New Patient Information

Chiropractic Clinic of Three Forks, PO Box 1307, Three Forks MT 59752, 406-285-6935

Please complete all questions

Name_____ Date_____

Address_____City_____State_____Zip_____

Phone_____ Cell_____Email_____

Birth Date_____Age_____Gender _____ Marital Status_____

Employer_____Occupation_____

Spouse's Name_____Spouse's Employer_____

Children's Names & Ages_____

Your Favorite Hobbies_____

Who may we thank for referring you?_____

When did you last see a chiropractor?_____Who?_____

List other doctors you have seen recently_____

Medications_____

Surgeries_____

Who is financially responsible for this bill?_____

Emergency Contact Name_____Phone Number_____

What are your major complaints?_____

On a scale from 1-10 how important is your health to you?_____

How many auto accidents have you been in?_____Motorcycle Accidents?_____

Which of the following sports have you been involved in? (circle)

Football Basketball Baseball Soccer Hockey Gymnastics Martial Arts
Dance Wrestling Horseback Riding Skating Water Skiing Other_____

Have you ever: [ ] Fallen down stairs [ ] Had a stress or strain injury while working
[ ] Slipped on ice or snow [ ] Had a sports injury

Do you: [ ] Sit more than four hours a day [ ] Drive more than one hour a day
[ ] Work at a computer more than two hours a day [ ] Use Tobacco

Please check all the health complaints you are experiencing:

[ ] Neck Pain	[ ] Arm/Hand Problems	[ ] Ear Infections
[ ] Upper/Mid Back Pain	[ ] Leg/Foot Problems	[ ] Frequent Colds
[ ] Low Back Pain	[ ] Asthma	[ ] Digestive Problems
[ ] Headaches	[ ] Allergies_____	[ ] High Blood Pressure
[ ] Spinal Curvature	[ ] Sinus Problems	[ ] Diabetes

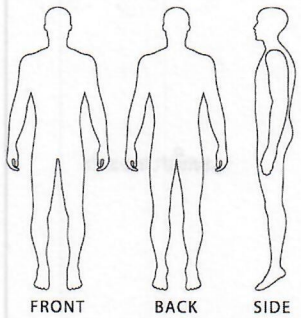
How long have you had the above complaint(s)?_____

How often have you had the above complaint(s)?_____

Is your problem(s) worse in the [ ] morning [ ] mid day
[ ] night [ ] all the time [ ] after activity?

Do you experience any of the following sensations?
[ ] Sharp pain [ ] Dull Pain [ ] Throbbing [ ] Aching [ ] Burning
[ ] Tingling [ ] Numbness [ ] Other_____

***Please mark areas of concern on the picture**



Initials____ The doctor will use hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as an "Adjustment". As the joints in your spine or extremity are moved, you may experience a "pop" as part of the process. There are certain complications that can occur as a result of a spinal or extremity adjustment. These complications include, but are not limited to, muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, oculosympathetic palsy, costovertebral strains and separation. A rare complication includes, but is not limited to, stroke. The most common complication or complaint following spinal or extremity adjustments is an ache or stiffness at the site of the adjustment.
The doctor is aware of these complications, and in order to minimize their occurrence, will take precautions. These precautions include, but are not limited to, the doctor taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of X-rays (see below)

Initials____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual cycle _____

Initials____ I instruct the chiropractor to deliver care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials____ I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that the Chiropractic Clinic of Three Forks will provide the necessary information to assist me in making collections from the insurance company and any amount authorized to be paid directly to the Chiropractic Clinic of Three Forks will be credited to my account. I, however, clearly understand and agree that **I am personally responsible for payment due for services rendered.**

Initials____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature_____**Date**_____

Guardian's Signature authorizing Minor's care_____

SF-12 Health Survey

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. **Answer each question by choosing just one answer.** If you are unsure how to answer a question, please give the best answer you can.

1. **In general, would you say your health is:**

☐1 Excellent ☐2 Very good ☐3 Good ☐4 Fair ☐5 Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	YES, limited a lot	YES, limited a little	NO, not limited at all
2. **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	☐1	☐2	☐3
3. Climbing **several** flights of stairs.	☐1	☐2	☐3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	YES	NO
4. **Accomplished less** than you would like.	☐1	☐2
5. Were limited in the **kind** of work or other activities.	☐1	☐2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	YES	NO
6. **Accomplished less** than you would like.	☐1	☐2
7. Did work or activities **less carefully than usual.**	☐1	☐2

8. **During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?**

☐1 Not at all ☐2 A little bit ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

These questions are about how you have been feeling during the past 4 weeks.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks…

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm & peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
10. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
11. Have you felt down-hearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6

12. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

☐1 All of the time ☐2 Most of the time ☐3 Some of the time ☐4 A little of the time ☐5 None of the time

Patient Name: _____ Date: _____

Visit type (circle one)

New 30 days 60 days 90 days 120 days 6 month 1 year

Chiropractic Clinic of Three Forks
113 S. Main St., Suite A, PO Box 1307
Three Forks, MT 59752
(406) 285-6935

Notice of Privacy Practices Acknowledgement & Authorization

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 have been given the opportunity to receive a copy of the Chiropractic Clinic of Three Forks *Notice of Privacy Practices (NPP)*. I also understand that this practice 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 (print) Patient's Date of Birth

_____ _____
Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____
(Print) Date

Signature of Personal Representative: _____Relationship to Patient: _____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Authorizations:
If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize *Chiropractic Clinic of Three Forks* (CCTF) disclosure of my individually identifiable health information to the individuals listed. I understand I can revoke this authorization at any time with notice to CCTF.

