Chiropractic Health Associates

● J. Chris Johnson, D.C. ● Gregory Kaye, D.C.
1407 Wyoming Avenue
Billings, Montana 59102
Phone # 406.656.3333 Fax 406.656.6633

***Referred By:**

Patient Information

Date_____ SS#_____

Patient Name

_____

First Name Middle Last

Address_____

City_____ State_____ Zip_____

Email_____

Sex ☐M ☐F DOB_____ Age_____

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced

Preferred Language_____

Occupation_____

Patient Employer/School_____

Employer/School Phone_____

Spouse's Name *(if applicable)*_____

Phone Numbers

Home # (____)_____

Cell # (____)_____

Best time to reach you: ☐AM ☐Lunch Hour ☐After 5

In case of emergency, contact:

*Name*_____ *Relationship*_____

Home# (____)_____ *Cell/Work#* (___)_____

Insurance

(if you have provided us a copy of your insurance card, you are not required to fill out card information)

Insurance Co_____

ID #_____ Group #_____

Subscriber's Name_____

DOB_____ SS#_____

Relationship to Patient_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Chiropractic Health Associates 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 authorize the use of my signature on all insurance submissions. The above named clinic may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will remain in effect as long as I receive care from the above named clinic and ask that they bill my insurance for any incurred charges.

_____

Signature of Patient, Parent or Guardian

_____

Print Name of Patient, Parent or Guardian

_____ _____

Date Relationship to Patient

Accident Information

Is condition due to an accident? ☐Yes ☐No Date_____

Type of accident ☐Auto ☐Work ☐Home ☐Other

Who have you reported your accident to?

☐Auto Insurance ☐Employer ☐Work Comp ☐Other

Attorney Name *(if applicable)*_____

I choose to decline receipt of my clinical summary after every visit *(these summaries are often blank as a result of the nature and frequency of chiropractic care)*

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of treatment methods used. If female, I attest that I am currently not pregnant and that it is okay to take any necessary x-rays. I also agree that I am responsible for all bills incurred in this office. I understand that the Doctor will provide care with the intent to remove energy blockages and if unable to achieve the level of care desired through treatment methods offered will refer me to and healthcare professional. **Revised January 2018**

Patient's Signature_____ Date_____

Parent or Guardian Signature_____ Date_____

Patient History

What is your chief concern?

When did this concern begin?

Is it getting better or worse? ◯ *Better* ◯ *Worse* ◯ *About the Same*

How often is this problem present?

When do you notice it most? ◯ *AM* ◯ *PM* ◯ *Constantly*

What makes it better?

What makes it worse?

What do you feel is causing this problem?

Does this problem interfere with any of the following?

◯ *Work* ◯ *Sleep* ◯ *Daily Routine* ◯ *Recreation*

Rate the severity of the problem / pain *(circle number that applies)*:

(Least Severe) 1 - - - - - - - 3 - - - - - - - 5 - - - - - - - 7 - - - - - - - 10 *(Most Severe)*

What treatments have you used for this concern?

What other health care professionals have you consulted about this concern?

What are your health goals in dealing with this concern?

☐ ***Relieve current symptoms***
☐ ***Deal with underlying causes to prevent return of symptoms***
☐ ***Enhance overall wellness and health***

What injuries or surgeries have you had?

Broken Bones:
Surgeries:
Accidents:
Hospitalizations:

What is the date of your last:

Physical Exam:
Blood / Urine Test:
Spine / Chest Xray:
MRI / CT Scan:
Tetanus Vaccination:

Are you currently pregnant? ☐ *Yes* ☐ *No* Due Date?

Have you had chiropractic care in the past?

For Doctor's Use

Family History

Please list any blood relatives who have had the following conditions:

Cancer:
Diabetes:
Heart Disease:
High Blood Pressure:
Stroke:
Arthritis:
Blood Clots:
Other Significant Family Illness:

Health History

Please circle "Y" for a condition that you currently have, "P" for a condition that you have had in the past, and "N" for a condition that you have never had.

