Welcome to Atlas Chiropractic

PATIENT INFORMATION:

Last Name:_____ First Name:_____ M.I._____
Gender: M F Date of Birth: ____/_____/_____ SS#_____ Marital Status:_____
Home Address:_____Apt #:_____
City:_____State:_____Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Employer Name:_____Occupation:_____

SPOUSE OR GUARDIAN:

Last Name:_____ First Name:_____ M.I._____
Employer Name:_____ Work Phone:_____
Cell Phone:_____ Date of Birth: ____/_____/_____ SS#_____
Family Physician:_____ Referred by:_____

INSURANCE INFORMATION: ***(Please Present Card)***

Insurance Company:_____Phone:_____
Insured's Name:_____ ID/Policy #_____
Group #_____ Work Comp/Auto Accident:_____
Phone:_____ Claim #_____

MEDICAL HISTORY INFORMATION:

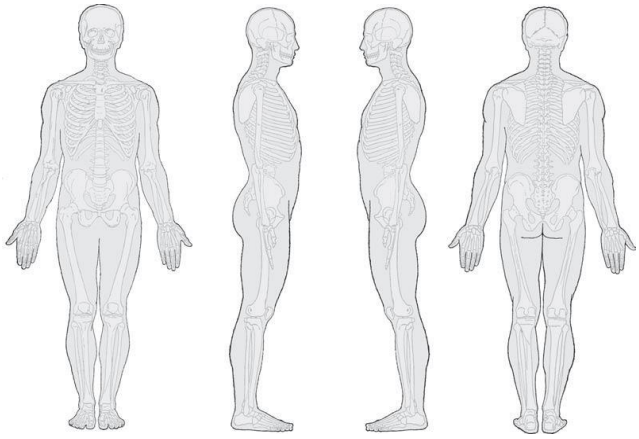
Present Complaint:_____
Is Injury do to Work?_____ Auto?_____ Other?_____
Date of Injury:_____ Brief Description of Accident:_____
_____
In the past have you had anything similar to this? YES NO Please Explain:_____
_____
Past Chiropractic Care? YES NO If yes, date of last adjustment:_____
For your present complaint have you seen any other doctors? YES NO If yes, who?_____
What treatment?_____
Have you had any X-RAY, MRI, CT scan or other imaging? YES NO If so when:_____

Please describe the character of your current pain: (you may check one or more answers)
☐Sharp ☐Stabbing ☐Burning ☐Shooting ☐Aches ☐Soreness ☐Weakness ☐Throbbing ☐Numbness ☐Dull
☐Constricting ☐Other_____

How often are the complaints present? ☐ Constant/100% of the time ☐ Frequent/75% of the time
☐ Intermittent/50% of the time ☐Occasional/25% of the time Comments:_____

Is the Pain: ☐ Increasing ☐ Decreasing ☐ Not Changing
Pain is aggravated by: ☐Walking ☐Sitting ☐Standing ☐Riding in a Car ☐Lifting ☐Bending
☐Stretching ☐Twisting ☐Other_____

Pain is reduced by: Medicine, Exercise, Rest, Adjustments, Therapy_____
Are your complaints affecting your ability to work or be active?
☐ No effect ☐ Some physical restrictions ☐Unable to perform regular duties
Is there any dizziness associated with problems? YES NO _____
Any fever or chills? YES NO _____
Any change in bowel or bladder (bathroom) function? YES NO _____
Are your complaints affecting your ability to sleep? YES NO _____
Have you missed any of days of work or school due to complaints? YES NO Dates: _____



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

*Please place the following applicable letters on the figures to the left indicating areas of pain.

O = Pain TT = Taunt/Tender

S = Spasm N = Numbness

PAST MEDICAL and SOCIAL HISTORY:

Check any of the following conditions you have had:

☐AIDS/HIV	☐Ear ringing	☐Neck Pain
☐Allergies	☐Epilepsy	☐Osteoporosis
☐Anxiety/Depression	☐Headaches	☐Poor Circulation
☐Arm/Shoulder Pain	☐Headaches – Migraine	☐Prostate Problems
☐Arthritis	☐Heart Disease	☐Rheumatoid Arthritis
☐Asthma	☐Hemorrhoids	☐Sciatica
☐Bladder Problems	☐Herniated Disk	☐Shingles
☐Cancer	☐High Blood Pressure	☐Sinus Infection
☐Chronic Fatigue	☐Insomnia	☐Stroke
☐Deafness	☐Irregular Cycle	☐Thyroid Problems
☐Diabetes	☐Kidney Problems	☐TMJ
☐Digestion Problems	☐Leg Pain	☐Venereal Disease
☐Earache	☐Low Back Pain	☐Vertigo/Dizziness

STRESSORS:

☐Smoking	Packs/Day _____
☐Alcohol	Drinks/Wk _____
☐Coffee/Caffeine Drinks	Cups/Day _____
☐High Stress Level	Reason _____

EXERCISE:

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Have you had any:	**Description**	**Date**
Automobile accidents	_____	_____
Surgeries	_____	_____
Broken Bones	_____	_____
Falls/Head Injuries	_____	_____

Females: Are you pregnant? YES NO # of pregnancies:_____ Date of last menstrual cycle:_____

List any medications you are taking:_____

_____

_____

Vitamins/Herbs/Minerals:_____

Any other health concerns:_____

PAYMENT METHOD: ☐Cash ☐Check ☐Credit Card ☐ACH auto payment (see attached financial policy)

I certify that the above information in correct. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation. I authorize Atlas Chiropractic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek services of another health care provider.

