PRO ADJUSTER CHIROPRACTIC CLINIC
1526 S. Reserve, Missoula MT 59801 Phone 406-721-5780 Fax 406-721-6487

Confidential Patient Health Record

Today's Date: ___/___/___

How did you hear about us? Family _____ Friend _____ Co-Worker _____
Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

Title: Mr. Ms. Mrs.

Last:_____ First:_____ Middle: _____

Suffix: Jr Sr II III

Birth Date: ___/___/_____ Age:_____ Sex: Male / Female SSN: _____

Marital Status: Single Married Widowed Divorced Separated

Address: _____Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

Home Phone: (_____) _____-_____ ext _____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ ext _____ Fax #: (_____) _____-_____ ext _____

Email Address: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact

Last:_____ First:_____Middle:_____

Relationship: Spouse Relative Friend Other _____

Home Phone: (_____) _____-_____ ext _____ Cell Phone: (_____) _____-_____ ext ___

Work Phone: (_____) _____-_____ ext _____

Employment Information

Business Name: _____

Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description _____

Patient Name: _____ Date: _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

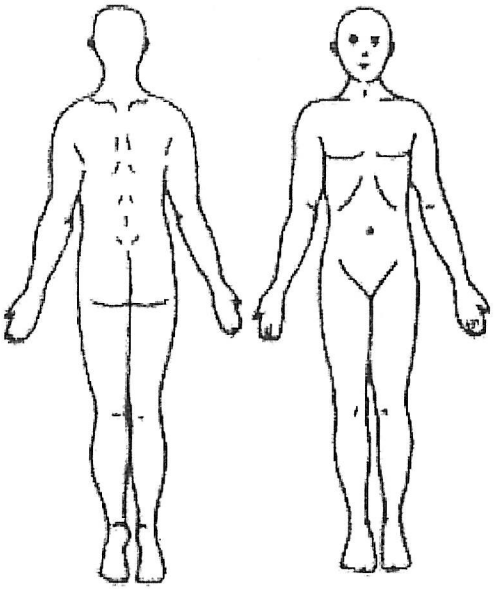
_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



When did this Condition BEGIN? ____/____/____

Has it ever occurred before? Yes No. When? _____

Is the Condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

_____

Date of Accident: _____ **Time of Accident:** _____ **am /pm**

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) Myself ONLY

Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____

Personal Health Insurance Carrier: _____ **Health ID Card #:** _____

Policy Holder's Name: _____ **Group #:** _____

Policy Holder's Date of Birth: ____-____-____ **Primary Care Physician:** _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ **Time:** _____ **am/pm**

Carrier: _____ **Policy #** _____

Carriers Phone #: (_____) _____-_____ **Adjuster:** _____

Claim #: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____

PRO ADJUSTER CHIROPRACTIC CLINIC

MONTANA BACK AND REHABILITATION INSTITUTE
1526 S. Reserve, Missoula Montana 59801 Phone 406-721-5780 Fax 406-721-6487

Acceptance of Terms/Notice of Privacy Practices (HIPAA)

The Health Insurance Portability and accountability Act (HIPAA) is designed to protect your rights and privacy. We follow these policies:

1. Patient information, such as medical records, radiology films, treatment plans or demographics, is to be kept confidential except as needed to provide services. This may include disclosing personal health information to other healthcare providers, health insurance companies or other payors, as well as others deemed necessary to maintain your care and well being.
2. Patients' written consent is needed for any other release of information to any parties not listed above. A signed consent expires in one years' time.
3. Out office may contact you for appointment reminders, announcements, and to inform you about our practice and its' staff.
4. You agree you bring any concerns or complaints regarding privacy to the attention of the office staff.
5. You have the right to request restrictions to the use of your protected health information.

Informed Consent to Chiropractic Care

These are the terms under which all patients are accepted for in this office:

It is clearly understood that there is no promise or offer of any kind, on the part of Pro-Adjuster Clinic to treat any symptoms, condition or disease. Although I may have come to this office with the initial expectation for relief of a particular symptom or condition, it has been clearly explained to me that the only purpose of chiropractic is to remove or reduce nerve interference caused by the presence of a vertebral subluxations. This correction is undertaken for no other reason than that these vertebral subluxations interfere with the capacity of the body to fully express life.

I hereby voluntarily request and consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

I hereby accept and consent to the above terms.

Signature of Patient_____Date_____

Signature of Parent /Guardian_____Date _____
(if patient is a minor)

Witness Signature_____Date_____

PRO ADJUSTER®
CHIROPRACTIC CLINIC

MONTANA BACK AND REHABILITATION INSTITUTE

1526 South Reserve Street Missoula, Mt 59801 406-721-5780

Financial Consent and Authorization

Payment is required at the time of service unless prior arrangements have been made.

I understand that the physician or staff may disclose all or part of my record to assist in the prompt payment of my bill.

It is my responsibility to know the terms of my health and accident insurance in regards to my care. Charges not covered by my insurance company, i.e. deductibles or co-payments, are my responsibility. Ultimately, I am responsible for payment in full of all charges.

I agree that if my account is not paid in full within 60 days it may be turned over to a collection agency and reported to the Credit Bureau. This will take place if you receive a final collection notice from our office and no arrangements are made to settle your account. **All third party collection fees will be your responsibility.**

I authorize that my insurance benefits be paid to PRO-Adjuster Chiropractic Clinic/ Montana Back and Rehabilitation and give them authorization to endorse co-issued checks for services rendered.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenace Organization (HMO). Subsequent rejection of a claim as a result of this admission due to your enrollment in H.M.O. will constitute responsibility for payment of claim on my part.

I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for my health insurance deductibles and coinsurance.

I hereby accept and consent to the above terms.

Signature of Patient_____ Date_____

Signature of Parent /Guardian_____ Date_____
(if patient is a minor)

Witness Signture_____ Date_____