AIDS/HIV	Y P N	Mononucleosis	Y P N
Alcoholism	Y P N	Multiple Sclerosis	Y P N
Allergies	Y P N	Mumps	Y P N
Anemia	Y P N	Osteoporosis	Y P N
Appendicitis	Y P N	Pacemaker	Y P N
Arthritis	Y P N	Parkinson's Disease	Y P N
Asthma	Y P N	Pneumonia	Y P N
Blood Clots	Y P N	Polio	Y P N
Breast Lump	Y P N	Prostate Problems	Y P N
Bronchitis	Y P N	Prosthesis	Y P N
Cancer	Y P N	Rheumatoid	Y P N
Cataracts	Y P N	Scarlet Fever	Y P N
Chicken Pox	Y P N	Stroke	Y P N
Depression	Y P N	Thyroid Problems	Y P N
Diabetes	Y P N	Ulcers	Y P N
Emphysema	Y P N	Whooping Cough	Y P N
Epilepsy	Y P N	Yeast Infection	Y P N
Fibromyalgia	Y P N		
Fractures	Y P N		
Glaucoma	Y P N		
Goiter	Y P N		
Gout	Y P N		
Heart Disease	Y P N		
Hepatitis	Y P N		
Hernia	Y P N		
Liver Disease	Y P N		
Lupus	Y P N		
Lyme's	Y P N		
Measles	Y P N		
Migraines	Y P N		

Other

For Doctor's Use

Systems Review

Please circle your responses

For Doctor's Use

Bowel Habits
Issues with: ☐ *Constipation* ☐ *Diarrhea* ☐ *Bloody stool*
Other _____
How often do you have a bowel movement?
_____

Bladder Habits
Issues with: ☐ *Incontinence* ☐ *Bedwetting* ☐ *Blood in the Urine*
☐ *Waking Up at Night to Urinate* ☐ *Burning with Urination*
Other _____
How often do you urinate during the day?
_____
How often do you urinate at night?
_____

Digestion
Issues with: ☐ *Gas* ☐ *Loss of Appetite* ☐ *Nausea*
☐ *Vomiting* ☐ *Acid Reflux* ☐ *Bloating*
Other _____

Respiratory / Cardiovascular
Issues with: ☐ *Shortness of Breath* ☐ *Coughing* ☐ *Poor Stamina*
☐ *Poor circulation* ☐ *Asthma* ☐ *Chest pain*
Other _____

Hormones / Endocrine
Issues with: ☐ *Cold hands or feet* ☐ *High or Low Body Temperature*
☐ *Poor Circulation* ☐ *Dry skin*
Other _____

Personal Habits

Smoking Status *(circle one)*:
☐ Every Day Smoker / ☐ Occasional Smoker / ☐ Former Smoker / ☐ Never Smoked

Do you consume alcohol? Y N Amount: _____
Do you consume coffee / tea / caffeine? Y N Amount: _____
Do you have a high stress level? Y N
Do you have an exercise regimen? Y N
Explain: _____

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ **Last Name:** _____

Email address: _____ @ _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: ( )	Offspring: ( )
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer _____

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer _____

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

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Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Chiropractic Health Associates or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.
-

Notice of Treatment in Open or Common Areas

Our treatment rooms are an open-air room, if you wish we do have private treatment rooms available.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Authorization to Share Information

You may give authorization for us to share information with a family member or guardian such as appointments and/or account info. Consent given to: _____ (relationship) _____
_____ (relationship) _____

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Revised January 2018

Office Policy

We believe that a clear definition of our office policies will allow both you, the patient, and us the doctors, to concentrate on the big issue -

REGAINING AND MAINTAINING YOUR HEALTH

APPOINTMENT POLICY

To minimize waiting and to ensure appointments coordinate with your schedule, we strongly suggest you schedule your appointments out. If for any reasons you are unable keep your scheduled appointment, we ask that you provide us with a 24-hour notice. If you arrive 5 minutes after your scheduled appointment, we will have to reschedule your appointment, or you will be given the option to see another doctor in our office if their schedule permits.

"NO SHOW" POLICY

If you incur 3 of the following in a calendar year:

1. "No Show" for a scheduled appointment
2. Arrive 5 minutes after your scheduled appointment, or
3. Call less than 30 minutes prior to scheduled appointment

You will no longer be able to reserve time on the Doctor's schedule. You will eligible for "same-day" appointments only.

CHECKING IN

We use electronic records format. Upon arrival for your appointment, you will be directed to the kiosk at the front desk and be asked to electronically check in. In doing this you are providing the doctor vital information for the purpose of the appointment. This is required for all patients we bill insurance for

X-RAY POLICY

Occasionally the doctor may find it necessary to take x-rays of your spine. Those x-rays are property of Chiropractic Health Associates. Should you need them for another doctor, you only need to sign a release and we will release them to you or another practitioner for a period up to 30 days.