1. Name _____ Relationship to Patient _____

Authorization to:
- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):
- ❑ ____/____/____ ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

BASIC NUTRITION QUESTIONNAIRE

Name_____ Date_____

Have you ever been told you have High Cholesterol or Triglycerides? YES / NO

Have you ever been diagnosed with High Blood Pressure? YES / NO

Have you been diagnosed as Diabetic? YES / NO

Have you ever been diagnosed as Pre-Diabetic or Metabolic Syndrome YES / NO

How many bowel movements do you have daily? _____

How many "fast food," "refined food", or "pre-prepared" meals do you eat per week? (1-3) (4-6) (7+)

How many servings of fruit do you eat per day? (0-1) (2-3) (4-5)

How many servings of vegetables do you eat per day? (0-1) (2-3) (4-5)

Do you regularly drink 1 or more per day of the following (circle all that apply):

Soda Diet Drinks Coffee Juice Milk Alcohol Energy Drinks

Do you need caffeine to wake up in the morning? YES / NO

How many servings of refined sugar do you eat per day? (Candy, Cookies, Cake, etc) (0-1) (2-3) (4-5)

Do you have energy crashes after you eat or in the afternoon? YES / NO

Please list all nutritional supplements/vitamins you take regularly (staff can photocopy a list if you have one):

Supplement Name/Type	Frequency	Brand/Where Purchased

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Financial Policy

It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation.

• All patient fees are expected to be paid at the time of service or according to a preset payment plan or program. Personal balances may not exceed $150 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require. *Initials* _____

• All patients (except "Cash" patients, who pay at the time of service) are required to participate in **EZ Pay** whereby you authorize credit card or Electronic Funds Transfer (EFT) payments for any outstanding balance remaining after any third party payer has paid their applicable portion. *Initials* _____

• Should payment be refused by your bank for any check written, this office will charge a fee up to $35 to offset the charges we will incur as a result of the returned check. *Initials* _____

• Any balance left unpaid after 60 days may be assessed an interest charge of 1% per month. *Initials* _____

• There is a $40 fee for any appointments for which you do not show without prior notice. *Initials* _____

• Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero. *Initials* _____

Insurance Policies

As a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility.

• The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a "Cash" patient and payment is expected at the time of service. As a courtesy to you, our office will attempt to pre-qualify your insurance coverage in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage. If we are unable to verify your insurance, a minimum of $75 must be paid at the first visit. *Initials* _____

• We cannot predict with certainty what an insurance company will pay for the usual and customary charges for services rendered. If we participate as a provider on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility. *Initials* _____

• If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If the bill remains unpaid within 120 days the balance becomes due and payable immediately and your assignment is revoked. *Initials* _____

• Insurance companies must deem services as "medically necessary" to consider payment. All patients whose treatment visitation schedule is once per month or longer or outside of a doctor prescribed treatment plan is considered under "maintenance," "wellness," or "supportive" care, which is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness or supportive care. *Initials* _____

Signed: _____ Date: _____ Staff Initials: ____ Date: _____

EZ Pay is a secure, easy and convenient way to pay your bill. When enrolled, we debit an account for the amount you owe. Our Credit Card Merchant uses the latest encryption and security measures to ensure your payment data is protected. There is no charge to use **Auto Pay**. You can use a HSA credit card or EFT, debit card or credit card to pay your bill. **EZ Pay** is used for any remaining balance after third party payments have been made. If the balance is greater than $150 we will give you a courtesy call prior to making the credit card charge or EFT.

EZ-Pay Authorization

I, _____, hereby authorize Chiropractic Clinic of Three Forks to initiate debit/credit card charges and/or corrections to previous debits/charges to my account with the financial institution identified by me on this form for payment of services /products rendered to me in the amount of the Balance Due.

I also hereby authorize the Chiropractic Clinic of Three Forks to initiate debit/credit card charges and/or corrections to previous debits/charges to my account with the financial institution identified by me on this form for payment of services/products rendered to me in the event:

1. My insurance company denies coverage
2. There is a remaining balance after insurance coverage has been paid
3. Or the insurance company sends payment to me and I do not bring the check to the Chiropractic Clinic of Three Forks within one week of the check's receipt.

The authorizations are to remain in effect indefinitely and may be withdrawn by me at any time by written request. I will receive an emailed receipt after any and all charges, if requested.

CREDIT CARD on file ending in (last 4 digits) ___ ___ ___ ___ Visa®/MasterCard®/Discover® CVV:_____

Card Holder Name: _____Card Holder Signature: _____ Date: _____

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threeforkschiropractor.com

Good Faith Estimate - Services & Products

Below are the current fees for services at our office, subject to change.

- "Maintenance" adjustments of the spine $60
- Adjustment to symptom or injury-free extremities $35
- Examinations and Progress Examinations $60-145
- X-rays to assess asymptomatic areas, spine biomechanics and/or for response to structural correction of the spine $50-150
- X-ray "Over Reading" by a radiologist $28-58
- Manual Therapy $40
- E-stim $38
- Low Level "Cold" Laser Therapy $25-60
- Traction $38
- Custom orthotics $200-358
- Orthopedic Supports and Rehabilitation Equipment (varies)
- Denneroll Orthotic Devices $45-55
- Koren Specific Technique (KST) $65
- Kinesiotaping $15
- Nutritional Supplements (varies)
- RockTape FMT Blade Therapy & products (varies)
- Spinal Traction beyond symptomatic relief, such as for improving normal spinal curves and postures $24
- Therapeutic Activities & Exercise $40

I acknowledge that health insurance plans may not cover the services and products listed above and I agree to pay for the services at the time of service.

Patient Name: _____ Guardian Name:_____

Patient Date of Birth:_____

Patient or Guardian Signature: _____ Date: _____