Signature of Patient, Parent, Legal Guardian Date

Atlas Chiropractic
46 Village Lp Rd
Kalispell, MT 59901

ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with the Federally Mandated Affordable Health Care Act

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 Smoker

CMS requires providers to report both race and ethnicity

Race (Circle One): American Indian or Alaskan Native / Asian / Black or African American / White (Caucasian)
Hawaiian or Pacific Islander / Other / I Decline to Answer

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

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5 mg 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: _____ / _____

Atlas Chiropractic

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Please read so that you understand the quality care you will agree to receive.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seed the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print Name)

All question regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission form child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of the last menstrual period: _____

_____ _____
(Signature) (Date)

ATLAS CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Atlas Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.*"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Atlas Chiropractic." "It is our policy to provide a substitute health care provider, authorized by Atlas Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
"*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Atlas Chiropractic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation
Atlas Chiropractic may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below:
"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Change of Ownership.
In the event that Atlas Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Atlas Chiropractic is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Atlas Chiropractic amend your protected health information. Please be advised, however, that Atlas Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Atlas Chiropractic.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Atlas Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Atlas Chiropractic is required by law to comply with this Notice. Atlas Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Tony Nieter, by calling this office at (406)257-4001. If Dr. Tony Nieter is not available, you may make an appointment for a personal conference in person or by telephone within 2working days.

Complaints

Complaints about your Privacy rights, or how Atlas Chiropractic has handled your health information should be directed to Dr. Tony Nieter, by calling this office at (406)257-4001. If Dr. Tony Nieter is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of January 1, 2012.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Atlas Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____
Patient's Signature

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy.

PATIENTS WITH INSURANCE

While the filing of insurance claims is a courtesy that we extend to our patients, ***all charges not covered by your insurance company are your responsibility.*** If you have insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. When possible, we will call your insurance company to verify your benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than supply factual information as necessary. You are responsible for the items listed above as well as any services considered "not medically necessary" by your insurance company. We participate with most insurance companies; however, if we do not participate with your insurance company, you are responsible for all out of network deductibles and co pays. We are legally and contractually obligated to collect ***ALL CO-PAYS AT TIME OF SERVICE***.

MEDICARE

We do accept assignment from Medicare. Medicare pays 80% of the allowable fee after your deductible has been met. **Medicare will cover the chiropractic adjustment only and for active conditions only.** Medicare for seniors does not cover or pay for initial exams! Medicare does not cover or pay for x-rays! But Medicare DOES REQUIRE by law that these procedures are performed prior to the beginning of care. As a courtesy and out of respect our office does offer a senior discount of $10.00 off the cost of these services. Medicare supplemental policies will cover only those charges that Medicare also allows. You are responsible for your Medicare deductible and all coinsurance.

PATIENTS WITHOUT INSURANCE

We require that 100% of the examination and x-ray exam be paid at the time of the visit, unless other arrangements have been made. To qualify for our Time of Service Reduction in fees you must pay on the day the service was performed. We are happy to accept cash, check, Master Card, Visa, or Discover.

WORKERS COMPENSATION

If you are injured on the job, your care may be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of their insurance carrier. If your claim is not allowed, you will be responsible for all charges accrued during your care. Additionally, please let us know if you are currently working with an attorney.

PERSONAL INJURY

Please notify your auto insurance of your visit to our office immediately. Although you are ultimately responsible for any charges accrued during your care, we will wait for a settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care all fees for services are due immediately. Additionally, please let us know if you are currently working with an attorney.

*Accounts past 30 days old with no attempt at payment will be charged an 18% annual finance charge, which will be added monthly to that account until the balance is paid in full. A $25 service fee will be charged for any returned checks.

*Patients with an outstanding balance more than 60 days overdue must make arrangements for payment prior to scheduling appointments.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ATLAS CHIROPRACTIC. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I GRANT PERMISSION TO MY INSURANCE COMPANY TO PAY ATLAS CHIROPRACTIC DIRECTLY FOR SERVICES RENDERED. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

Patient/Guardian Signature_____Date_____

Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying you bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Your health is priceless, and we are committed to helping you get the best results in the shortest amount of time at an affordable rate.