Dr. Martin Schmaltz - Chiropractic Physician
7161 N Lindbergh Blvd - Hazelwood MO 63042 - (314) 731- 4383

Patient Name _____ Date _____

Confidential Patient Health Record

Personal Information

Last: _____ First: _____ Middle: _____

Suffix: [ ] Jr. [ ] Sr. [ ] II [ ] III Birth Date: ____/___/_____ Age:_____ Sex: [ ] Male [ ] Female

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext_____

Home Phone: (_____) _____-_____ Fax #: (_____) _____-_____ Ext _____

Email Address:_____ Social Security # _____

Emergency Contact

Last: _____ First: _____ Middle: _____

Relationship: [ ] Spouse [ ] Relative [ ] Friend [ ] Other _____

Best Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext_____

Employment Information

Business Name:_____

Phone: (_____) _____-_____ Fax #: (_____) _____-_____ Ext _____

Occupation/Job Title:_____ Describe Job Activities: _____

Before your auto injury, were you experiencing any of the following symptoms/problems?

HEALTH HISTORY [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] vision problems [ ] headaches [ ] dizziness [ ] ringing in the ears [ ] balance problems
[ ] pain in arm or hand [ ] tingling in arm/hand [ ] pain in leg/foot [ ] tingling leg/foot [ ] jaw pain

Have you seen a doctor for any of the previous listed health problems? [ ] Yes [ ] No Yes, when?_____

Dr.'s Name: _____ Type of treatment: _____

Have you previously been treated for injuries due to an auto collision? [ ] Yes [ ] No When_____

Current Medications: List all medications you are currently taking.

Medication	For What Condition?	Medication	For What Condition?

Patient Name _____ Date _____

Adult Illnesses: CHECK all health conditions. CIRCLE IF IT IS CURRENT

[ ] arthritis	[ ] fibromyalgia	[ ] liver disease	[ ] psychiatric problem
[ ] blood issues	[ ] heart disease	[ ] lung problems	[ ] RSD
[ ] cancer	[ ] hepatitis	[ ] lupus	[ ] seizures
[ ] depression	[ ] HIV	[ ] multiple sclerosis	[ ] strokes
[ ] diabetes	[ ] high blood pressure	[ ] Parkinson's disease	[ ] other health issues

Surgery (ies): List all surgical procedures.

Surgery	**Date**	**Surgery**	**Date**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Injury (ies): List all PRIOR injuries.

[ ] back injury	[ ] fall (severe)	[ ] motor vehicle accident
[ ] broken bones	[ ] head injury	[ ] sports injury
[ ] disability (ies)	[ ] joint injury	[ ] work accident

Your Auto Insurance

Date Of Accident: ____/____/____ Time: _____ Where did accident happen? [ ] Missouri [ ] Illinois [ ] Other _____

Did the police come? [ ] Yes [ ] No Did you report the accident/injury to your insurance company? [ ] Yes [ ] No

Insurance Company: _____ Policy # _____

Insurance Phone #: (_____) _____ - _____ Adjuster: _____

Medical Claim #: _____ Attorney: _____

Person Who Hit You - Insurance

Persons Name:_____

Insurance Company: _____ Policy # _____

Insurance Phone #: (_____) _____ - _____ Adjuster: _____

Medical Claim #: _____ Attorney: _____

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Dr. Martin Schmaltz, D.C.
7161 North Lindbergh Blvd., Hazelwood MO 63042
ph: 314.731.4383, fax: 314.731.4204

Patient: _____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPPA) is available here: http;//ww.cms.hhs.gove/SecurityStandards/Downloads/securityproposedrule.pdf.

1. The patient understands and agrees to allow this office to use their PHI for purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This includes the named attorney of record representing you. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patient have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment & Informed Consent

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocation and sprains. Serious complications after manipulation of the cervical spine are estimated to be 1 in 4 million manipulations or fewer.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all the third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred. This includes release of medical & financial information to the patient's attorney.

Initial _____

Financial Obligation

The patient accepts full financial responsibility for services by this practice.

