Contact Information Update ~ Pediatric

First name	Middle Initial	Last name		
Address		City	State	Zip

Parent/Guardian's Information	
Name	Date of Birth
Home Phone Number	May We Leave A Message?
Cell Phone Number	May We Leave A Message?
Work Phone Number	May We Leave A Message?

Address (if different than child's)	City	State	Zip
Email Address			

Other Parent/Guardian's Information ☐ may not discuss the child's medical information	
Name	Date of Birth
Phone Number	May We Leave A Message?
Alternate Phone Number	May We Leave A Message?
Email Address	

Name and phone number of Child's Primary Care Physician		
Name of school child attends	City	State
List Allergies		
Other info		

1. I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment at the time of service.
2. I am responsible for a payment of $75 for any missed appointment for which I have not given 24 hours' notice.
3. The staff at the Center for Health & Healing will call to confirm my appointments. If they are unable to contact me, I understand the Center for Health & Healing reserves the right to cancel the appointment. I am responsible for informing the office if I change my phone number or email address.
4. I understand Dr. Schultz is not a Primary Care Physician and I need to have or establish a relationship with a PCP. Over a dozen years ago, Dr. Schultz voluntarily chose to give up his hospital admitting and staff privileges in order to devote his time entirely to Functional and Integrative Medicine at the Center for Health & Healing; he is not on staff at any hospital. Therefore, I understand I am responsible for establishing a relationship with a primary care provider.
5. I understand Dr. Schultz is not a provider with any insurance plans whatsoever, including Medicare and Medicaid.
6. I understand Dr. Schultz and the staff at the Center for Health & Healing are not responsible for writing letters or explaining medical necessity to insurance carriers, labs or other physicians.
7. I understand Dr. Schultz and his staff are not responsible for obtaining prior authorization for prescriptions or outside lab testing.
8. I understand it is not the responsibility of Dr. Schultz or his staff to determine and/or obtain insurance coverage, including Medicare coverage, for any lab testing. I understand it is my responsibility as the patient to contact labs and insurance carriers in order to obtain possible coverage for any services.
9. I understand Dr. Schultz does not fill out or assist with disability forms or *Family and Medical Leave Act* forms.

Parent/Legal Guardian's Signature _____ Date _____

Center for Health and Healing, S.C.
Fred J. Schultz, M.D., F.A.A.F.P.
FAMILY PHYSICIAN SINCE 1980
2150 Manchester Road • Wheaton, IL 60187
(630) 933-9722

PATIENT INFORMATION RELEASE FORM

This form is used for our office to determine whether or not we have your authorization to disclose your child's protected health information to persons other than yourself. This authorization is valid until you notify our office of your decision to revoke it.

Child's Name: _____

Child's Date of Birth: _____

Disclosure Authorization Preference - Check box #1 or #2

1. ❒ You may discuss my child's health care with the following people:

Name_____ Relationship to child _____

Name_____ Relationship to child _____

Name_____ Relationship to child _____

Name_____ Relationship to child _____

OR

2. ❒ I do not give my permission to release my child's health information to anyone other than myself or my insurance carrier.

Parent/Guardian Information

Printed Name_____

Signature_____ Date_____

Center for Health and Healing, S.C.
Fred J. Schultz, M.D., F.A.A.F.P.
2150 Manchester Road • Wheaton, IL 60187
NPI #169 9801 985

Private Contract between Physician and Patient

This agreement is between Fred J. Schultz, M.D. (hereinafter called "Physician"), whose medical office is located at 2150 Manchester Road, Wheaton, IL, and _____ (please print your name, hereinafter called "Patient"), who resides at _____ (please print your address).

Background

Dr. Fred Schultz has **opted out of the Medicare program** effective on 04/01/17 for a period of at least two years. This information is important for all patients to understand, as the Patient's Medicare eligibility or status may change throughout the course of treatment under Physician. Patient agrees not to expect payment from Medicare for any services provided by Physician. Physician has not been excluded from participation under the Medicare program under Section 1128, 1156 or 1892.

Obligations of Physician

Dr. Fred Schultz agrees to provide medical services to the Patient and in exchange for these services the Patient agrees to make payments directly to Dr. Fred Schultz at the time of service, pursuant to Dr. Fred Schultz's current fee schedule. Dr. Fred Schultz agrees not to submit any claims under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.

Obligations of Patient

- ✓ Patient or his/her authorized legal representative agrees not to submit a claim (or to request that Physician submit a claim) under the Medicare program for items or services Physician may provide, even if such items or services are otherwise covered under the Medicare program.
- ✓ Patient or his/her authorized legal representative agrees to be responsible for payment in full for items or services provided and understands that no reimbursement will be provided under the Medicare program for such items or services.
- ✓ Patient or his/her authorized legal representative understands that Medicare will not reimburse Patient for any service provided by the Center for Health & Healing since Dr. Schultz has opted out of the Medicare program.
- ✓ Patient or his/her authorized legal representative acknowledges that Medicare limits do not apply to what Physician may charge for items or services furnished.
- ✓ Patient or his/her authorized legal representative acknowledges that Physician will not submit a claim on any service provided.
- ✓ Patient or his/her authorized legal representative acknowledges that Medigap plans do **not**, and other supplemental insurance plans may elect not to, make payments for items and services not paid for by Medicare.
- ✓ Patient or his/her authorized legal representative acknowledges that (s)he has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that (s)he is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.
- ✓ Patient or his/her authorized legal representative agrees not to request that Physician submit a claim to a secondary carrier.
- ✓ Patient is not currently in an emergency or urgent health care situation. Patient understands Physician is not a Primary Care Physician and does not treat patients in an emergency state. If Patient is in an Urgent or Emergency condition, (s)he should immediately go to an Urgent Care facility or Emergency Room.
- ✓ Patient or his/her authorized legal representative understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
- ✓ Patient or his/her authorized legal representative acknowledges that a copy of this contract has been made available to him or her.
- ✓ Patient with Medicare Part B as a secondary insurance carrier may submit Statement of Services to their primary insurance company for possible out-of network level reimbursement.
- ✓ Patient or his/her authorized legal representative agrees to reimburse Physician for any costs and attorney fees that result from violation of this Agreement by Patient or his beneficiaries.

Term and Termination

This agreement shall commence on the date below and shall continue in effect until at least 04/01/2019, at which time a new 2-year agreement must be signed in order to receive ongoing treatment from Physician. Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Patient agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract, shall survive this contract.

I have read and understand the provisions regarding private contracting. Payment is not to be expected from the Medicare program for services provided by a Physician who has opt-out status with Medicare. By signing this contract, I accept full responsibility for payment of charges to Physician for all services furnished to me.

Printed Name of Physician: Fred J. Schultz, M.D. Printed Name of Patient: _____

Signature of Physician: _____ Signature of Patient: _____

Staff initials: _____ Date: _____