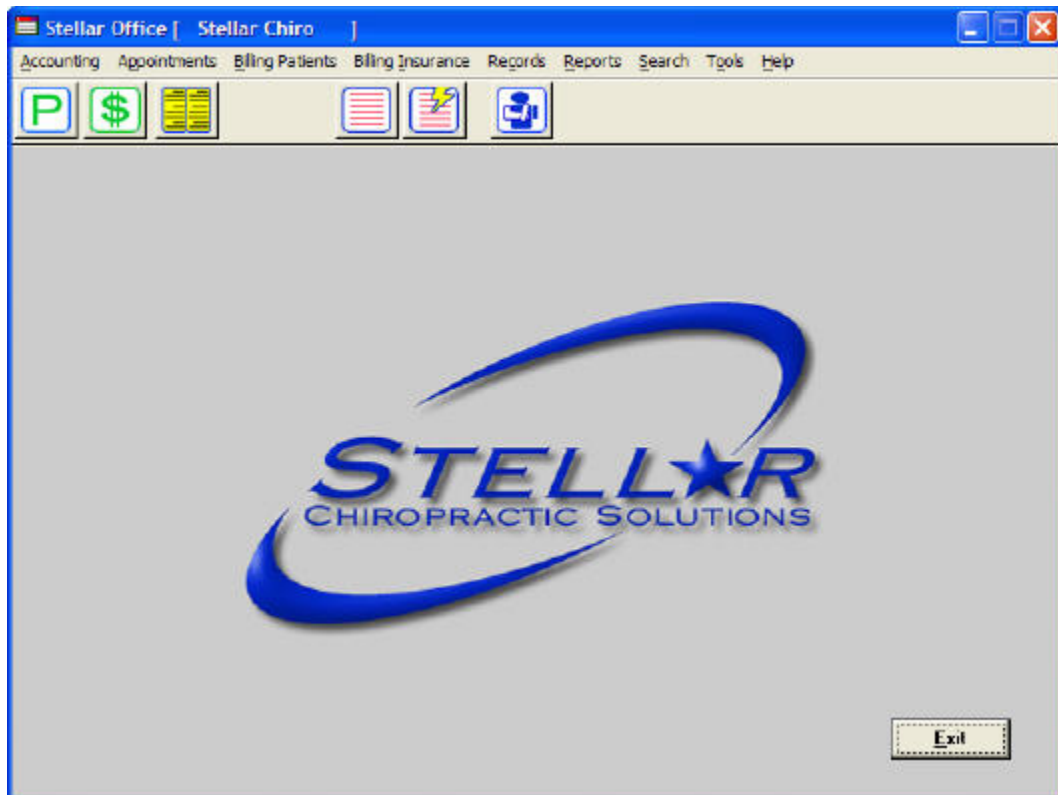


Introduction to Stellar Office

Welcome to Stellar! You have made the right decision to a better and more efficient practice. This introduction will be your guide to familiarizing yourself with the many useful features of this powerful office management tool.

Getting Started

After installation, open Stellar Office from the shortcut on your desktop. The large buttons across the top under the menu open the most often used functions:



The two green buttons on the left are shortcuts to the programs in which you add services and charges to your patients' files, as well as make payments and corrections. In Stellar Office, we

generally refer to “adding services” as “posting transactions”. The button with the “P” on it opens the Post Transactions program for adding daily transactions and services to your patients’ files. The button with the \$ on it opens the programs for entering payments and corrections to the accounting. The button with the yellow book opens the Appointment program. The next two red buttons are for printing insurance claims, and for filing electronic claims. The final button with the blue patient icon opens your patient files.

The menu across the top will drop down when clicked on to show more detailed lists of functions. All of the programs that are accessed from the large buttons are also available from this menu. Experienced Stellar users will soon feel at home because all previous menu functions (and more!) have been retained in the new Windows version.

The following are instructions of the tasks you must complete prior to using Stellar Office. You may complete the following tasks in any order. Changing and adding treatments, as well as adding a provider/doctor, **MUST** be done before you start using Stellar. The remaining items can be completed while you are adding patient records, but it will be less time consuming to take care of those items first. If you wish to complete the items while adding patients into Stellar, simply click on the ? button in the appropriate places in the patient files.

Changing and Adding Treatments/Services

Stellar Office comes with a treatment file. Your first task as a new user of Stellar Office is to click on the **Records** menu, and then click on **Treatments**. Then click on the Print button and print all the treatments sorted in the order you prefer. Change your printout to agree with the charges that are standard for your office, as well as the treatment descriptions. You may also make changes to the key numbers assigned to the treatments for organizational purposes; for example, you may want all of the New Patient items to be numbered from 1 to 10, Established Patient items 11 to 20, Therapy from 21 to 30, etc. Make sure all data is correct and includes what you expected, because after you begin posting to patients you cannot easily change the key numbers of the Treatment records. Return to Stellar and enter the changes. (For specific instructions on making the changes, click on the **Help** menu, click on **Stellar Manual**, double click on the word “Records” in the left column, and click on Treatments.)

Treatments

Treatment Key: 58

CPT Code: 98941

Treatment Group: EP - Established Patient

Description: 3-4 SPINAL ADJ

Charge: \$48.00

Normal Modifiers:

Charge w/Modifier: \$48.00

Write Off Amount: \$0.00

Submit to Insurance

Count for Insurance Limits

Multiple Units Allowed

Charge Sales Tax (see Configuration for Amt)

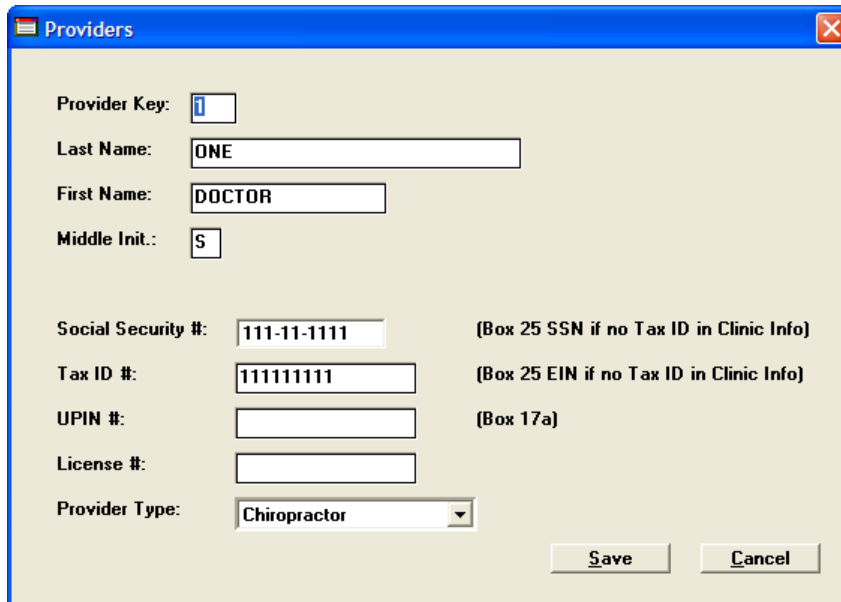
Inventory Information

Quantity on Hand: 0 Reorder Point: 0

Save Cancel

Adding Providers/Doctors

Click on the **Records** menu, and then click on **Providers**. Click on the Add New button, add your doctor into the program and click on the Save button.



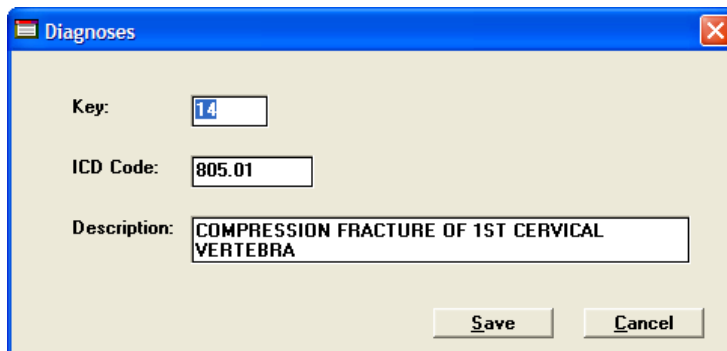
The screenshot shows a dialog box titled "Providers" with a blue title bar and a close button (X) in the top right corner. The dialog contains several input fields and a dropdown menu:

- Provider Key:** A small text box containing the number "1".
- Last Name:** A text box containing "ONE".
- First Name:** A text box containing "DOCTOR".
- Middle Init.:** A small text box containing "S".
- Social Security #:** A text box containing "111-11-1111" with a note "(Box 25 SSN if no Tax ID in Clinic Info)".
- Tax ID #:** A text box containing "111111111" with a note "(Box 25 EIN if no Tax ID in Clinic Info)".
- UPIN #:** An empty text box with a note "(Box 17a)".
- License #:** An empty text box.
- Provider Type:** A dropdown menu with "Chiropractor" selected.

At the bottom right of the dialog are two buttons: "Save" and "Cancel".

Changing and Adding Diagnoses

Stellar Office comes with a diagnosis file. You may want to repeat the process you used for treatments to change and add diagnoses. It can be done when you are adding patient records, but it will save some time to do it in advance. Click on the **Records** menu, and then click on **Diagnoses**. Click on the Print List button, and choose to print the diagnoses in the order you prefer. Make changes on your printout, return to Stellar and enter the changes. (For specific instructions on making the changes, click on the **Help** menu, click on **Stellar Manual**, double click on the word "Records" in the left column, and click on Diagnoses.)



