WELCOME

Thank you for selecting The Maple Center for your care.
Office of Kathleen Stienstra, MD. Please fill out this form completely.
If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information

Name_______________________________________ Prefer to be called ______________________

Date____________________ Birth date_______________ Soc. Sec # __________________________

Address____

City, State, Zip ____

Occupation________________________ Employer _______________________________________

Work Phone___________________ Ext. __________ Home Phone ___________________________

Cell Phone ______________________ E-mail ____

Gender: Male /Female Language of Choice:_______________ Name of PCP_______________

In the event of emergency, who should we contact?

Name ___________________________________ Relationship _______________

Work # _________________ Home #____________________ Cell phone # _____________________

Responsible Party for the account if not same as above

Name ___________________________________ Relationship to patient _____________________

Birth date____________________ Soc. Sec. # ____

Address ____

City, State, Zip ____

Occupation________________________ Employer _______________________________________

Employer Address____

Work # _________________ Home #____________________ Cell phone # _____________________

Authorizations and Release

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly any assigned insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual billed services; I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____
Signature of patient or parent if minor Date

Pharmacy of Choice _______________ Mother's Maiden Name___________________

The Maple Center Health History

This information is confidential and will not be released without written authorization.

Name____Age__________

What are your health concerns? ____

____

Allergies____

Current Medications (include non prescription & supplements)____________________

____

____

____

Surgeries (include your age and/or date)_________________________________

____

Other hospitalizations, reason, age and/or date______________________________

____

Infections (circle those you have had): Hepatitis Rheumatic Fever TB HPV Pneumonia Herpes Gonorrhea Chlamydia Syphilis Mumps Chickenpox Measles Bladder or Kidney

Medical Illness (circle those you have had): High blood pressure Diabetes Heart Disease Cancer Arthritis Thyroid Disease Depression Other______________________

Broken bones or serious injury____

Immunizations (circle if you've had): Pneumovax Prevnar Influenza Chickenpox 2nd MMR Hepatitis B Hepatitis A HPV DPT Menactra (meningococcus) Polio Shingles

Tetanus-did it include pertussis/whooping cough? (last given)__________ Other______________

When did you last have these screening tests? Physical_________ Rectal (>40 yrs)_________

Colonoscopy (>50 yrs)_________ Stool Blood Cards (>50 yrs)_________ Cholesterol_________

WOMEN ONLY

Are you possibly pregnant or breastfeeding? Y N

Did your mother take hormones (DES) when pregnant with you? Uncertain Y N

Ever have an abnormal PAP smear? Y N

Age at 1st period_____ 1st day last period_______ Last PAP________ Last Mammogram_________

Problems with periods or premenstrual symptoms?______________________________

Pregnancies_______ Vaginal______ Cesarean______ Miscarriages______ Abortions______

CHILDREN ONLY

Birth weight____________ Vaginal delivery or C-section?____________________

Complications with pregnancy or delivery?____________________________________

Development: At what age did child roll over______ sit alone_______crawl______first word_____

Water supply source (circle): City water Well Bottled water

How did you find out about our office? ____________________________________

Who else is on your "healing team" – other health care providers?__________________

____

Circle those you ***now*** have or that have been ***significant*** problems in the past.

Fever or chills
Weight change in past 6 months
Fatigue
Headaches
Seizures or convulsions
Fainting or passing out
Dizziness
Vision problems
Earaches
Hearing difficulties
Ringing in ears
Nosebleeds
Sinus problems
Trouble with teeth or mouth
Hoarseness, prolonged
Breast lump or discharge
Chronic or frequent cough
Coughed or vomited blood
Night sweats
Chest pain
Palpitations
Amnesia

