?
WHAT IS YOUR MAJOR CONCERN?
OTHER CONCERNS OR ISSUES
HOW LONG HAVE YOU HAD THIS CONDITION?
HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST?
WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?
IS THIS CONDITION INTERFERING WITH YOUR: WORK☐ SLEEP☐ DAILY ROUTINE☐ OTHER☐ (PLEASE EXPLAIN)
HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD?

PLEASE CONTINUE ON OTHER SIDE

List surgical operations:	
Are you taking any medications?	If yes, please list them on the enclosed Drug List
Are you taking any non-prescription Supplements?	If yes, please list them on the enclosed Supplements List
Other doctors seen for this condition: MD ☐ DC ☐ DO ☐ DDS ☐ Other ☐	
Doctor's Name	
Diagnosis	
Treatment	
Results	
Length of time under care	
Were you off work?	If so, how long?
Have you returned to your same job?	If not, why?
List Allergies:	
Other Info:	

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I am also responsible for payment for any missed appointment for which I have not given 24 hours' notice. I understand Dr. Schultz is not responsible for writing letters or explaining "medical necessity" to insurance carriers. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature ______________________ Date ______________

updated 3/3/2011

Center for Health and Healing, S.C.
Fred James Schultz, M.D., F.A.A.F.P
FAMILY PRACTICE
2150 Manchester Road • Wheaton, IL 60187
Phone: (630) 933-9722 • Fax: (630) 933-9724

PATIENT INFORMATION RELEASE FORM

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PERSONS OTHER THAN YOURSELF.

I. DISCLOSURE AUTHORIZED

☐ I do not give my permission to release my health information to anyone other than myself or my insurance carrier.

Or, if you give permission, please indicate the extent by checking one or both of the following options:

☐ You may discuss my health care with the following people:

☐ You may forward my health records to the following people:

Name______________________________ Relationship__________________________

Name______________________________ Relationship__________________________

Name______________________________ Relationship__________________________

II. INFORMATION FOR PATIENT AUTHORIZING CONSENT

Name____

Signature_____________________________________

Date Of Birth___________________________________

III. DURATION OF AUTHORIZATION

This authorization is valid until you notify our office of your decision to revoke it.

Center for Health and Healing, S.C.
Fred James Schultz, M.D., F.A.A.F.P.
2150 Manchester Road · Wheaton, IL 60187

Private Contract between Physician and Patient

This agreement is between Fred J. Schultz, M.D. ("Physician"), whose principal place of business is 2150 Manchester Road, Wheaton, IL, and patient ______________________________ ("Patient"), who resides at ____ .

Physician has informed Patient that Physician has opted out of the Medicare program effective on 04/01/09 for a period of at least two years and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"): Evaluation & Management, Consultation and Professional Component Services. In exchange for the Services, the Patient agrees to make payments directly to Physician at the time of service, pursuant to the Physician's current fee schedule.

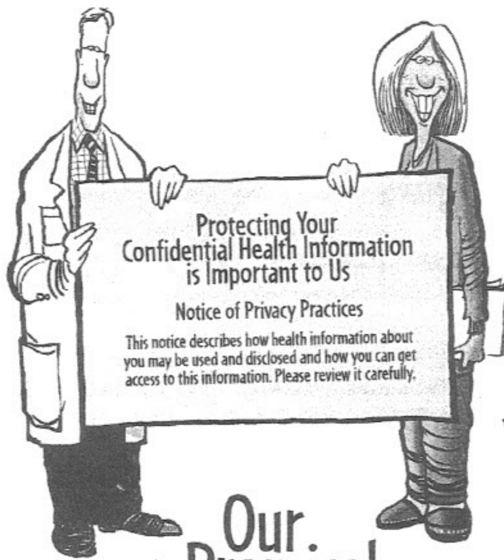
Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician or staff submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that MediGap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he or she has a right, if a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the patient is not compelled to enter into private contract that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
- Patient agrees to be responsible to make payment in full for the Services and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient agrees not to request that Physician or staff submit a claim to a secondary carrier.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him or her.
- Patient agrees to reimburse Physician for any costs and reasonable attorney fees that result from violation of this Agreement by Patient or his beneficiaries.
- Patient with Medicare Part B as a secondary insurance carrier may submit Statement of Services to their private insurance company for possible out-of network level reimbursement.
- Patient without Medicare Part B coverage but with coverage from a private carrier may submit Statement of Services to their private insurance company for possible out-of-network level reimbursement.

Executed on ________________ (date) _______ (Staff initials)

____ (Patient signature)

____ (Physician signature)



Our Promise!

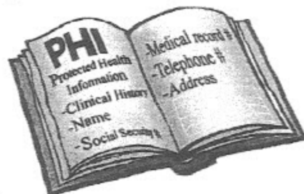
Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

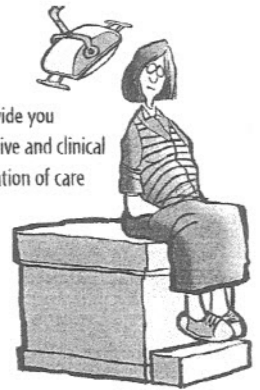
We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.



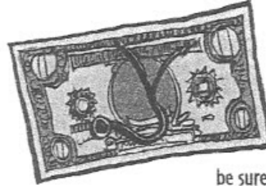
We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment



We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

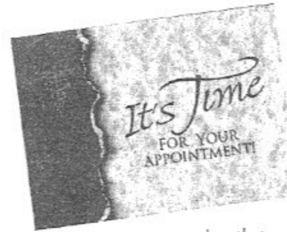


To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.



In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

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For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):______________________________

____

____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

____
Patient Signature
Date:______ /______ /______

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

#FM-0305 • Printed in U.S.A.

Center for Health and Healing
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Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices information and I have been provided an opportunity to review it.

Name:____

Date of Birth:____________________

Signature:____

Today's Date:____________________