

WELCOME TO THE CHIROPRACTOR WHITEFISH

NAME_____DATE_____

ADDRESS_____CITY_____

STATE_____ZIP_____PHONE#_____

EMAIL_____SS#_____

CELL#_____CELL PROVIDER_____

BEST WAY TO REACH YOU? TEXT EMAIL PHONE CALL

MALE/FEMALE BIRTHDATE_____AGE_____

WHO CAN WE THANK FOR THE REFERRAL?_____

EMERGENCY CONTACT_____PHONE#_____

1ST COMPLAINT OR CONCERN_____

HOW LONG HAS THIS BEEN GOING ON?_____

RATE DISCOMFORT ON SCALE OF 1 (MILD) TO 10 (SEVERE)_____

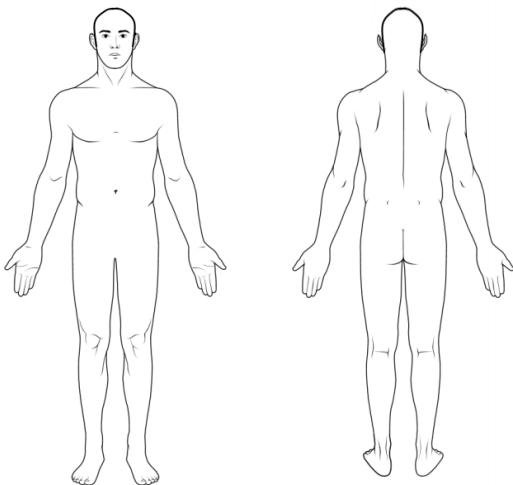
TYPE OF PAIN:

SHARP DULL THROBBING

SHOOTING TIGHTNESS

BURNING TINGLING NUMBNESS

SWELLING OTHER



ON THE DIAGRAM, PLEASE PUT AN
X ON AREAS THAT ARE BOTHERING
YOU

SECONDARY CONCERNS_____

HEALTH HISTORY HAVE YOU EXPERIENCED THE FOLLOWING:

- | | | | |
|--|---|---|--|
| <input type="radio"/> Allergies | <input type="radio"/> Arthritis | <input type="radio"/> Bronchitis | <input type="radio"/> Fertility problems |
| <input type="radio"/> Bowel/Bladder issues | <input type="radio"/> Buzzing/Ringing in ears | <input type="radio"/> Diabetes | <input type="radio"/> Headache |
| <input type="radio"/> Constipation | <input type="radio"/> Depression | <input type="radio"/> Fainting | <input type="radio"/> Irritability |
| <input type="radio"/> Dizziness | <input type="radio"/> Fatigue | <input type="radio"/> Herniated Disk | <input type="radio"/> Loss of smell/taste |
| <input type="radio"/> Fever | <input type="radio"/> Fractures | <input type="radio"/> High Blood Pressure | <input type="radio"/> Menstrual irregularity |
| <input type="radio"/> Hernia | <input type="radio"/> Hot flashes | <input type="radio"/> Loss of Balance | <input type="radio"/> Nervousness |
| <input type="radio"/> Jaw Problems | <input type="radio"/> Kidney Disease | <input type="radio"/> Menstrual Pain | <input type="radio"/> Shoulder Pain |
| <input type="radio"/> Light sensitivity | <input type="radio"/> Miscarriage | <input type="radio"/> Neck Stiffness | <input type="radio"/> Thyroid problem |
| <input type="radio"/> Mood Swings | <input type="radio"/> Neck Pain | <input type="radio"/> Seizures | |
| <input type="radio"/> Numbness | <input type="radio"/> Pins & Needles | <input type="radio"/> Stroke | <input type="radio"/> OTHER |
| <input type="radio"/> Sinus problems | <input type="radio"/> Stomach Upset | <input type="radio"/> Back Pain | _____ |
| <input type="radio"/> Ulcers | <input type="radio"/> Asthma | <input type="radio"/> Cancer | |
| | | <input type="radio"/> Digestive issues | |

HAVE YOU HAD X-RAYS OR AN MRI IN THE LAST YEAR? YES/NO

WHERE?_____FOR WHAT?_____

DOES YOUR HEALTH INTERFERE WITH YOUR LIFE IN ANY OF THESE AREAS?