Heart murmur
Swelling of ankles
Nausea
Jaundice
Indigestion or heartburn
Peptic ulcer
Constipation or diarrhea
Abdominal pain
Bloody or tarry stools
Change in size, shape, or color of bowel movement
Pain or frequent urination
Waking at night to urinate
Control of urine
Difficulty in starting urine
Blood in urine
Discharge from penis
Sexual problems
Vaginal discharge or itching
Inability to have children
Joint pains
Kidney stones
Difficulty swallowing

Tremor/hands shaking
Recurrent backache
Leg pain when walking or at night
Weakness or paralysis
Numbness or tingling
Sleep problems
Snoring
Nervousness
Depression/crying spells
Difficulty concentrating
Memory loss
Fears
Disturbing thoughts
Varicose veins/phlebitis
Skin problems
Thyroid problems
Increased thirst/hunger
Heat/cold intolerance
Vomiting
Pain in extremities
Shortness of breath
Burning sensation in sex organs or rectum (other than during intercourse)

Family History

	Age if Living	Age of Death	Major Illnesses, Cause of Death
Father			
Grandfather			
Grandmother			
Mother			
Grandfather			
Grandmother			
Brothers & Sisters			
Spouse			
Children			

Circle those diseases other blood relatives (aunts, uncles, cousins have had): cancer, diabetes, heart disease, high blood pressure, stroke, TB, thyroid disease, kidney disease, anemia, migraine, mental illness, depression, suicide, alcoholism, drug abuse, asthma, colon polyps, glaucoma, arthritis, high cholesterol, Other ________________________

Social and Personal History

Current occupation________________________ Educational Level________________

Married, single, domestic partner______________ Partner's occupation________________

Who lives at home with you?________________________________

Do you have a spiritual practice from which you derive benefit? ________________

Hobbies and Interests________________________________

Do you use tobacco or have you used it in the past? How long?__________How much?__________	Y	N
Are you happy with your weight?	Y	N
Do you feel your diet is healthful?	Y	N
Do you exercise regularly? What form & how often?________________	Y	N
Do you feel life is stressful?	Y	N
Do you drink alcohol? If so, when was your last drink?________________	Y	N
Have you ever had a drinking problem?	Y	N
Do you use marijuana or street drugs?	Y	N
How many caffeine containing beverages do you average per day?__________		
Have you been sexually intimate with a male partner or partners?	Y	N
Have you been sexually intimate with a female partner or partners?	Y	N
What type of birth control or protection do you use?________________		
Have you ever had sex with someone who used IV drugs, had had many other partners, was a prostitute, gay or bisexual man, or whose needle use or sexual past was unknown to you?	Y	N
Have you been exposed to harmful chemicals or radiation?	Y	N
Do you wear a seatbelt?	Y	N
Do you have relationship (spouse, family, friends) problems?	Y	N

The Maple Center

Release of Protected Health Information

I, ______________________________, hereby authorize the Maple Center to release/discuss my protected health information with the following people.

Name	Relationship	Phone Number

1.

2.

3.

I understand I have the right to revoke this authorization, in writing, at anytime by sending written notice to The Maple Center. I understand that if I revoke the authorization, the revocation will apply to information that has already been or received based on this authorization.

If I have any questions about the use and disclosure of my information, I can contact The Maple Center @ 812-235-4867.

______________________________ ______________________________

Patient Signature Date

______________________________ ______________________________

Witness Date

Email Use Authorization

Initial appropriate clauses below and sign if interested.

_____ I am interested in the assignment of non-identifying email sign on and password through which information can be conveyed electronically. I understand that names and indentifying information will be avoided in the emails but that email is not reliably confidential. By signing below, this gives us authorization to email you personal information regarding appointments, records, labs, test results, etc.

_____ I give permission for the use of my regular email address:______________________________

For electronic communication that includes personal information regarding the same information listed above. I understand that email is not confidential.