The screenshot shows a dialog box titled "Diagnoses" with a blue title bar and a close button (X) in the top right corner. The dialog contains three input fields:

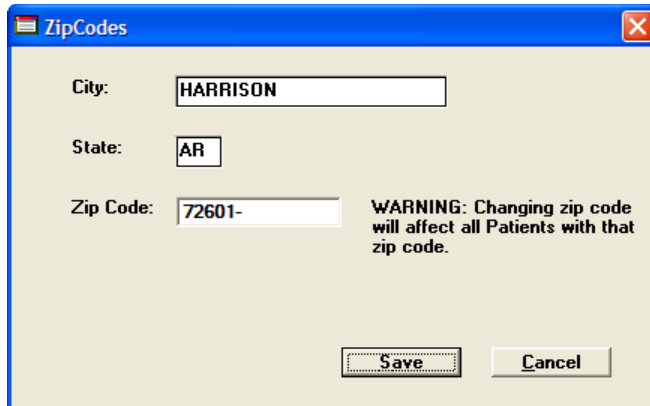
- Key:** A small text box containing "14".
- ICD Code:** A text box containing "805.01".
- Description:** A text box containing "COMPRESSION FRACTURE OF 1ST CERVICAL VERTEBRA".

At the bottom of the dialog are two buttons: "Save" and "Cancel".

Adding Zip Codes

Click on the **Records** menu, and then click on **Zip Codes**. Click on the Add New button, and enter the city, state, and zip codes most commonly found in your patient files. This will save you some

time when adding your patient records to Stellar. Click on the Save button when finished adding each zip code.



ZipCodes

City: HARRISON

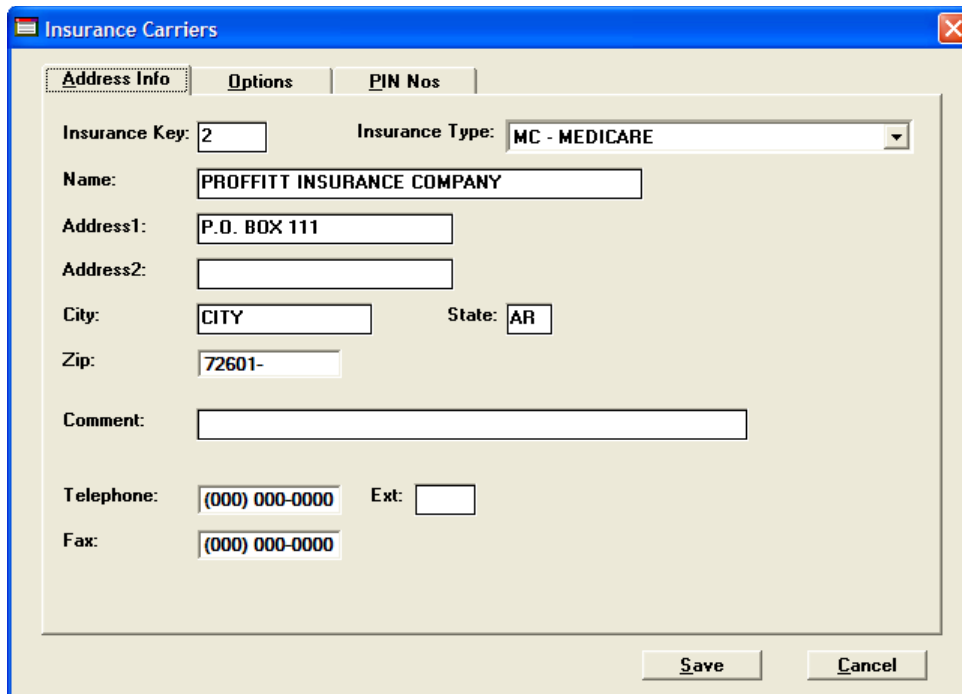
State: AR

Zip Code: 72601- **WARNING: Changing zip code will affect all Patients with that zip code.**

Save Cancel

Adding Insurance Carriers

Click on the Records menu, and then click on Insurance Carriers. Click on the Add New button. Fill in the information on each tab, and then click on the Save button. For more detailed instructions or explanations concerning the items found in the insurance carrier files, click on the **Help** menu, click on **Stellar Manual**, double click on the word “Records” in the left column, and click on Insurance Carriers.



Insurance Carriers

Address Info Options PIN Nos

Insurance Key: 2 Insurance Type: MC - MEDICARE

Name: PROFFITT INSURANCE COMPANY

Address1: P.O. BOX 111

Address2:

City: CITY State: AR

Zip: 72601-

Comment:

Telephone: (000) 000-0000 Ext:

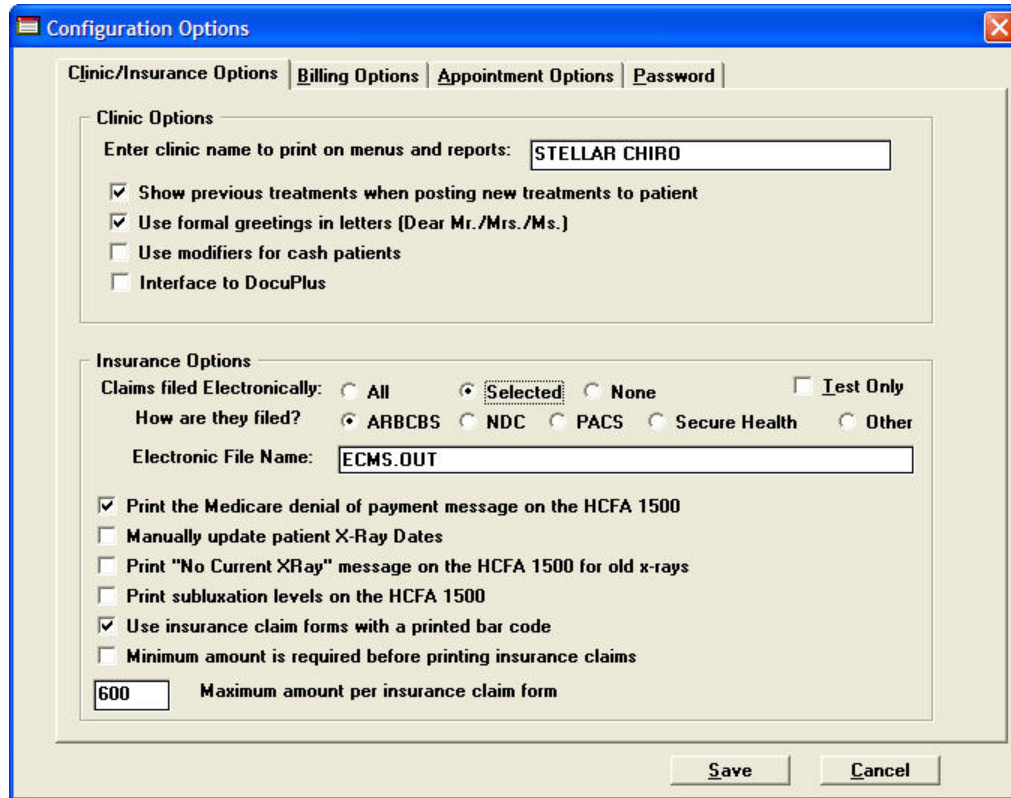
Fax: (000) 000-0000

Save Cancel

Setting the Insurance, Billing, and Appt. Options

There is one last section that should be completed prior to using Stellar Office. Click on the **Tools** menu, click on **Configuration Options**, and click on **Insurance, Billing, & Appointment**

Options. Make the necessary changes on each tab and click on the Save button. If you need assistance or further explanation of the items shows in this screen, click on the **Help** menu, click on **Stellar Manual**, double click on the word “Tools” in the left column, and click on Insurance, Billing & Appointment Options.

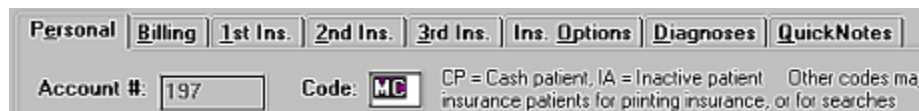


Getting Around in Stellar Office

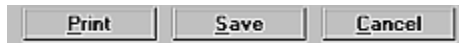
The following section is a guide that will show you how to use some of the different controls found in Stellar Office.

Using the Keyboard As Much As Possible

Most push buttons and tabs in Stellar Office are programmed so that there is an underline beneath one letter of the label that appears on the push button or tab:



Example of Tabs in Stellar Office



Example of Push Buttons in Stellar Office

If you wish to choose a particular tab or push button without using the mouse, you may hold down the Alt key while you type the underlined letter that appears on the tab or push button, such as “Alt c” to Cancel. If the underlined letter is capitalized, you do NOT need to capitalize the letter before typing it.

You may also choose items from the menu on the main window of Stellar Office by using the Alt key and the underlined letter. But to choose an item from the submenu that opens, all you do is type the underlined letter, WITHOUT using the Alt key.

NOTE: Users of Windows XP must first turn off the option to hide the underlines before they can see the underlines in Stellar Office. To do this, right click anywhere on your desktop (not on an icon or shortcut or program). Then click on Properties. Click on the Appearance tab and click on the Effects button. Uncheck the box that says “Hide underlined letters for keyboard navigation until I press the ALT key” and click on OK. Click on OK again and you will now be able to see the underlined letters in Stellar Office.