FEES CHARGED

All fees are based upon individual services rendered, not results achieved, and may vary from visit to visit depending upon doctor specific recommendations.

INSURANCE (INCLUDING MEDICARE)

In order for us to bill your services, we must obtain a copy of your insurance card. We will verify benefits as a courtesy to you. Please note: calling insurance is not a guarantee of payment. Benefits are subject to eligibility at the time of service. It is your responsibility to insure we have an accurate copy of your insurance card on file. All co-pays and deductibles are due at the time of service. If we are unable to verify your insurance at the time of service it is our policy to collect 20%.

WORK COMP/PERSONAL INJURY

Our office does accept work comp and personal injury (auto). However, it is not considered work comp or personal injury until we have all insurance information and has been verified with an insurance adjustor. You are financially responsible for any and all services up until we receive verification. We do not accept third party liability claims. In the event you have had to involve an attorney to assist in payment of your claim, you will become responsible for any and all services as they are rendered. If you miss 3 appointments or fail to reschedule and let more than 6 weeks lapse between visits, you will be considered self-dismissed and your case will be closed with this office.

MEDICARE

Medicare coverage is fairly straight forward. Medicare and all supplemental insurances only cover the chiropractic adjustment. They do not cover exams, re-exams, x-rays or any modalities. If you receive any of these you will be responsible for payment of these services. Medicare coverage is also based on medical necessity. It is important to report any and all subjective complaints as well as inform us of any new injuries or flare ups. New guidelines set forth by Medicare require us to gather additional information every 30 days. This requirement is not set forth by our office, but by Medicare directly. The additional form is called a Functional Outcome Assessment. It is essential that you complete this when asked. If you refuse, we will not be able to bill Medicare for you and you will be financially responsible for the visit. If your visit is deemed not medically necessary by the doctor, you will be responsible for payment in full at the time of service.

PAYMENT

It is our policy to collect at the time of service, or at the end of each week. We collect in full for all nutritional supplements at the time of service. Patient balances may not exceed $200 at any time. There is a $30 NSF fee for all returned checks. Accounts not paid within 90 days will be turned over to collections. All financial arrangements are to be made with the Office Manager prior to the charge being incurred. Ultimately you are responsible for any and all charges incurred within this office regardless of insurance or third-party liability.

RETURN POLICY

If you make a purchase of a supplement or orthotic device, such as a pillow, we will be happy to take the item back as long as it has not been opened and it is within 30 days of the purchase. A credit will be applied to the account that may be used for future services.

By signing below, I acknowledge that I have read, understand and agree to the terms of this office and the financial policies of the Chiropractic Health Associates. (Policy Revised January 2018)

Patient Signature _____ Date _____

Parent/Guardian Signature (if patient is a minor) _____ Date _____

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INFORMED CONSENT

Patient Name: _____

Please read this entire document before signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it, if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic in spinal manipulative therapy. We will use that treatment to treat you. We may use hands or a mechanical instrument upon your body in such a way as to move your joints. This may result is a "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As part of the analysis, examination and treatment, you are consenting to the following procedures: Spinal Manipulative Therapy, Palpation, Vital Signs, Range of Motion Testing, Orthopedic Testing, Basic Neurological Testing, Muscle Strength Testing, Postural Analysis, Ultrasound Therapy, Hot/Cold Therapy, Electric Muscle Stimulation, Radiographic Studies, Trigger Point Therapy, Myofascial Release Therapy, other (please explain)_____

The material risks inherent in chiropractic adjustment

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disk injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separation, and burns. In rare cases manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and/or X-ray. Stroke and/ or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of the treatment options

Other treatment options for your condition may include:

Self-administered, "over the counter" analgesics and rest, Medical care and prescription drugs such as anti-inflammatory, muscle relaxer, and pain killer medications, Hospitalization, Surgery

If you choose one of the above treatment options. You should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers attendant to remaining untreated

Remaining untreated may allow formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

Consent to treat a minor

I hereby authorize Chiropractic Health Associates to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____

This authorization extends to all doctors and staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above, (If applicable). Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read, or had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that is in my best interest to undergo the treatment recommended. Having been informed or the risks, I hereby give my consent to that treatment.

Patient Signature: (Parent/Guardian) **Date**

_____ _____

Patient Name (print):

_____

Doctor Signature: **Date**

_____ _____

Doctor Name (print:)

_____