NEW PATIENT INFORMATION

PATIENT INFORMATION Date: ____/____/____

Name:_____ S.S. # ____-____-____
LAST FIRST MI

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:(___)_____ Work Phone:(___)_____ Cell:(___)_____

Occupation:_____ Employer: _____

Work Status: □ Full-Time □ Part-Time □ Self-Employed □ Unemployed □ Off-Work □ Student

Date of Birth: ____/____/____ Age:_____ Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed

Children: □ Yes □ No How many?_____

Spouse's Name:_____ Phone:(___)_____

Spouse's Employer:_____ Phone:(___)_____

Emergency Contact:_____ Phone:(___)_____

INSURANCE/PAYMENT INFORMATION

Is your injury/illness work related? □ Yes □ No

If yes, have you reported the injury to your employer? □ Yes □ No Date of Injury: ____/____/____

Is your injury/illness related to an automobile accident? □ Yes □ No If yes, please complete the following:

Your auto insurance company name and address:_____

_____

Claim #:_____ Policy #:_____

Attorney name and address:_____

_____

Do you have health insurance? □ Yes □ No If yes, please complete the following:

1. Primary insurance company name:_____

   Address:_____

   Insured's Name:_____ ID #:_____ Group #:_____

2. Secondary insurance company name:_____

   Address:_____

   Insured's Name:_____ ID #:_____ Group #:_____

ASSIGNMENT AND RELEASE

I, the undersigned assign directly to Stillwater Spine & Sports Center, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Stillwater Spine & Sports Center, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and/or request pertaining to my physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and/or medical opinions.

_____ ____/____/____

RESPONSIBLE PARTY SIGNATURE **RELATIONSHIP** **DATE**

PATIENT CONDITION

Describe your major complaint(s):_____

_____

Date you fist noticed symptoms:_____ Describe how they began:_____

_____

Have you had these symptoms before? ☐ Yes ☐ No If yes, when:_____

How often do you experience the symptoms?

- Constantly (76%-100% of the day)
- Frequently (51%-75% of the day)
- Occasionally (26%-50% of the day)
- Intermittently (0%-25% of the day)

How would you describe the symptoms?

Sharp	Shooting	Stabbing	Weakness
Dull	Burning	Stiffness	Throbbing
Numb	Tingling	Cramps	Achy

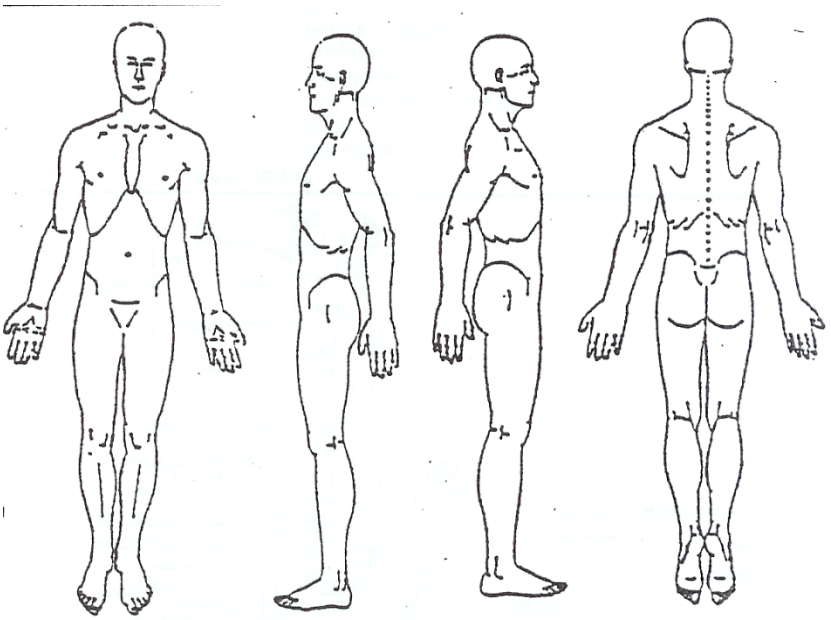
How are your symptoms changing?

Getting Better Getting Worse No Change

How would you rate your symptoms at their:

	None										Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

PLEASE MARK BELOW WHERE YOU HAVE SYMPTOMS



How do your symptoms affect your ability to perform daily activities?