To move around in a window within Stellar Office, you may use either the Enter key or the Tab key, or you may use the mouse to click in a field you wish to change.

Do not type the dashes, parentheses, or slashes in the zip code, social security number, phone number, and date fields. Simply enter the numbers, and Stellar Office takes care of the rest.

Changing Dates

To change a date within Stellar Office, you may either type in the date field in the MM/DD/YY format, or click the arrow down button and choose a date from the calendar by clicking on it. If the date in the date field is NOT highlighted and you want to change it by clicking on the arrow down button, you will have to click on the arrow down button *twice* to activate the calendar.

If you are entering a date, such as a birth date, that uses “19” in the first two digits of the year, you must type it in the MM/DD/YYYY format (enter the full year, instead of the last two digits of the year).

Using List Boxes

All records are accessed from list boxes, such as the one shown. You may choose a record to view or change by double clicking on that record in the list box, or by clicking once on it to highlight the record, and then clicking on a button below the list box. To find a particular record within the list box, you may use the arrow buttons on the right. The single arrows will move the list up or down by one record at a time, while the double arrows will move the list up or down by one page at a time. If you click and hold the mouse button down on the arrows, the list will scroll continuously (and rather quickly), either one line at a time for the single arrow, or one page at a time for the double arrow. Another method to find a particular record if you know the key# or name is to simply start typing the number or name, and the list box will move you to the correct record in the list.

Key	CPT Code	Description	Type	Charge
0001	99201	Brief/Exam	NP	40.00
0002	99202	Limited/Exam	NP	50.00
0003	99203	New Patient - OV Extended	NP	70.00
0004	99204	New Patient - OV Comprehensive	NP	90.00
0005	99211	Established Patient - OV Minimal	EP	30.00
0006	99212	Established Patient - OV Brief	EP	45.00
0007	99213	Established Patient - Intermediate	EP	60.00
0008	99214	Established Patient - OV Intermediate	EP	85.00
0009	98940	CMT Spinal 1 to 2 regions	EP	30.00
0010	98941	CMT Spinal 3 to 4 regions	EP	45.00
0011	98942	CMT Spinal 5 regions	EP	60.00
0012	98943	CMT Extraspinal	EP	15.00
0013	98940	MC ACUTE/ 1st Office visit	NP	26.00
0014	98940	MC office visit	EP	26.00
0015	97012	Cervical TX/Mechanical	EP	15.00
0016	97012	Intersegmental TX	EP	15.00
0017	97124	Trigger Point TX	EP	15.00
0018	97014	EMS/unattended	EP	15.00
0019	97032	EMS/attended TX	EP	15.00
0020	97010	Cyotherapy	EP	12.00

Example of a list box in Stellar Office

Using Drop List Entry Fields

The following illustration shows a drop list entry field located in the patient file. This type of control is found throughout Stellar Office. There are several ways of using the drop list entry field:

- If you already know the choices available in the list, you may simply type in the first letter or two of your chosen item for it to appear in the field.
- You may use the arrow keys, both up and down or left and right to see the choices from the list one at a time in the entry field.
- To drop the list down in order to see more than one of the choices at the same time, you may either click on the arrow down button or press the F4 key. To choose from the list, use the up and down arrow keys on the keyboard to move the cursor from one word to the next before hitting Enter, or just click on your choice with the mouse.

Example of a drop list entry field in Stellar Office

The ?

If you see a push button at the end of an entry field with a question mark on it, you may click on that button to open a list box from which you may choose an item for the entry field, either by double clicking on the correct item or by clicking on the item and then clicking on the OK button below.

Using Grid Boxes

There are a few grid boxes in Stellar Office such as the one shown below. There are some grid boxes in which we do not allow you to make changes, such as the History grid box in Patients. The primary grid boxes you will be using are found in Post Transactions in the Accounting menu, or in Changes in the Tools menu. To make changes within a grid box, click on the grid box first, and then you may use the arrow keys on the keyboard to move around and type the change you wish to make in a particular cell. You may also use the mouse to click on another cell to change, instead of the arrow keys.

NOTE: Windows98 users must press the Enter key before they move to another cell with the arrow keys after making a change. You can still use the mouse to click into another cell without pressing the Enter key.

If there are certain cells to which we do not permit changes in a grid box, you will not be able to click on those cells or use your arrow keys to move to those cells. When using the grid boxes, watch the bottom of the screen for messages that pertain to the cells you are choosing.

Insurance Key	Insurance Carrier	Non-Medic Subsidy?	NEIC Payor#	Ins. Type	Assign ment	Mod. Req.	Own Form
2	Palmetto GBA	N		MC	N	Y	N
3	GA Dept of Community Health (PPO)	N		PP	Y	Y	N
4	Georgia Dept. Of Community Health	N		OT	Y	Y	N
5	Cigna Healthcare	N		OT	Y	Y	N
6	Blue Cross Blue Shield of GA	N		BS	Y	Y	N
7	BC/BS of GA	N		BS	Y	Y	N
8	BC/BS of Alabama	N		BS	Y	Y	N
9	BC/BS Of Georgia	N		FE	Y	Y	N
10	Core Administrative Services	N		OT	Y	Y	N
11	MailHandlers Benefit Plan	N		OT	Y	Y	N
12	21st Century Health	N		OT	Y	Y	N
13	Middle GA EMC	N		OT	Y	Y	N
14	Secure Health Plans Of GA	N		WC	Y	Y	N
15	Cigna Healthcare	N		OT	Y	Y	N
16	Union Bankers Ins Co	N		WC	Y	Y	N
17	Nippon Life Ins. Co.	N		OT	Y	Y	N
17	Nippon Life Ins. Co.	N		OT	Y	Y	N

Example of a grid box in Stellar Office

Oversized Screen Fonts

Oversized screen fonts cause problems with certain controls in Stellar Office, such as the list boxes. We recommend that screen fonts be returned to their normal size prior to using Stellar Office.

Daily Tasks

This next section will cover the basic daily tasks you will perform in Stellar Office. All items in this introduction are also covered in the **Stellar Manual**, which can be found in the **Help** menu. This section covers in detail adding patients, posting services or transactions, filing insurance, making payments and corrections to a patient's account, and making appointments.

Working With the Patient Files

Patients [#2-JANE S. PATIENT]

Personal | Billing | 1st Ins. | 2nd Ins. | 3rd Ins. | Ins. Options | Diagnoses | QuickNotes | Balance: \$475.00

Account #: 2 Next unused # 57 Acc. Code MC CP = Cash patient, IA = Inactive patient Other codes at your discretion to group insurance patients

c/o Name:

Last Name: PATIENT Sex: Male Female Appointment: First Visit: 08/25/2003

First Name: JANE MI: S Marital Status: Married Last Visit: 11/13/2003

Address: 123 MAIN ST Last Pay: 10/07/2003

Zipcode: 72601- ? City: HARRISON State: AR Discharge:

Birth Date: 01/01/1975 Ins. Age Date: 08/26/2003 W

Provider: 1 ? ONE, DOCTOR S. Referral Information Key Number: ?

SSN#: 111-11-1111 Last Name:

Home Ph: (111) 111-1111 Office: () - Ext. First Name: MI:

Cell Ph: () - Pager: () - Type:

E-Mail: UPIN:

Employer:

Messages History Print Save Cancel

WILL PAY \$25 PER MONTH

Adding a New Patient

1. From the main screen, choose **Records**.
2. Click on **Patients**.
3. Click on the Add New button.
4. The program assigns the next available key number, which you may change to any unused number, up to six digits. If you have chosen to input the key numbers yourself (a choice that is made upon initial installation of Stellar Office), you will need to type it in at this point.

Personal Tab

5. The first item you will need to fill in for this patient is the Account Code. You may enter any of your own 2-digit codes except for CP and IA, which are reserved for Cash Patients and Inactive Patients. All other codes are treated as insurance codes. Patients whose bills are submitted to a lawyer are treated as insurance patients; therefore, you will need your own code for those patients. If you do not assign a particular code to a patient, the program defaults to the code of AA, and the patient is treated as an insurance patient.

NOTE: You may use this field to group your patients, such as “WC” for Workers Compensation, “MC” for Medicare, etc. The insurance submittal programs allow you to use this code as a filter, letting you submit your various types of insurance separately. The important thing is to be consistent. If you want all insurance in just one category, use the default of “AA” for all insurance

patients. This code is also used for grouping and sorting by various functions in the menu item **Reports**.

6. Stellar Office has a separate zip code file, so you will only need to enter the zip code, and the city and state automatically appear. If you enter a zip code that is not on file, the words “not on file” appear in the City field. You should then click the question mark next to the Zip Code field to enter a new zip code into the file.
7. Any date, such as the birth date, in which the year begins with “19” instead of “20” will need to be entered using the MM/DD/YYYY format (all four numbers of the year must be typed in). All dates in which the year begins with “20” may be entered using the MM/DD/YY format.
8. Enter the key# of the provider for this patient, if you have more than one, or you may look up or add a new provider by clicking on the question mark.
9. If you have configured Stellar Office to allow family billing (see **Tools/Configuration Options/Insurance, Billing, Appointment Options**), you will need to enter the key# of the Family Head (the patient responsible for this patient’s bill), if this patient is not responsible for his own bill. If you do not know the key#, click on the question mark, choose the family head from the list, and click on the OK button. The monthly statement information for this patient will then be included on the bill of the family head. If this patient IS the family head, you will see a list of patient numbers of the members of this patient’s family.
10. If you would like to make an appointment for this patient as you are entering the information, simply click on the Appointment button.
11. The First Visit date is automatically filled in with the current date when you enter a new patient into the system. You may change it if necessary.
12. The Last Visit date is automatically updated as treatments are entered for this patient.
13. The Last Pay date is automatically updated as payments are entered for this patient, and it shows whether the payment is an insurance payment or a cash payment.
14. The Discharge date is for your records only and designates when a patient has been discharged. This information will not be printed anywhere on the insurance forms.
15. The Insurance Age date is maintained by the program to coincide with the oldest pending or waiting insurance, as long as you age your insurance (see **Billing Insurance/Insurance Aging**). The program will choose whichever date is older.
16. If the new patient has been referred, enter the key# of the referral or use the question mark to look up a referral. Click on the referral and click on the OK button, and the information will automatically be entered into the patient’s file. If you wish to add a new referral, click on the Add New button.