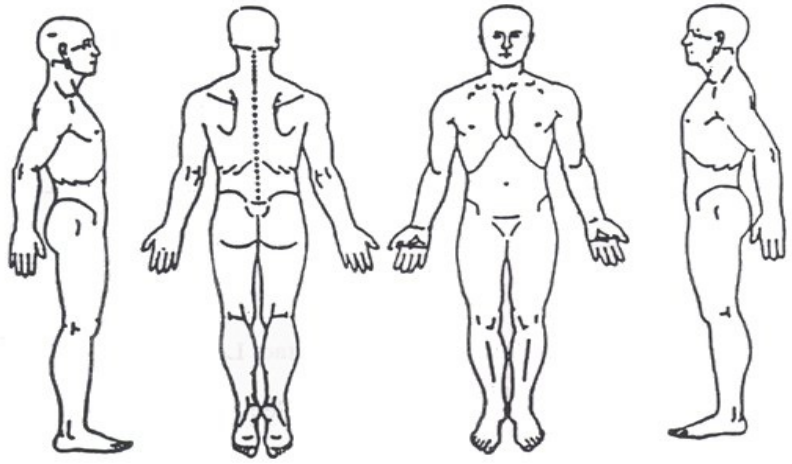
Initial _____

Patient's Signature: _____ **Date:** _____

Name_____ **Today's Date** _____/_____/_____

AUTO INJURY HISTORY **Date of Injury** _____/_____/_____ **Time of Injury**_____

Please mark the area of your pain or discomfort:



1. Is your condition currently... [ ] worsening [ ] improving [ ] unchanged?
2. Is your condition worse in the: [ ] Morning [ ] Afternoon [ ] Night [ ] With Activity
3. Is it mostly: [ ] Intermittent [ ] Constant throughout the day.
4. Mark the home treatments you have done: [ ] Nothing [ ] Cold [ ] Heat [ ] Massage [ ] Exercise [ ] Over the counter medication [ ] Prescription medication [ ] Rest [ ] Stretching [ ] hot baths/showers

Circle any of the following you have experienced since your auto collision.

Mood swings	Depression	Sensitive to sound	Dizziness
Confusion	Concentration Difficulties	Nausea	Balance problems
Ringing in the ears	Sensitive to light	Vomiting	Visual Problems

Patient Name _____ Date _____

Please **use the following scale** to rate the intensity of **each** area injured from 1-10.

0 -1: NO PAIN- to just barely noticeable
2 - 3: MILD - Pain is present but does not limit your activities
4 - 5: MODERATE – You can do most activities with rest periods
6 - 7: SEVERE – **Unable to do SOME** activities because of pain
8 -9: EXTREME- **Unable to do MOST** activities because of pain
10: DISABILING – **Unable to do ANY** activities: including putting on clothes, bathing, cooking, driving, almost any movement.

Circle each area that is affected by this injury	Where do you hurt	How much of the day do you hurt? Infrequent Occasional Intermittent Frequent Constant	Intensity 1-10	Sharp	Dull	Aching	Throbbing	Shooting	Stabbing	Burning	Pins & Needles		
Example Neck	***right side of neck, more on back of neck***	***frequent***	***6***	***x***			***x***	***x***					
Head													
Jaw													
Neck													
Mid Back													
Low Back													
Shoulder Joint													
Elbow													
Wrist													
Fingers													
Hip													
Knee													
Ankle													
Foot													
Toes													

The next form (page 11) is a request for medical records. If you have sought medical care of any kind and went to the hospital or saw a doctor for your complaint, we need your permission to obtain a copy of those medical records.

Please sign the next form but leave the Doctor/Hospital information blank.

List below the hospital(s) and/or doctor(s) that you have seen.

