

IT'S NOT ABOUT YOUR BACK,  
IT'S ABOUT YOUR HEALTH



BETTER HEALTH,  
THROUGH CHIROPRACTIC

**Today's Date \_\_\_\_\_ PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Sex M F

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Who is responsible for this Acct. \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

Which Yellow pages do you use? Rusell Country, Community, Dex (please circle one)

**INSURANCE INFORMATION**

Name of insured \_\_\_\_\_ Their Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Ins. company \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

**HISTORY**

Reason for consulting this office \_\_\_\_\_

Current Medical Treatment? \_\_\_\_\_ Medications? \_\_\_\_\_

Is your condition related to an accident or injury? \_\_\_\_\_ If yes please describe \_\_\_\_\_

**Please check the choice that most closely describes your current goals for your Health/Well-Being:**

- I am only concerned about relief of a particular symptom
- I am only concerned about relief of a particular symptom and preventing its return
- I want optimum health and well-being on every level available to me

**CO-PAYS ARE DUE AT TIME OF SERVICE, WE ACCEPT PAYMENT BY CASH, CHECK, CREDIT CARD AND CARE CREDIT**

I understand that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient and/or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## PLEASE REVIEW THIS INFORMATION CAREFULLY

In the course of your care as a patient at **Big Sky Chiropractic** we may use or disclose personal and health related information about you in the following ways:

- Your personal health information may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis or treatment
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier if they are or may be responsible for the payment of your services.
- Your name, address, phone number and health care records may be used to contact you regarding appointment reminders or other health related information.

If you are not home a message may be left on your answering machine. You have the right to inspect or obtain a copy of the information we use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Under federal law, we are permitted or required to use or disclose your health information without your consent in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicate with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use of your protected health information, other than outlined above, will only be made upon your written consent. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home please advise us in writing. You have the right to inspect and/or copy your health information for seven years from the date the record was created or as long as it remains in our files. Requests to inspect, copy or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. All changes will apply for all your health information in our files. Information we use to disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules. If you have a complaint regarding our privacy notice, practices or any aspect of our privacy activities you should direct your complaint to our Privacy Officer.

This notice is effective as of **February 13, 2008**. This notice and any amendments made hereto will expire seven years after the date upon the record that was created. My signature acknowledges that I have received a copy of this.

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Name (Please Print)

Signature

Date

If you are a minor, or if you are being represented by another party

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Personal Representative

Printed name

Date



Thank you for choosing **BIG SKY CHIROPRACTIC** for your chiropractic health care needs. Our goal is to provide quality Chiropractic care to you and your family. Our doctors are trained in various techniques to offer the most effective care possible. We know each patient is an individual, and what may work for one person will not necessarily work for another. We treat each case specific to his/her needs. If you are not completely satisfied with the quality of care you receive please let us know immediately. We will strive to meet each patients needs.

Referrals are the biggest form of flattery. If we have helped you please tell your neighbors and family members, so they can enjoy the same quality of health care that you receive.

## INFORMED CONSENT

In our experience, the most effective treatment for spinal joint dysfunction involves manipulation of spinal joints. Specifically manipulation can reduce pain, tenderness, and muscle spasm, and can improve the mobility of your spine, as well as many other health benefits.

As with all other forms of treatment, manipulation of the spinal joints or other joints of the body, it can have some unwanted side effects of which you should be aware. A very small percentage of patients (less than one percent) may experience discomfort after a manipulation, ranging from an aching feeling or stiffness to actual soreness. This may, depend on the type of condition you have, and for how long you have had it. In very rare instances, serious neurological damage may occur as a result of chiropractic treatment.

We take every precaution in our diagnosis and treatment to minimize these occurrences. Although we offer spinal manipulation with the utmost confidence in its proven benefits, you have the choice to decide not to have this type of treatment. There are other forms of Chiropractic care available to you in our office, including soft tissue therapy, Myofascial release, Manual Joint mobilization.

Please sign below if you understand the described risk and consent to treatment.

## PAYMENT POLICY

- If your insurance requires a co-pay, payment is expected at the time of visit
- If you have not met your insurance deductible, payment is expected at the time of service and we will notify your insurance company for you to help you meet your deductible. If you have difficulty with your payment, we can accept a 50% payment with the balance due within 30 days of receiving your statement.
- If we have billed your insurance and you have a balance owing, it is due within 30 days after you receive your EOB from your insurance company.
- If you do not have insurance for us to bill, we require 50% of the first visit to be paid at the time of service, with remaining portion to be paid within 30 days of billing.
- If for any reason this policy cannot be met, please contact our office immediately so we can discuss payment options with you. **Our main concern is your health**
- A fee schedule is available for you to review upon request
- Please remember, even if you have insurance, your bill is your responsibility.

BY SIGNING BELOW YOU HAVE READ THE INFORMED CONSENT AND PAYMENT POLICY

NAME (print) \_\_\_\_\_ SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_