Billing Tab

17. In the Billing Cycle field, you may enter a number from 0 – 9 which controls grouping of the patients for billing purposes. This is especially useful when you wish to bill groups of patients at different times during the month. Leave the number set to 0 if you bill all patients at the same time.

Tip: Some offices will designate a billing cycle number for patients they never want to bill, and therefore never choose that group when billing from **Billing Patients/Billing, Monthly, By Cycle**.

18. The Billing Code tells the program how to compute the portion of the total balance for which the patient is responsible. Treatments that you have marked to NOT submit to insurance will be applied only to the patient part. Insurance patients should have a code of “Co-Insurance”, “Deductible Only”, “Patient Co-Pay”, or “Insurance Co-Pay”, for if they do not, the program must calculate that either all the charges are owed by the patient, or none of the charges are owed by the patient. Insurance patients who have one of these codes and whom you do not wish to send a monthly bill can be placed in a separate billing cycle that you will never bill. The following billing codes are available:

Bill All to Patient: This bills the patient for the total balance in his account - 100% is applied to the patient part. In general, patients who pay in cash should only have this billing code. Also, patients who file their own insurance and patients for whom you do courtesy filing (while they themselves receive the insurance benefits) should also have this billing code, and the Benefits Assigned to Clinic field on the Insurance Options tab should be unchecked.

Do Not Bill Patient: 100% of the balance is applied to the insurance part. This will also prevent the printing of a monthly statement for this patient from the **Billing Patients** menu.

Co-Insurance: This will cause the patient to be billed only for the co-insurance (a percentage) and deductible amounts. Insurance will be billed for the rest. You will need to enter the percentage that the insurance carrier pays in the Insurance Pays field. For example: if the insurance carrier pays 80% of the bill for this patient, type “80” in the Insurance Pays field. If a co-insurance patient has a deductible, Stellar Office will bill the patient 100% until the deductible is met. Once the deductible is met, the program automatically starts billing the patient 20% for the patient’s part.

Deductible Only: This causes the patient to be billed ONLY for the deductible amount, and then 100% is applied to the insurance part.

Patient Co-Pay: This causes the patient to be billed for a flat fee per visit plus any deductible amount. You will enter the amount per visit that the patient is required to pay in the Patient Pays field. The program will bill the patient 100% until the deductible is met, and once that is met, it will charge the patient only the fixed amount for each visit.

Insurance Co-Pay: This causes the primary insurance carrier to be billed for a flat fee per visit after the patient has met his deductible. Once the deductible is met, the patient will be charged everything above the flat fee that is submitted to the insurance carrier. You will enter the amount per visit the insurance carrier will pay in the Insurance Pays field.

19. The Aging Data, including the fields Previous, 30 Day, 60 Day, 90 Day, 120 Day, and Original balances, are calculated by the program and are for display only. The Previous Balance is the patient’s total balance as of the

last billing; the 30/60/90/120 Day balances are calculated by accounts receivable aging; and the Original Balance is the balance at the time an *existing* patient is added to the system (for a new patient the original balance will be \$0.00). The number is permanently applied to this field from the amount you enter into the total balance field (see #23 below) when adding an existing patient to the system.

20. *If* you have configured your system for late charges (see **Configuration Options** in the **Tools** menu), you will be able to check the box next to Apply Late Charge. This allows you to bill some patients for late charges and not others.
21. The Minimum Payment Due is an optional item containing the minimum amount that the patient has agreed to pay per month. This figure will be printed on the patient's monthly statement as the minimum payment due.
22. The Last Bill Date field is display only, and will automatically show the date on which you last printed a bill for this patient from **Billing Patients/Billing, Monthly, By Cycle**.
23. The Total Balance field contains the mathematical total of charges and credits applied to the patient's account, adjusted by the Original Balance. You are only able to make an entry in this field when entering an *existing* patient into the system for the first time; otherwise, the program computes this balance automatically.
24. The Patient Part of Total Balance field displays the part the patient owes. You generally only make an entry here when entering an *existing* insurance patient into the system for the first time; otherwise, the program computes this balance automatically.
25. The Deductible Date field is the beginning date for the insurance deductible. The program defaults to January 1 of the current year. You may change this date by typing in the correct date in the MM/DD/YY format.
26. Enter the full amount of the deductible from the patient's insurance policy in the Deductible Amount field.
27. The Against Deductible, Total field is the amount of insurable treatments that have been charged against the deductible since the policy's deductible date. This may have all been charged at your clinic, or it may have been done elsewhere. This field will show the total of whatever is entered in the Against Deductible, Elsewhere field with whatever insurable treatments are charged to the patient's account.
28. Enter the amount of treatments charged against the patient's deductible from other providers in the Against Deductible, Elsewhere field. You may need to call the patient's insurance company to find out what this amount is.
29. The Patient Payments field contains the amount of credits made only against the patient's part of the balance. This field is automatically updated when entering a payment made by the patient.
30. *If* you have configured your clinic for family billing (see **Configuration Options** in the **Tools** menu) and the patient you are looking at is a family head or a family member, you will see the total balance of all members of the family in the Family Balance field.

Insurance Tabs: 1st, 2nd, and 3rd

NOTE: If the same insurance carrier is used for more than one of the patient's carriers, a new carrier having the same information must be created by using a new key number. This is the only way the program is able to distinguish between the two. A specific name may be given to it also, if desired.

31. In the Insurance Key field, type in the key# of the insurance carrier if you know it. If not, click on the question mark and choose the insurance carrier from the list box by double clicking on it, or by clicking on it, and clicking on the OK button. If the insurance carrier has never been entered into the system before, click on the question mark, and click on the Add New button.
32. You will then need to enter the insurance Plan name for each insurance carrier, which is printed in Box 9d of the HCFA 1500 insurance form.
33. In the Print field, you may choose whether to automatically print an insurance claim for each insurance carrier when you submit the insurance. Some clinics wait until payment is received from the first insurance carrier before printing the second insurance claim. If you choose No for the second insurance carrier, you will see the prompt, "Submit treatments to special insurance print queue?" when you are entering an insurance payment from the first carrier. If the patient's primary carrier (such as Medicare) will automatically send the information to the patient's secondary carrier, choose Crossover for this field and Stellar Office will show the secondary insurance as already sent.
34. For secondary and tertiary insurance only: if the patient's primary carrier is Medicare, and the patient has a secondary or tertiary carrier that is approved for Medigap, check the box next to Medigap.
35. The next several fields containing the Insured's Information default to this patient's information. However, if this patient is *not* the person holding the insurance policy, then you will need to change these fields to the policyholder's information.
36. Type the name of the insured's employer in the Empl field. It will be printed in Box 9c of the HCFA 1500.
37. The ID# is the identification number of the insured person and is printed in Box 1a of the HCFA 1500. This defaults to the patient's social security number. If this is incorrect, change it to the correct number.
38. The Grp# is the insured's policy group number, and is printed in Box 11 of the HCFA 1500.
39. The Rel field refers to the relationship of the patient to the person holding the insurance policy, and is printed in Box 6 of the HCFA 1500. You have a choice of Self, Spouse, Child, or Other.
40. Some insurance carriers require that the clinic request an authorization number before they will pay for the patient's care. Enter that number in the Auth field. It will be printed in Box 23 of the HCFA 1500 form.
41. If you are sending claims electronically, and the patient's insurance card indicates an NEIC PAYOR SUB-ID (a four digit number which is assigned when a carrier has several different paying offices), it goes in the NEIC Sub ID field. This number will be printed in Box 11c of the HCFA 1500.
42. The CCT field (Commercial Claim Type) is also a requirement for electronic filing. You have a choice of Employee Group, Non Employee Group, or Private.

43. For primary insurance only: the Maximum Allowed in the Payment Limits box is the absolute maximum the primary insurance will pay for this patient per year.
44. For primary insurance only: the Payments to Date field shows how much the primary carrier has already paid this year on this patient.
45. For primary insurance only: the Payments Exceeded field should be set to “Bill as usual”, unless the primary carrier has stopped paying on this patient. If the primary carrier payments are exceeded, the program will inform you when you post new treatments to the patient’s file. If you no longer submit insurance on this patient, you should change this field to “Stop billing insurance”, and the full amount will be applied to the patient’s part, but no insurance claims will be printed. If the coverage is exceeded but you still submit to insurance, change this field to “Submit insurance and bill all to patient”, and the full amount will be applied to the patient’s part, and the claims will still be printed.