No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Sever, no activity possible
0	1	2	3	4	5	6	7	8	9	10

What makes your symptoms worse?_____

What makes your symptoms better?_____

Have you seen any other health care professionals for this condition? ☐ Yes ☐ No If yes, list the providers:

Name/Address: Date:

Name/Address: Date:

Have you had any tests done for your symptoms? ☐ Yes ☐ No If yes, please check test and give date:

☐X-Rays_____ ☐CT Scan_____ ☐MRI_____ ☐Lab_____ ☐Other:_____

Please indicate findings if known:_____

Last blood tests:_____ Last eye exam:_____ Last dental visit:_____

Any other diagnostic tests in past 3 years, is so what and when:_____

Have you seen any other health care professionals for any other condition? ☐ Yes ☐ No If yes, please list:

Name/Address: Date:

Name/Address: Date:

Have you seen any other health care professionals for any other condition? ☐ Yes ☐ No If yes, please list:

Name/Address: Date:

Name/Address: Date:

*If ***child***, last well child visit:_____ *If ***male***, last prostate exam/PSA evaluation:_____

*If ***female***, last Pap test:_____; Pelvic exam:_____; Breast exam:_____;

Last mammogram:_____; Do you do self breast exams? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, Due Date:_____

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Dizziness	Yes	No	Kidney Disease	Yes	No	Rheum. Fever	Yes	No
Alcoholism	Yes	No	Eating Disorder	Yes	No	Liver Disease	Yes	No	Ringing in Ears	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Loss of Balance	Yes	No	Shortness of		
Ankle Swelling	Yes	No	Excessive Thirst	Yes	No	Loss of Sleep	Yes	No	Breath	Yes	No
Arthritis	Yes	No	Fainting	Yes	No	Miscarriage	Yes	No	STD	Yes	No
Asthma	Yes	No	Fatigue	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Bleeding			Fever	Yes	No	Multiple			Thyroid		
Disorder	Yes	No	Fractures	Yes	No	Sclerosis	Yes	No	Problem	Yes	No
Bowel/Bladder			General			Nausea	Yes	No	Tuberculosis	Yes	No
Changes	Yes	No	Stiffness	Yes	No	Night Sweats	Yes	No	Tumors	Yes	No
Breast Lump	Yes	No	Glaucoma	Yes	No	Numbness	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Goiter	Yes	No	Osteoporosis	Yes	No	Unintentional		
Chemical			Gout	Yes	No	Pacemaker	Yes	No	Weight Loss	Yes	No
Dependency	Yes	No	Headaches	Yes	No	Pinched Nerve	Yes	No	Vaginal		
Chest Pain	Yes	No	Heartburn	Yes	No	Pins/Needles Feeling			Infections	Yes	No
Chronic Cough	Yes	No	Heart Problem	Yes	No	in Limbs	Yes	No	Venereal		
Cold Limbs	Yes	No	Hernia	Yes	No	Pneumonia	Yes	No	Disease	Yes	No
Depression	Yes	No	Herniated Disc	Yes	No	Polio	Yes	No	Visual Problem	Yes	No
Diabetes	Yes	No	Herpes	Yes	No	Prostrate			Vomiting	Yes	No
Diarrhea	Yes	No	High			Problem	Yes	No	Other_____		
Digestive			Cholesterol	Yes	No	Prosthesis	Yes	No	_____		
Problems	Yes	No	Hypertension	Yes	No	Psychiatric Care	Yes	No	_____		

EXERCISE

None
Moderate
Daily
Heavy

WORK ACTIVITY

Sitting
Standing
Light Labor
Heavy Labor

HABITS

Smoking: Packs / Day:_____
Alcohol: Drinks / Week:_____
Caffeine: Cups / Day:_____
High Stress: Reason:_____

DIET & WATER

List any special dietary plans that you may be following (Paleo diet, Vegetarian diet, etc.):_____

_____

List any particular dietary items that you may be avoiding (diary, gluten, etc.):_____

Approximately how many ounces of water do you drink a day?_____

INJURIES / SURGERIES / ACCIDENTS

	Description	Date
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries (Including Cosmetic):		
Automobile Accidents:		

MEDICATIONS

Name	Dosage

VITAMINS / HERBS / SUPPLEMENTS

Name

ALLERGIES

Drugs?_____

Foods?_____

Environmental or chemicals?_____

FAMILY HISTORY

Do you have a family history of any of the following diseases: (Check those that apply)

	Brother/Sister	Mother	Maternal GM	Maternal GF	Father	Paternal GM	Paternal GF
Asthma/Hayfever/Hives							
Arthritis							
Autoimmune Disease							
Cancer							
Dementia							
Diabetes							
Epiliepsy							
Heart Disease							
High Blood Pressure							
Stroke							

Any other relevant family history?_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: In cases where Stillwater Spine & Sports Center, Inc. has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ Social Security Number:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare and practice operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ashli Scales, Office Manager

Telephone: (406)756-7634

Address: Stillwater Spine and Sports Center, Inc. 3171 Hwy 93 N., Suite C, Kalispell, MT 59901

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, health care and practice operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Stillwater Spine & Sports Center, Inc.

