

WELCOME TO THE CHIROPRACTOR WHITEFISH

NAME _____ DATE _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER _____ HOME / CELL? _____

EMAIL _____

BEST WAY TO REACH YOU? TEXT EMAIL PHONE CALL

MALE / FEMALE BIRTHDATE _____ AGE _____

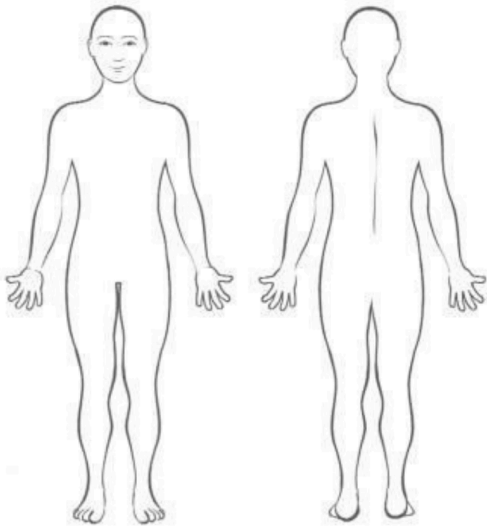
WHO MAY WE THANK FOR THE REFERRAL? _____

EMERGENCY CONTACT _____ PHONE _____

1ST COMPLAINT OR CONCERN _____

HOW LONG HAS THIS BEEN GOING ON FOR? _____

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



TYPE OF PAIN:

SHARP DULL THROBBING

SHOOTING TIGHTNESS

BURNING TINGLING NUMBNESS

SWELLING OTHER

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

SECONDARY CONCERNS _____

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

PLEASE DESCRIBE ANY THAT APPLY: _____

HEALTH HISTORY → HAVE YOU EXPERIENCED THE FOLLOWING?

PLEASE DELINEATE WITH AN "X" FOR PAST AND A "C" FOR CURRENT

- | | | |
|--|--|---|
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> MISCARRIAGE | <input type="checkbox"/> FERTILITY PROBLEMS |
| <input type="checkbox"/> BOWEL/BLADDER | <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> HEADACHE |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> PINS & NEEDLES | <input type="checkbox"/> IRRITABILITY |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> STOMACH UPSET | <input type="checkbox"/> LOSS OF SMELL / TASTE |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> MENSTRUAL IRREGULARITY |
| <input type="checkbox"/> HERNIA | <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> NERVOUSNESS |
| <input type="checkbox"/> JAW PROBLEMS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> SHOULDER PAIN |
| <input type="checkbox"/> LIGHT SENSITIVITY | <input type="checkbox"/> FAINTING | <input type="checkbox"/> THYROID PROBLEM |
| <input type="checkbox"/> MOOD SWINGS | <input type="checkbox"/> HERNIATED DISK | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> HIGH BLOOD PRESSURE | |
| <input type="checkbox"/> SINUS PROBLEMS | <input type="checkbox"/> LOSS OF BALANCE | |
| <input type="checkbox"/> ULCERS | <input type="checkbox"/> MENSTRUAL PAIN | |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> NECK STIFFNESS | |
| <input type="checkbox"/> BUZZING / RINGING IN THE EARS | <input type="checkbox"/> SEIZURES | |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> STROKE | |
| <input type="checkbox"/> FATIGUE | <input type="checkbox"/> BACK PAIN | |
| <input type="checkbox"/> FRACTURES | <input type="checkbox"/> CANCER | |
| <input type="checkbox"/> HOT FLASHES | <input type="checkbox"/> DIGESTIVE ISSUES | |
| <input type="checkbox"/> KIDNEY DISEASE | | |

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 you will pay your account at the time services are rendered or will make financial arrangements satisfactory to The Chiropractor in return for the services provided.

CASH: Payment is expected on the day that services are rendered. We accept cash, check, or credit cards. The price of an initial visit is \$100 (\$45 new patient intake and \$55 adjustment). Adjustments after the initial visit are \$55. A re-exam is \$20 + \$55 for your adjustment. Re-exams may be added at the doctor's discretion (common cases include: new injury and/or visit after a hiatus).

MEDICARE: We are a non-participating provider with Medicare. The 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.

MONTHLY STATEMENTS: We will send you a monthly statement if there is a personal patient balance on the account. 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 I may be turned over to the collection agency used by The Chiropractor Whitefish if my account is delinquent past 90 days without financial arrangement with the office manager.

RETURNED CHECKS: There is a fee of \$35 on any checks returned by the bank due to insufficient 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 payment of any outstanding balance on my account or the accounts of my dependents.

SIGNATURE _____ **DATE** _____



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 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 are 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 and 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 the doctor finds unusual non-chiropractic findings during care, 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** _____