Insurance Options Tab

46. Choose the patient’s Claim Type which will be printed in Box 10a-c of the HCFA 1500. You have a choice of Major Medical, Workmen’s Comp, Personal Injury, or Auto Accident. When you submit insurance, you will be able to use this field as a sort field; in other words, you can choose to print only major medical claims; a group of workmen’s comp, personal injury and auto accident claims; or a group of all the different types of claims.
47. Choose the patient’s Employment Status. You have a choice of Full Time, Part Time, Not Employed, or Unknown.
48. Enter the patient’s Student Status. You have a choice of Full Time, Part Time, or Unknown.
49. The box for Benefits Assigned to Clinic must be checked for all patients having insurance Billing Codes, and a message will be printed in Box 13 of the HCFA 1500 that the patient’s signature is on file, allowing the insurance carrier to pay the clinic directly. If your patient is paid directly by the insurance carrier, you must set this patient’s Billing Code to Bill All to Patient (the same as for a cash patient, so that all charges are the patient’s responsibility).
50. If you check the box for Release Patient Info to Insurance, a message will be printed in Box 12 of the HCFA 1500 that the patient’s signature is on file.
51. If the insurance company carries over the deductible from year to year, check the box for Carryover Deductible.
52. In the Documentation field, you have up to 48 characters for any additional information that will help this claim get paid. This message is printed in Box 19 of the HCFA 1500. Do not type in x-ray information here, as you may choose for each insurance carrier whether x-ray information should be printed on the claim form.
53. You next have a choice to Figure Patient Part of the balance Before or After Reception of Benefits (EOB). If you want the patient to pay his part immediately, choose to figure the patient’s part before you receive the EOB.
54. If the payment of the primary insurance carrier is short or over, you have three choices of how to handle the patient’s part of the balance. #1 is NO automatic discount; NO change to patient part. #2 is NO automatic

discount; ADJUST patient part (the patient's part will automatically be increased by the amount an insurance payment is short when posting the payment). #3 is Automatic discount; NO change to patient part. If #3 is chosen, and you post an insurance payment which is short, the difference will be offered as an insurance discount which you can choose to accept or change, if the patient has no secondary insurance carrier.

55. This next section, Treatment Limits, allows you to keep track of the number or dollar amount of treatments that the patient has had this year, or per diagnosis, for carriers (like Medicare) that may set a limit to the treatments they will pay for. Once the initial information is entered, the program will automatically keep count of the number of a particular treatment or the amount charged for a particular treatment (see NOTE below). When a patient has reached his limit, you will be notified when adding a treatment to the patient's file, but you will *not* be prevented from entering more treatments into the patient's file.

NOTE: This treatment counter will keep track of treatments only if it is told to by checking the box to Count for Insurance Limits, found in **Records/Treatments.**

56. If the patient has had an accident, enter the Accident/Onset Date. If a date is entered without a description, the date will be printed in Boxes 14 and 19 of the insurance form. If an Accident Description (see #58 below) is entered without a date, the description will be printed in Box 14 of the HCFA 1500. If neither is entered, the Consult Date (also found on the Insurance Options tab) will be printed in Box 14.
57. If the patient was in an auto accident, you will need to enter into the Accident State field the two-letter abbreviation of the state in which the auto accident occurred. This will be printed in Box 10b of the insurance form.
58. The next line, Accident Description, allows you to enter a brief description of the accident, such as the cause, nature, whether it was at work, etc. You have up to 40 characters for this description. This will be printed in Box 19 of the HCFA 1500.
59. You may check the box for Previous Symptoms, if the patient has displayed previous symptoms of his current condition.
60. If you checked the box for Previous Symptoms, you may enter the date on which the previous symptoms began in the Previous Symptoms Date field.
61. The Xray Date is automatically updated by the program when an x-ray treatment code is added to the patient's file. If you have chosen for the patient's insurance carrier to print the x-ray date on the HCFA 1500 which is occasionally required by the state and/or carrier, then this is the date that will be printed. You have the option of changing this field yourself rather than letting the program update the x-ray date.
62. Enter the date that the patient first visited the provider for this injury or illness in the Consult Date field. The program defaults to the current date, but this date can be changed at any time. It will be automatically updated if you are changing a diagnosis for a patient and you choose to update the Consult Date field. If there is no Accident/Onset Date for this patient, the Consult Date will be printed in Box 14 of the HCFA 1500 form.
63. If the patient has a Disability, you may choose whether it is Total or Partial. Leave it on None to indicate no disability. By choosing Total or Partial,

you may then enter the disability starting and ending dates, as well as a date for returning to work.

Diagnoses Tab

64. On this screen you may enter up to four diagnoses for the patient, which can be changed at any time if necessary. You may enter the key# of the diagnosis if you know it (these are numbers assigned by Stellar Office to the list of industry standard diagnoses), or you may enter the ICD code, including the period. If you do not know either of these, simply click on the question mark and choose the diagnosis from the list box by clicking on it and clicking the OK button, or by double clicking on the diagnosis. If you do not see your diagnosis in the list, you may add it by clicking on the Add New button.
65. The Diagnosis Effective Date defaults to the current date when adding a new patient.

QuickNotes Tab

NOTE: On this page of the patient's file, you may enter up to 26 lines of notes for each date. These notes are primarily for in-office use only, and may be printed at any time.

66. If the current date is not correct, type in the date below in the MM/DD/YY format and press enter.
67. Click into the notes box and start typing. Just use the Enter key when you want to start typing on a new line.
68. Move back and forth between dates of notes by clicking on the Previous Date button and the Next Date button.
69. If you wish to print a list of notes for this patient, click on the Print Notes button and choose the correct printer.

Messages Button

NOTE: This item allows you to attach a message to a patient's file, and that message will be displayed on the screen in **Records/Patients**, **Accounting/Payments and Corrections**, and **Accounting/Post Transactions**. You will have the option of printing the message on the patient's statements and visit sheets by making that choice in **Tools/Configuration Options/Insurance, Billing, & Appointment Options**. There are two message lines available, with 40 characters on each line.

70. Click on the Messages button.
71. Type your message(s) into one or both lines, and click on the Save button to save the messages. You will see the messages immediately at the bottom of the patient's file screen.

Viewing a Patient's Information

1. From the main screen, choose **Records**.
2. Click on **Patients**.
3. Just start typing the key number or name to locate the patient you want to view.

4. Choose the correct patient by clicking on it, and then click on the View button.
5. You will not be able to save any changes from this screen – this is simply for viewing only. Click on the Cancel button when finished.

Changing a Patient's Information

1. From the main screen, choose **Records**.
2. Click on **Patients**.
3. Just start typing the key number or name to locate the patient you want to change.
4. Choose the correct patient by double clicking on it, or by clicking on it once and then clicking on the Change button.
5. Make the necessary changes and click on the Save button.

Changing a Patient's Billing Code, Co-Pay Amount, Deductible or Against Deductible

WARNING: If you make a change to the patient's Billing Code, Insurance or Patient Pays, Deductible, or Against Deductible, Elsewhere fields, you will need to enter and confirm some additional information after you click on the Save button. You will NOT be able to cancel this operation once you have clicked on the Save button in the patient's file.

1. When the Deductible Change screen appears, enter the first date of the patient's history that is affected by the change you have made.
2. You must click on the Recalculate button, and check the amounts provided.
3. Change the Against Deductible, Elsewhere field, if necessary.
4. Change the Patient Part of Balance, if necessary.
5. Click on the Save button.

Changing or Adding an Insurance Carrier to an Existing Patient

If you change a cash patient to an insurance patient, you will be asked to enter the effective starting date for the primary and/or secondary insurance.

If you add a secondary carrier to an existing insurance patient, you will be asked to enter the effective starting date for that insurance carrier.

If you delete either a primary or secondary carrier, you will be asked to enter the effective ending date for those carriers.

If you change from one primary carrier to another, any treatments that have not yet been submitted will be submitted with the new carrier.

Changing a Patient's Diagnosis

If you change a patient's diagnosis, you may choose for the program to update both the Diagnosis Effective Date, which appears on the

Diagnoses tab, and the Consult Date, which appears on the Insurance Options tab in the patient's file.

Viewing a Patient's History

Patients [#2-JANE S. PATIENT] Balance: \$475.00

Transaction History | Credit History | Running Balance | Yearly Totals | Deductible Info

D	ServcDate	cd	CPT#	Description	Key#	Amount	Status	SubmitDT
1	9/03/2003	IP		PROFFITT INSURANCE COMPANY	0002	24.00-		07/21/03
1	9/04/2003	AT	98941	3-4 SPINAL MANIPULATION REGION	0160	35.00	pending	09/08/03
	9/04/2003	IS		Primary Insurance Submittal	0002	35.00		09/08/03
1	9/04/2003	CK		Check Payment		30.00-		
1	9/09/2003	AT	98941	3-4 SPINAL MANIPULATION REGION	0160	35.00	pending	09/15/03
	9/09/2003	IS		Primary Insurance Submittal	0002	35.00		09/15/03
1	9/23/2003	AT	98941	3-4 SPINAL MANIPULATION REGION	0160	35.00	pending	09/29/03
	9/23/2003	IS		Primary Insurance Submittal	0002	35.00		09/29/03
1	9/23/2003	CP				10.00-		
1	10/01/2003	AT	98941	3-4 SPINAL MANIPULATION REGION	0017	35.00	pending	10/06/03
	10/01/2003	IS		Primary Insurance Submittal	0002	35.00		10/06/03
1	10/01/2003	CK		Check Payment		30.00-		
1	10/07/2003	IP		PROFFITT INSURANCE COMPANY	0002	24.00-		08/25/03
1	10/10/2003	AT	98941	3-4 SPINAL MANIPULATION REGION	0017	35.00	pending	10/13/03
	10/10/2003	IS		Primary Insurance Submittal	0002	35.00		10/13/03
1	11/04/2003	AT	98941	3-4 SPINAL MANIPULATION REGION	0017	35.00	waiting	
1	11/13/2003	AT	98940	1-2 SPINAL MANIPULATION REGION	0016	30.00	waiting	

Show 1st Insurance Show 2nd Insurance [Add/View Memo](#) [Print](#) [Back](#)

1. When in the patient's file, click on the History button.
2. When you are finished viewing, click on the Back button to return to the main portion of the patient's file.