3171 Hwy 93 N.
Suite C
Kalispell, MT 59901

PAYMENT POLICIES

Insurance

- We will gladly submit insurance claims to your insurance carrier at no additional charge to the Patient or Responsible Party. We submit claims to only two insurance carriers (primary and one supplemental). The only exception is Medicare which we are legally required to bill. *Medicare* will then submit your claim to any supplemental insurance you may have.
- State law requires that your insurance submit payment to us within 30 days however, sometimes insurance can be reluctant to pay or just plain slow! Payment is due on accounts within 60 days, regardless of your insurance coverage. We will be glad to assist you in contacting your insurance company regarding your claim, but ultimately the Patient or Responsible Party is expected to contact his/her insurance company if the insurance carrier fails to respond, is late responding, pays only a portion of what is due, or denies the claim.
- We will resubmit your claim one time only at no additional charge. If your insurance carrier has not paid after resubmitting your claim, Stillwater Chiropractic, Inc. cannot pursue collection of insurance accounts without additional costs to the Patient or Responsible Party. Should you notice that your insurance has not paid on your account, you are responsible for contacting your insurance carrier to determine the status of your claim.
- If a claim is returned to Stillwater Chiropractic, Inc. due to an improper address, incorrect identification number or any other incorrect information, we will resubmit your claim after confirming correct information with you. Claims are submitted via the United States Postal Service. In the event a claim is not received by your insurance carrier, it will be returned to us in the mail.
- Insurance coverage and deductible information will be verified before Stillwater Chiropractic, Inc. considers an account an "Insurance Account". We estimate the Patient's or Responsible Party's portion or co-pay based on information from your insurance carrier. Please realize that this may contribute to a Credit on your account or a Balance Owing greater than was estimated.
- If your insurance carrier is unavailable at the time of service and cannot verify your coverage or deductible, a payment or some portion of payment is expected at the time of service.
- Some charges billed by this office **may not** be covered by your insurance. The Patient or Responsible Party is ultimately responsible for any amount over and above what your insurance will cover in addition to any co- pay that applies to your policy.

General

- Payment in full is expected at the time of service. However, we are sensitive to the fact that some Patients may not be able to pay in full. We will assist you in setting up an individual payment plan requiring a monthly payment. We do require, however, that your balance be **kept under $300.00**. In the event that your balance does exceed $300.00, you will no longer be able to receive treatment until a payment has been made. A 1.5% finance charge will be applied to any account on any balance over 60 days.
- In the unlikely event that your account is turned over to a collection agency, the Patient or Responsible Party will be responsible for payment of any and all collection fees, attorney fees and court costs incurred in the collection of your unpaid balance owed, including finance charges. Should an account be designated a "Collection" account, you will be approved as a "Cash Only" account, to be paid in full at the time of service should you require our services in the future.
- Our office can be a very busy place. If we are given plenty of notice on cancelled appointments, we can fill those appointment times. However, we have a *non-cancellation* or *no-show* policy. A $20.00 charge will be applied to your accounts for appointments not cancelled at least 4 hours prior to the scheduled time or for failure to show up for scheduled appointments. **This charge cannot be billed to insurance!**

By Signing Below, you Are Stating That You Fully Understand and Agree With The Terms Set Forth In These Payment Policies

_____ _____

Date Signature of patient or Responsible Party

Stillwater Spine & Sports Center, Inc.

3171 Hwy 93 N.
Suite C
Kalispell, MT 59901

PAYMENT OPTIONS

Stillwater Chiropractic, Inc. provides several options for payment, Cash, Credit Card (Visa or MasterCard), or Check. In addition, we accept most major medical insurance (General Insurance), Personal Injury (PI), Workers Compensation and Medicare. Please inquire at the front desk regarding the option of your choice.

Cash

Payment is expected at the time of service. However, we are sensitive to the fact that some Patients may not be able to pay in full. We will be happy to assist you in setting up an individual payment plan. We do require, however, that your balance be kept under $300.00. In the event that your balance does exceed $300.00, you will no longer be able to receive treatment until a payment has been made. A 1.5% finance charge will be applied to accounts over 60 days old.

Insurance

Once your insurance coverage has been verified, Stillwater Chiropractic, Inc. will submit your claim to your insurance carrier at no additional charge to you. We will submit your claim to two carriers (primary and one supplemental). If your insurance carrier fails to respond or denies coverage due to incorrect information, we will *resubmit* your claim once. Some charges billed by this office **may not** be covered by your insurance. The Patient or Responsible Party is ultimately responsible for any amount over and above what your insurance will cover in addition to any co-pay that applies to your policy.

Things We Don't Like To Do

Our office can be a very busy place. If we are given plenty of notice on cancelled appointments, we can fill those appointments times. However, we have a *non-cancellation* or *no-show policy*. A $20.00 charge will be applied to your accounts for appointments not cancelled at least 4 hours prior to the scheduled time or for failure to show up for scheduled appointments. **This charge cannot be billed to insurance.**

PLEASE FEEL FREE TO TAKE THIS PAGE HOME FOR FUTURE REFERENCE