WORK	SLEEP	ENERGY	PRODUCTIVITY
EXERCISE	SELF CARE	ATTITUDE	CREATIVITY
RECREATION	RELATIONSHIPS	PATIENCE	OTHER_____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:_____

HAVE YOU EXPERIENCED THE FOLLOWING IN RECENT MONTHS/YEARS?

BROKEN BONES AUTO ACCIDENT HEAD INJURY STROKE HOSPITALIZED

DESCRIBE ANY THAT

APPLY:_____



124 Central Ave.
Whitefish, MT 59937
406-730-2233
Dr. Tim Dudley

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this office has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Guardian Name

Date

Signature

TERMS OF ACCEPTANCE OF CARE

When a patient seeks Chiropractic care and we accept such a patient for care, it is important that both parties be working toward the same goal. Chiropractic has one goal: to facilitate the body's correction of vertebral subluxation. Chiropractors do this by making specific adjustments to the spine. Health is a state of optimum function physically, mentally, socially, and emotionally, not merely an absence of disease. Vertebral subluxation is a misalignment of 1 or more of the 24 vertebrae which causes an alteration in nerve function, interference of the mental impulses, which lessens the body's ability to achieve maximum health.

We do not diagnose, or treat any disease besides vertebral subluxation, though you may find relief from many symptoms when the subluxations are treated. If during care, the doctor finds unusual non-chiropractic findings, he will advise you. Our only practice objective is to eliminate a major interference to the body's expression of innate wisdom, by adjusting the vertebral subluxation. My signature indicates that I have read the above statement and accept chiropractic care with this understanding.

Signature _____ Date _____

FINANCIAL AGREEMENT

We strive to always inform patients of the expected course of care and the cost that will be incurred receiving the care. You agree that in return for the services provided by the doctor, you will pay your account at the time services are rendered or will make financial arrangements satisfactory to The Chiropractor for payment.

CASH: Payment is expected on the day that services are rendered. A fee reduction will be applied to services only if paid in **full** at the time of service and if your account is at a zero balance. We accept cash, check, or credit card. The cash price of an adjustment is \$49.

INSURANCE: Insurance is a contract between you and your insurance company. You will need to pay your coinsurance and/or co-payments at the time of service. We bill insurance as a courtesy to you and although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You will be responsible for any balance left unpaid by the insurance company. We are currently only in contract and billing the following insurance companies: **Blue Cross/Blue Shield, Allegiance, and Pacific Source**. You have the option to submit your own claims to other insurance companies not listed. The cost of an adjustment billed to insurance is \$55.

Medicare: We are a non- participating provider with Medicare. We agree to bill Medicare, for 30 reasonable and customary adjustments. There may be services rendered in our office that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/Guarantor. By signing the ABN, it is understood that you are financially responsible for payment of any services that are not deemed medically necessary by Medicare.

Medicaid: We do take Medicaid if patient has a referral specifying the treatment and terms of care. If for some reason Medicaid does not pay or approve of care, the Doctor will have the option to switch patient to cash pay or release the patient from care. The doctor reserves the right to stop treatment or limit the amount of Medicaid patients within the practice at one time.

Monthly Statement: If there is a personal patient balance on the account, we will send you a monthly statement. Patients are responsible for all charges resulting from treatment provided at The Chiropractor Whitefish. Payment is due within 30 days of receipt of this statement, unless other financial arrangements have been made with the office manager.

Past Due Accounts: I understand and agree that if my account is delinquent past 90 days without financial arrangement with the office manager, I may be turned over to the collection agency used by The Chiropractor Whitefish. **Returned Checks:** There is a fee of \$35.00 on any checks returned by the bank due to non-sufficient funds or otherwise.

I have read the financial policy and agree to the terms set forth in the agreement. I can choose to discontinue care at any time, but that will not release me from paying any outstanding balance on my account or the accounts of my dependents.

Signature_____Date_____