Transaction History Tab

This is the first page of information that you will see upon opening the patient's history. It includes every type of transaction ever added to the patient's file, in time order. When more than one transaction is made on a particular date, the date on the first transaction appears in black, while the rest appear in gray. That makes it easier to differentiate between the dates.

Any amount credited to the patient's file appears in red. All charges appear in black. Insurance submittals, patient billings, errors, etc. are shown in blue.

You have the choice of showing history for primary insurance or secondary insurance if the patient has more than one insurance carrier by clicking on the button at the bottom of the screen to Show 1st Insurance, or Show 2nd Insurance.

The following columns are included in the Transaction History screen in this order: D (Doctor key#), ServcDate (service date), cd (transaction code), CPT# (CPT code), Description, Key# (key# for

either treatments or insurance carriers), Amount, Status (showing whether an item has been paid, or whether an item has an error attached), SubmitDT (submit date), Comment, OtherDT (other date), Carrier, Modifier, and Sublx (subluxation level).

The different codes you may see in the cd (Transaction Code) column are CP Cash Payment, ID Insurance Discount, DA Debit Adjustment, CK Check Payment, RD Remove Debit, RC Remove Credit, CC Credit Card, WO Write Off, R+ Raise Patient Part, IP Insurance Payment, AT Treatment Added, R- Lower Patient Part, LP Lawyer Payment, RI Reimburse Insurance, IS Insurance Submittal, CA Credit Adjustment, RO Reimburse Overpayment, IN Insurance Pymt. Note, CD Cash Discount, TX Tax Record, BN Patient Billing.

The IN record, or Insurance Payment Note, is a note of an insurance payment that is attached to the original insurance submittal record (the actual IP or Insurance Payment record appears in date order).

When a debit or credit is removed, the word “error” is attached to both the original debit or credit, as well as the RD (Remove Debit) and RC (Remove Credit) records.

Insurance Memo

This memo allows you to make notes regarding the status of an insurance submittal. It is attached directly to the submittal record on which you are making the notes, and is only available when you are viewing the Transaction History screen.

1. When in the patient’s history, click on the Transaction History tab.
2. Click anywhere on the Insurance Submittal record for which you wish to make a note.
3. Click on the Add/View Memo button.
4. Type your note in the window provided.
5. If you have more than one submittal with notes attached, you may scroll from date to date by clicking on the Previous or Next buttons.
6. When you have resolved this insurance submittal to your satisfaction, you may check the box for Item Resolved.
7. Click on the Save button to save your message, or Cancel to exit without saving.

Credit History Tab

This list shows in date order all credits that have been made to the patient’s account. The columns in order are as follows: D (doctor key#), Credit Date, cd (transaction code), Description, Key# (of an insurance carrier making a payment), and Amount.

Running Balance Tab

This screen show in date order all debits and credits made to the patient’s account, and they are added and subtracted to compute a running balance of the patient’s account. The columns are in the following order: D (Doctor key#), ServcDate (service date), cd (transaction code), CPT# (CPT code), Description, Key# (key# for either treatments or insurance carriers), Amount, and Balance.

Yearly Totals Tab

The yearly totals screen defaults to the current year's dates, but you may enter whatever dates you wish to find the totals during that period of time. Totals are shown for credits, what the patient has paid, what insurance has paid, debits and charges.

Deductible Info Tab

On this page you may see the deductible, insurance, and billing code history of the patient.

Printing a Patient's Information

1. When in a patient's file, either on the main pages or in history, click on the Print button.
2. You may choose to print personal and insurance information alone, transaction history alone, or both together.
3. You have the option of checking the box to include a signature line on the printout.
4. If you choose to print transaction history, you have the additional choice of printing All History, Credits Only, Running Balance, or Yearly Totals.
5. If you choose to print transaction history, enter the earliest date for which to start printing.
6. Click on the Print button and choose the correct printer.

Posting Services or Transactions

This menu item is designed for entering the daily transactions of a patient. You may enter up to 12 transactions per patient at a time, including adding treatments, cash payments, credit card payments, check payments, cash discounts, insurance discounts, or write-offs. Using this menu item saves time whenever entering more than one transaction per patient, and especially when posting all the patients at the end of the day. Any transaction other than those mentioned above must be entered from **Payments and Corrections** in the **Accounting** menu.

The following is an example Daily Transaction screen:

Daily Transactions - [Patient# : 000002 JANE S. PATIENT]

Treatment Date: 11/14/2003 Account Code MC X-Ray Date: 06/29/2001 Pat. Part: \$404.00
 Provider: 1 DOCTOR S. ONE Visits Today: 00 Balance: \$440.00
 Referred by: # Visits Authorized: Remaining:

Key	CPT	Description	Fac.Key	Modifier	Unit	Diag	Charge	Taxes
17	98941	3-4 SPINAL MANIPULATION REGIONS		GAGY	01	1	35.00	

Insurance Plans:
 2 PROFFITT INSURANCE COMPANY
 No Insurance Plan Found
 No Insurance Plan Found

Diagnoses: Diag. Effective Date: 06/23/2003
 739.1 C4 SEG. DYS.
 722.4 DEGENERATION
 739.3 L5 SEG. DYS.
 722.52DEGENERATION

Tally
 Taxes: \$0.00
 Paid: \$0.00
 All Credits: \$0.00
 All Charges: \$35.00

New Pat. Part: \$404.00
 New Balance: \$475.00

Walkout Statement Message
 Thank you.
 Print Walkout Statement

Appointment: 11/20/2003 08:00a Save Cancel

1) PAYMENT PLAN \$30.00 A MONTH 2)

Posting Daily Transactions

1. From the **Accounting** menu, choose **Post Transactions**.
2. Choose your patient from the list box and click on Post Transactions, or double click on the patient's name.
3. If treatments have previously been entered for the patient on this same date, the program will ask you whether to count a second visit for the patient.
4. If it is necessary to change the date, you may either type it in using the MM/DD/YY format, or click on the arrow down button and double click on the correct date on the calendar.
5. You can change the provider by clicking on the arrow down button and choosing a different provider number.
6. If you have chosen to show previous treatments when posting new treatments to a patient on the Clinic/Insurance Options Tab located in **Tools/Configuration Options/Insurance, Billing & Appointment Options**, you will see the treatments displayed from the patient's previous visit. If the current visit does not include the same items, simply enter the correct key number or transaction code for the new transactions, press enter, and press the right arrow key to move across the grid box. Stellar Office will replace the old item shown with the new treatment or transaction you have entered. If any of the previous items are the same as for the current visit, just use your arrow down key to get to the first line of the grid box in which you wish to add a new transaction.

NOTE: Look at the line on the bottom of the display screen for instructions on how to proceed within the grid box.

7. To enter a new treatment or transaction, simply type the treatment key number or the transaction code in the Key column of the grid box. If you do not know the treatment key number, click on the arrow down button on the screen, choose the correct treatment from the list, and press enter. Please skip to instruction #9 for a description of other transactions that may be entered from this screen.
8. Upon entering a treatment key number, the CPT code, description and standard charge will be displayed. The other header items, MOD (modifiers), UNIT (number of units of the treatment), DIAG (diagnosis), LEVEL (subluxation levels), etc. are only required for certain combinations of carrier, treatment and configuration. The list below includes brief descriptions of these items. If your configuration requires one of these items, the cursor will stop under them and additional prompt information will appear in the lower part of the screen.
 - *If* the treatment contains a modifier and the insurance carrier allows modifiers, you may either leave what appears in the Modifier column of the grid box, or type one or more new modifiers, up to eight characters, two for each modifier with no spaces between.
 - *If* the treatment is checked in the treatment file to allow multiple units, you may enter the correct unit count in the Unit column of the grid box. This allows you to bill items such as electrical stimulation as one treatment with multiple areas of application (much quicker than entering the same treatment for each application).
 - *If* you have activated the diagnosis/treatment link in the insurance carrier's file, the patient's diagnoses will be displayed in the lower left corner of the screen and you may enter the appropriate diagnoses in the Diag Column of the grid box; for example, enter 124 to attach this treatment to diagnoses 1, 2 and 4. The numbers must be in ascending order with no spaces between.
 - *If* the insurance carrier is Medicare *and* your clinic is configured for subluxation levels (located in **Configuration Options** in the **Tools** menu), you may enter the subluxation level in the Sublux Level column of the grid box.
 - *If* you have activated a treatment limit in a patient's file *and* the treatment is designated as a treatment that is counted for insurance limits, then you will see the total visits and/or amounts accumulated by this patient displayed in the lower left corner of the screen. If these limits have been exceeded, the screen will display a message indicating this. This allows you to prevent posting charges beyond Medicare or HMO limits.
 - *If* the treatment is marked as an inventory item that needs to be reordered at a certain level, you will be prompted to reorder that item when you reach that level.
 - *If* a treatment has been defined with a write-off amount, the program will display the amount on the next line of the grid box after the treatment, once you have entered the treatment and used

the arrow down button to reach the next line. You may accept the displayed amount or delete the “WO” code and press enter, if you do not wish to use the automatic write-off.