Acknowledgement of Receipt of Notice of Privacy Practices

Clinical Office of Kathleen Stienstra, MD

By signing this document, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices

______________________________ ______________________

Patient/Authorization Representative Date

____

Printed Name

____

Office Use Only

Date Acknowledgement Received______________________ Initials________________

OR

Reason Acknowledgement was not obtained

____

____

____

Kathleen Stienstra, MD, PC Payment Policy

Thank you for choosing to be seen in our office. We are committed to providing you with excellent integrative medical care. Because you may have questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Fee Schedule

Our fee schedule is available to you for review. Charges for office visits will be based mostly on the time spent with you. Follow up visits are usually scheduled for 30 minutes. If you think that you will require more time, please let us know at the time the appointment is made. *If our visit lasts 45 or 60 minutes, the charges will be adjusted accordingly.*

If you are scheduled for a 30 minute acupuncture session and have medical concerns which require examination, diagnosis, or prescriptions, there will be an additional office visit charge that is not part of the acupuncture package.

Form completion (insurance applications, medical leave, disability paperwork, letters for flexible spending accounts, etc.) that require physician time will also incur a minimum fee of $10. Additional fees will be based on $10 for each additional 10 minutes.

Payment and Cash Discount

Payment in full is expected at the time of service (cash, debit, check or VISA/Mastercard.) There is a 3% surcharge for those who pay by credit card and 2% for debit card. You may be surprised to know that the cost to the practice for you to use a credit card is over 4% of your payment and the "rewards" you receive are paid by the vendor (us) rather than the credit card company.

For those visits (excluding acupuncture) that do not require insurance billing (or receipt of a CMA 1500 insurance form), we discount the care by 8% (our cost for billing.) By eliminating several middle vendors, we can reduce your cost as well.

Insurance

We do not participate in insurance networks and are considered an Ordering/Referring physician for Medicare. This decision was not made lightly, but the reimbursement rates for in network providers do not cover costs for the longer visits provided in our office. Your insurance plan may still reimburse for care from an "out of network provider" but usually at a lower rate or higher deductible. As long as your labs, x-rays, hospitalizations occur in "in network" facilities, they will usually still be covered at the "in network" rate. You'll need to check your specific policy as some will only cover if an in-network provider orders the tests. If you request, we will file our visit charges with your insurer with the help of our billing company, but the reimbursement (if any) will be paid to <u>you</u> by your insurance company.

Prior Authorizations-Many insurances require prior authorization for procedures, imaging services or referrals. We will provide this service for you at no charge if the prior authorization process takes less than 10 minutes of staff time. Unfortunately, with many insurance companies, this is a time consuming, lengthy, and frustrating process on the telephone. We will pass the cost of the staff time on to you at $50/hour. You are welcome to do this process yourself.

<u>Hoosier Healthwise (Indiana Medicaid) or Healthy Indiana Plan (HIP)</u>

We are no longer participants in Indiana Medicaid or HIP.

Hospital Care/Charges

If you do not have a primary care or specialty physician that will see you in the hospital, Dr. Stienstra refers her patients to the hospitalists at Union Hospital. She does have privileges for acupuncture at the hospital and can arrange for outpatient services there. We will bill you and file with your insurance if applicable. Any insurance reimbursement will go directly to you, and you are expected to pay our office for services when a bill is received.

Our Billing Company

Romar Professional Services, Inc., 229A West Pearl Street, Union City, IN 47390. 866-633-1408 or 765 964-4100 FAX 765-964-4300. E-mail: info@romarproservices.com. Website: www.romarproservices.com. Please call them if you have insurance billing questions.

Nonpayment.

If your account is over 60 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless arrangements have been made. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, Dr. Stienstra or Ms. Brooks will only be able to treat you on an emergency basis.

Missed appointments.

Our policy is to charge $30 for missed appointments not canceled within a reasonable amount of time (4 business hours prior to your appointment.) This charge will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or by calling to cancel or reschedule at least 24 hours before. Two consecutive or three total missed appointments may lead to a discharge from the practice.

Our practice is committed to providing excellent treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

Updated 8/16