Patient Name:_____

Hospital: _____ **Were X-rays taken? Y N**

Address:_____

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

Phone:_____ **When did you go?:**_____

Doctor: _____

Address:_____

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

Phone:_____ **When did you go?:**_____

Doctor: _____

Address:_____

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

Phone:_____ **When did you go?:**_____

Doctor: _____

Address:_____

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

Phone:_____ **When did you go?:**_____

Dr. Martin Schmaltz
7161 N Lindbergh Blvd, Hazelwood MO 63042
(314) 731-4383 Fax (314) 731-4204

REQUEST FOR MEDICAL RECORDS

Date:_____

REQUESTING FROM:

_____ **RECORDS FAX:** _____
Doctor or Hospital Name

_____ **RADIOLOGY FAX:** _____
Address

_____
City, State, Zip

PATIENT INFORMATION

_____
Patient Name

_____
SS#

_____
Date Of Birth

Please send imaging films or disc and medical records from _____ to the present.

_____
I authorize the release of my imaging films or disc and medical records to be sent to the requestor:

Dr. Martin Schmaltz
7161 N Lindbergh Blvd, Hazelwood MO 63042
(314) 731-4383 Fax (314) 731-4204

This request is valid for 180 days past the date of signature seen below.

_____
Patient Signature **Date**

INCLUDE –or- ATTACH ALL PERSONAL INJURY INFO NEEDED FOR BILLING

PATIENT NAME		
STREET		
CITY		
STATE & ZIP		
TELEPHONE		
SOC. SEC #		
DATE OF BIRTH		
AGE AND SEX		

SEND BILL TO:

- ☐ ATTORNEY ONLY
- ☐ ATTORNEY + INSURANCE
- ☐ AUTO INSURANCE

CONDITION IS RELATED TO:

- ☐ AUTO ACCIDENT
- ☐ OTHER ACCIDENT
- ☐ EMPLOYMENT

PI - INSURANCE COMPANY INFO		SECONDARY INFO	ATTORNEY NAME
NAME			
STREET			
CITY			
STATE & ZIP			
PHONE			
POLICY #			
CLAIM #			
INSURED NAME			
ADJUSTOR NAME			
ADJUSTOR PHONE			
DATE OF ACCIDENT			

AUTHORIZATION TO RELEASE MEDICAL INFORMATION I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

AUTHORIZATION TO PAY BENEFITS I HEREBY AUTHORIZE PAYMENT OF THESE REASONABLE CHARGES TO Radiology Consultants Midwest FOR SERVICES RENDERED TO ME IN ACCORDANCE WITH §430.225, §430.230 RSMo, UPON ALL CLAIMS, COUNTER CLAIMS, DEMANDS, SUITS, OR RIGHTS OF ACTION BY ME AGAINST THE DEFENDANT/LIABLE PARTY IN WHICH ALLEGED LIABILITY IS INSURED. I AUTHORIZE PAYMENT DIRECTLY TO Radiology Consultants Midwest BENEFITS THAT WOULD NORMALLY BE DUE ME. I HEREBY AUTHORIZE MY ATTORNEY TO PAY DIRECTLY TO THE PROVIDER SUCH SUMS WHICH MAY BE DUE AS A RESULT OF THIS ACCIDENT AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT Radiology Consultants Midwest.

AGREEMENT TO PAYMENT TERMS I AGREE TO REMIT IN FULL ANY BALANCE WHICH IS NOT COVERED OR PAID IN FULL BY ANY INSURANCE CARRIERS OR OTHER PARTIES THAT MAY HAVE RESPONSIBILITY OR LIABILITY FOR THE SERVICES RENDERED.

PATIENT SIGNATURE _____ PARENT/GUARDIAN _____ DATE _____

RADIOLOGY CONSULTANTS/MIDWEST
201 ENCHANTED PARKWAY
BALLWIN, MO 63021

(636)256-7779
(636)227-0624 FAX
FED ID # 43-1912520

DR MARTIN SCHMALTZ
NPI 1841552478

NORTH COUNTY PAIN RELIEF CENTER
COMMENT or QUESTION:

RCM OFFICE USE ONLY

C/S 2 3 5 7 B _____
T/S 1 2 _____
L/S 2 3 4 5 B _____
PELVIS _____
F/S 1 2 _____

_____ _____

_____ _____

RADIOLOGIST 1 2 3