- *If any treatment you have entered has a sales tax designation, you may accept or change the amount shown in the Taxes column of the grid box, or delete it if it is not needed.*
9. The codes for the other transactions available on this screen are as follows: cash payments (CP), check payments (CK), credit card payments (CC), cash discounts (CD), insurance discounts (ID), and write offs (WO). Following the code you will be prompted to enter a comment (or a check number for CK) for which you are allowed up to twenty characters. This comment will be attached to the transaction and will be displayed whenever you view the patient’s information or print it on a statement. Then the cursor will stop in the Charge column of the grid box in which you can enter the amount of the payment.
 10. If you wish to make a new appointment for this patient, click on the appointment button to open the appointment book.
 11. If your clinic is configured to print walkout statements, the box marked “Print Walkout Statement” will be automatically checked. Otherwise, you may check it to print a walkout statement for this patient. You have the option to change the message that appears on the walkout statement – just retype it in the box marked “Walkout Statement Message”. After you click on the save button, the program will prompt you to choose the correct printer.

Making Payments or Corrections

This item is primarily designed for entering insurance payments and for doing account corrections. All credits, debits, corrections, write-offs, discounts and reimbursements may be entered here. Single treatments may also be entered here; however, multiple transactions to a patient’s account are entered more easily and more quickly from **Post Transactions** in the **Accounting** menu. Each entry will affect the patient’s Total Balance, except for Raise Patient Part and Lower Patient Part, which adjust both the Patient Part and the Insurance Part without changing the Total Balance.

One of the convenient features of Stellar Office is shown on the **Payments and Corrections** screen: the numbers that appear in gray next to the buttons are the sum total for that type of transaction which you have entered in one session. (If you exit this function and return later to post more payments, you will no longer see those numbers from the previous session.) This feature can be very helpful, for example, if you lose track when entering a number of insurance payments. It is much easier to compare the total displayed to the total you should have entered without checking each patient separately.

Some of these transactions are very similar in function. The different transaction types, however, allow Stellar Office to show separate totals on the Daily, Monthly, and Yearly Summary reports and thus give you greater flexibility in running your practice and tracking the cash flow. They are also used for calculating the patient’s part of the balance and affect functions in other parts of the program.

If you need further instruction or explanation for any of the following items, please open the **Stellar Manual** from the **Help** menu in the Stellar program.

Payments and Corrections - [Patient #2-JANE S. PATIENT]

Appointment

Patient Part: \$404.00 Balance: \$440.00

Transactions That Lower a Patient's Balance		Transactions That Raise a Patient's Balance	
Payments		Charges	
Cash Payment (CP)	.00	Add a Treatment (AT)	.00
Check Payment (CK)	.00	Reimburse Insurance (RI)	.00
Credit Card (CC)	.00	Reimburse Overpay (RO)	.00
Insurance Payment (IP)	.00	Add a Tax Record (TX)	.00
Lawyer Payment (LP)	.00	Adjustments	
Adjustments		Debit Adjustment (DA)	.00
Credit Adjustment (CA)	.00	Remove Credit (RC)	
Cash Discount (CD)	.00	Transactions That Adjust a Patient's Part	
Insurance Discount (ID)	.00	Raise Patient Part (R+)	
Remove Debit (RD)		Lower Patient Part (R-)	
Write Off (WO)	.00		

Select using a single click.

Back

PAYMENT PLAN \$30.00 A MONTH

Transactions That Lower a Patient's Balance

Cash Payment (CP)

This transaction allows you to post a cash payment, lowering the patient's total balance, as well as the patient's part, by the amount that you enter.

Check Payment (CK)

This transaction works exactly the same as a cash payment, but allows you to enter the check number for your records.

Credit Card Payment (CC)

This transaction also works exactly the same as a cash payment, but the credit card number is generally entered in the Comments field for your records.

Insurance Payment (IP)

This transaction is for payments received from insurance carriers. It lowers the balance due by the amount you enter. You will only be able to view and mark as paid those treatments that are pending (have already been submitted), and not waiting to be submitted to the insurance carrier.

If the patient's insurance carrier refuses to pay for a treatment, you will need to enter a \$0 payment here so that the insurance pending flag is removed from the treatment and it will not continue to reappear as an unpaid pending treatment.

For co-insurance, deductible-only, and co-pay patients, insurance payments lower the total balance, but **NOT** the patient part unless the payment is made by a secondary carrier.

Lawyer Payment (LP)

This transaction works exactly the same as an insurance payment; however, it includes treatments that are waiting to be submitted as well as pending treatments. Using a separate transaction of Lawyer Payment allows you to separate the different types of payments in your records.

Credit Adjustment (CA)

This transaction allows you to credit a patient's total balance, as well as the patient's responsible part if necessary, by the amount that you enter.

Cash Discount (CD)

This transaction allows you to give a discount when a patient pays cash. It will lower the patient's total balance by the amount you enter.

Insurance Discount (ID)

This transaction works the same as the cash discount and allows you to give a discount on insurance payments. The total balance will be credited, but not the patient's part. If you wish to give a discount automatically when an insurance payment is short, you may choose the correct option on the Insurance Options Tab of the patient's record. This method allows you to enter the difference as an insurance discount when you post an insurance payment, and it will be unnecessary for you to utilize this separate insurance discount screen.

Remove Debit (RD)

This transaction allows you to remove any debit transaction, such as a treatment charge that has been mistakenly entered. Also, if the wrong date was accidentally entered on a debit transaction, it can be corrected using the Remove Debit transaction. You can move the debit to another date automatically without having to re-add the treatment by entering the new date in the field that says "To Change Service Date, Enter the New Date Here:". You will also be able to move or delete any attached insurance submission notes and insurance or lawyer payment notes. (These should only be moved or deleted if the treatment to which it is attached is moved or deleted.)

NOTE: You should not move or delete treatments/services that have already been marked as paid with an insurance or lawyer payment unless the payment itself is first removed by using the REMOVE CREDIT transaction. After the payment has been removed, you can then move or delete the treatment/service. If you choose to override and move or delete the treatment anyway, this may cause errors to the patient's part of the balance by breaking connections in the history records that affect other parts of the program.

Write Off (WO)

This transaction allows you to give a write-off to a patient (for example, if the insurance carrier will not pay the full amount of a treatment), and lowers the patient's total balance by the amount entered.

Transactions That Raise a Patient's Balance

Add a Treatment (AT)

On this screen you may add a single treatment for a patient. If you wish to add multiple treatments at the same time for a patient, use **Post Transactions** from the **Accounting** menu.

If you wish to apply a treatment to the patient's file that will NOT be submitted to insurance, this is the only place you can override the flag set in the treatment file about whether the treatment will be submitted to insurance. You are not able to make this choice from **Post Transactions** in the **Accounting** menu.

Reimburse Insurance (RI)

This transaction is used to adjust the patient's account if an insurance carrier has overpaid and then subsequently notified you of the overpayment. It will increase the patient's total balance.

Reimburse Overpayment (RO)

This transaction is used to adjust the patient's account if a patient has overpaid and been reimbursed. It will increase both the patient's total balance and the patient's part.

Add a Tax Record (TX)

If you have forgotten to mark a treatment item for sales tax, and you are adding this treatment to a patient's account, you may add the tax amount here.

Debit Adjustment (DA)

This transaction allows you to debit a patient's account by the amount that you enter. It will increase the patient's total balance, as well as the patient's responsible part if you so choose.

Remove Credit (RC)

This transaction allows you to remove any credit transaction from a patient's account. Also, if the wrong date was accidentally entered on a credit transaction, you can move the credit to another date by using the New Date field.

Transactions That Adjust a Patient's Part

These functions allow you to adjust the patient's part of the balance - there will be no effect on the total balance. You may also adjust the patient's part directly (without entering a transaction) by changing it in **Patients** in the **Records** menu. These functions are not available if the patient is not being billed at all, or is being billed 100% of the Total Balance (Billing Code is either Do Not Bill Patient, or Bill All to Patient, found on the Billing tab of **Records/Patients**). If the Billing Code is Do Not Bill Patient, then the Patient Part always remains at \$0. If the Billing Code is Bill All to Patient, then the Patient Part always equals the Total Balance.

Filing Insurance Electronically

This item will only be used if you submit your insurance claims electronically. It allows you to create a file containing claims in National Standard Format for later transmission via the phone line to a clearinghouse, or submitting through the Internet. This program functions the same as

submitting claims on paper, and submits only those carriers which have been set to submit electronically in **Records/Insurance Carriers**. These carriers are automatically skipped when submitting paper claims.

You should enter all information that may have changed pertaining to your patients and their insurance information *before* you submit insurance claims; for example, diagnosis and treatments, patient and insurance addresses, onset and accident dates.

Treatments that have been posted to a patient's account, but not yet submitted (printed on paper or filed electronically), will show the word "Waiting" next to the treatment in the patient's history.

If the insurance has previously been submitted, but not yet paid, a "P" (pending) will show in the patient's history, as well as the submit date. Treatments for which the insurance carrier has paid and you have entered in the system will no longer show a pending flag ("P").

You may want to run a pre-insurance report before you submit insurance claims. You will see the diagnosis for each patient whose insurance claims will be printed and the age date of the diagnosis. This way you will be able to change the diagnosis, if needed, before the insurance claim is submitted.

Key	Name
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Submitting New Insurance Claims Electronically

1. From the main screen, choose **Billing Insurance**.
2. Go to **Electronic Claims**.
3. Click on **New Claims**.
4. Select the type of claims you would like to submit: Major Medical; Auto, PI, WC (auto accident, personal injury and worker's comp); or All Types.
5. If you have chosen in **Tools/Configuration Options/Insurance, Billing & Appointment Options** to require a minimum amount prior to printing

claims, you will need to enter the amount in the entry field labeled “Minimum Amount”.

6. You may choose to submit only those patients having a specific Account Code (set on the Personal Tab in **Records/Patients**. This is a field in which you can enter your own codes for sorting and grouping purposes, except for “CP” which designates cash patients, and “IA” which designates inactive patients.)
7. You then have the following choice to submit claims for All Patients, a Single Patient, or a Single Provider. If you choose a single patient, you will be able to pick which one from the list box that appears on the screen. Either highlight the name by clicking on it once, and then clicking on the Create Claims button, or double click on it to create claims. If you choose a single provider, put the number of the provider in the entry field labeled “Provider” and click on Create Claims.
8. You have the choice of filing claims for one or all providers if you choose All Patients.
9. If you have an existing file of electronic claims you have already sent through the phone lines or internet, choose to delete the file. You may add to the existing file if it has not yet been sent.
10. If no patients or treatments are found that match the choices, the program will inform you that there are no treatments to be submitted.
11. Close Stellar Office and follow your clearinghouse instructions for sending electronic claims.

Printing Insurance Claims

This will print insurance claim forms only for patients who have treatments to be submitted (waiting). You should enter all information that may have changed pertaining to your patients and their insurance information *before* you submit insurance claims; for example, diagnosis and treatments, patient and insurance addresses, onset and accident dates.

Treatments that have been posted to a patient’s account, but not yet submitted (printed on paper or filed electronically), will show the word “Waiting” next to the treatment in the patient’s history.

If the insurance has previously been submitted, but not yet paid, a “P” (pending) will show in the patient’s history, as well as the submit date. Treatments for which the insurance carrier has paid and you have entered in the system will no longer show a pending flag (“P”).

You may want to run a pre-insurance report before you submit insurance claims. You will see the diagnosis for each patient whose insurance claims will be printed and the age date of the diagnosis. This way you will be able to change the diagnosis, if needed, before the insurance claim is printed.

Submitting New Insurance Claims On Paper

1. From the main screen, choose **Billing Insurance**.
2. Go to **Paper Claims**.
3. Click on **New Claims**.
4. Select the type of claims you would like to submit: Major Medical; Auto, PI, WC (auto accident, personal injury and worker's comp); or All Types.
5. If you have chosen in **Tools/Configuration Options/Insurance, Billing & Appointment Options** to require a minimum amount prior to printing claims, you will need to enter the amount in the entry field labeled "Minimum".
6. You may choose to submit only those patients having a specific Account Code (set on the Personal Tab in **Records/Patients**. This is a field in which you can enter your own codes for sorting and grouping purposes, except for "CP" which designates cash patients, and "IA" which designates inactive patients.)
7. Choose the provider for which you would like the claims printed, or accept the default of 0 for all providers.
8. You then have the following options to print insurance forms for:
 - a. all patients (will print for all patients with waiting claims)
 - b. a range of patients (will print for a range of patients that you specify in alphabetical or patient number order)
 - c. one insurance carrier, all patients (will print only for those patients covered by a specific insurance carrier)

- d. a single patient (choose from the list box below by clicking on the patient once and skip to #10, or simply double click on the patient and choose the correct printer)
 - e. all carriers in numeric order
2. For All Patients, a Range of Patients, a Single Carrier, or All Carriers you may choose to print your claims in alphabetical order or numerical order. When you choose All Carriers, the forms are sorted first by carrier in numerical order, and then in alphabetic or patient number order, according to which one you choose.
 3. If you have chosen a Range of Patients, you must enter the beginning and ending names or numbers, according to whether you choose to print in alphabetic or numeric order.
 4. Click on the print button and choose the correct printer.
 5. If no patients or treatments are found that match the choices, the program will inform you that there are no treatments to be submitted.

Making Appointments

Before using Stellar Office's new appointment book, it would be wise to set your clinic's hours in **Configuration Options** in the **Tools** menu. Then, your open hours will appear in the daily schedule with a yellow background – closed hours are shown in gray. When adding an appointment (see instructions below), you may choose different types of appointments that will show on your schedule in different colors according to the following list:

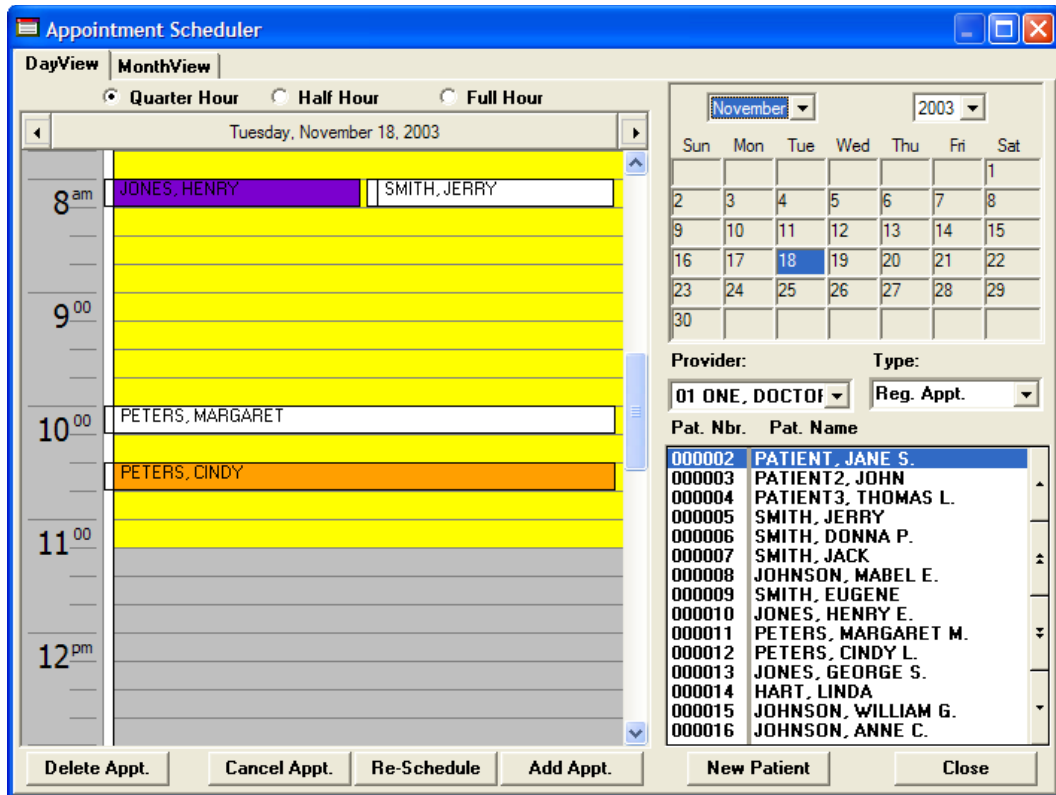
Regular Appointment	White	
New Patient Appointment	Orange	
Re-Exam		Green
ROF (Return on Findings)	Blue	
Maintenance		Purple

This list is a default list provided by Stellar. If you want to make changes to this list, or to the colors associated with each appointment type, you will need to make the changes in **Configuration Options** in the **Tools** menu. Click on the Appointment Options tab, and then the Appt Types button.

The calendar on the upper right in the appointment book allows you to quickly and easily choose a day to make an appointment, just by clicking on the day. The patient list on the lower right makes it easy to pick your patient without opening another screen. You may even add a new patient from here with a minimum of information, and the record can be filled in completely when your patient comes in for the first time. Also, if you are trying to find a less busy day on which to make an appointment, simply click on the MonthView tab to see how many appointments are scheduled for each day.

If you make a mistake and enter an appointment for the wrong day, time, or patient, you may delete it, using the Delete button, without leaving any trace in your records. If, however, a patient cancels an appointment, and you want to keep track of how many appointments are being cancelled, use the Cancel button to remove the appointment from the appointment book. You will still have a record of the cancelled appointments in **Appointments/Appointment Listing**.

Here is a sample appointment book screen:



Adding a New Appointment

1. From the main screen, click on the **Appointments** menu.
2. Click on **Appointment Book**.
3. You may choose to view the schedule with quarter hours, half hours, or just hours, by clicking on the correct circle.
4. Choose the correct day from the calendar at the upper right by clicking on the day, or change the month and year if necessary, and then click on the day.
5. Click on the time for the appointment on the daily schedule.
6. Choose the correct provider from the drop list entry field below the calendar.
7. Choose the appointment type from the drop list entry field below the calendar.
8. Find the correct patient either by typing a patient number, a patient name, or using the arrows on the right to scroll through the list box. You may then select the patient either by double clicking on it, or by clicking on it and then clicking the Add Appt. button below.