HIGHLAND
FAMILY
CHIROPRACTIC, P.C.

WELCOME!

Highland Family Chiropractic, P.C. extends a warm and personal welcome to you on behalf of the staff and doctors. Our goal is to provide you with the finest health care as well as offer you many informative and entertaining education opportunities.

HEALTH HISTORY

First Name: _____Last Name:_____ Gender: Male / female

Date of birth_____ Age:_____ Email:_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

HOME PHONE(_____)_____ CELL(_____)_____

Provider: Verizon/AT&T/Other:_____ Receive text alerts for apt reminders? Y/N

Employer_____ Job Title: _____

Marital Status: Single Married Widowed Divorced Other:_____

Spouses Name: _____ Phone #: (_____)_____

Emergency Contact Name: _____ Phone#: (_____)_____

How did you find our office? (internet, fair booth, email, mailer, friend, family member, other)

Who may we thank for referring you?_____

What brings you to our office today? _____

Work Injury (Yes / No) Auto Accident (Yes / No) *If yes to either, please let our receptionist know*

Onset Date:_____ Duration of Pain:_____

Have You Had This Before? (Yes / No) Explain:_____

Does the Pain Travel? (Yes / No) If yes, where?_____

Rate your pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst

Frequency of Pain: Constant Intermittent Occasional Rare

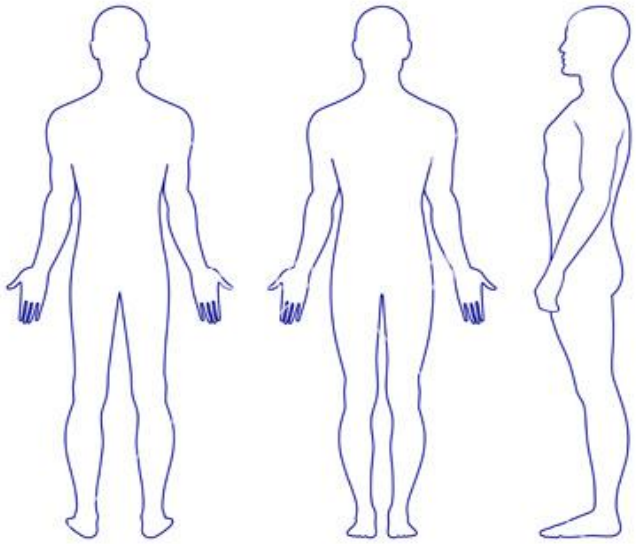
Is this getting: Better Worse Staying the same

Describe the pain: Dull Achy Tingling Sharp Shooting Hot Cold Tight Stiff Throbbing

Other health care providers seen for your symptoms _____

_____

Please locate your symptoms with an "X":



Back Front

Past Health History:

Have you had any surgeries? (Yes / No)

_____Date:_____ _____Date:_____

_____Date:_____ _____Date:_____

_____Date:_____ _____Date:_____

Have you had any major traumas? (Yes / No) Please list_____

_____

Medications you are currently taking:_____

_____

Major illnesses you have had: _____

_____

Are there any hereditary conditions we should be concerned with? _____

_____

FEMALE ONLY: Are you currently Pregnant? Yes / No If yes, due date:_____

Other Symptoms

___ Headaches
___ Migraines
___ Neck Pain
___ Sleeping Problems
___ Back Pain
___ Nervousness
___ Tension
___ Irritability
___ Chest Pain
___ Dizziness
___ Face Flushed
___ Neck Stiff
___ Heavy Feeling of Head
___ Hip Pain
___ Decreased Appetite
___ Twitches
___ Pins & Needles in Legs
___ Pins & Needles in Arms
___ Numbness in Fingers
___ Numbness in Toes
___ Shortness of Breath
___ Fatigue/Lack of Energy
___ Depression
___ Lights Bother Eyes
___ Blurred Vision
___ Double Vision
___ Loss of Memory
___ Eye Difficulty
___ Hyperactivity
___ Decreased Attention
___ Ear Ringing
___ Fever
___ Bed Wetting
___ Asthmatic Symptoms
___ Skin Disorder
___ Acne
___ Fainting
___ Loss of Smell
___ Loss of Taste
___ Diarrhea
___ Feet Cold
___ Hands Cold
___ Hemorrhoids
___ Increased Sweating
___ Seizures
___ Stomach Upset
___ Indigestion
___ Heart Burn
___ Constipation
___ Cold Sweats
___ Loss of Balance
___ Buzzing in Ears
___ Decrease in Hearing
___ Sinus Difficulties
___ Reoccurring Infections
___ Ear Infections
___ Reproductive Difficulty

EXERCISE.
___ None
___ Moderate
___ Daily
___ Heavy

WORK ACTIVITY
___ Sitting
___ Standing
___ Light Labor
___ Heavy Labor

HABITS (Circle One)
___ Smoking
___ Alcohol
___ Coffee/Caffeine Drinks
___ High Stress Level

Have you ever smoked? Yes No **Do you smoke?** Yes No
Packs/Day _____
Drinks/Wk _____
Cups/Day _____
Reason_____

Insurance Information

Do you have insurance? YES____ NO ____

Patients must bring a copy of their insurance information card to our office to bill insurance

(The person who owns the policy)

Policy Holder's Name _____ Policy Holder's DOB _____

Insurance Companies Name _____ Policy Holder's SSN _____

Assignment & Release Statement (Insurance)

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I give authorization to **Highland Family Chiropractic, P.C.** for my treatment.

_____ _____

Policy Holders Signature Date

_____

Dependents Names

Financial Policy

I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

Signature_____ Date: _____

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128 W. Granite St. Butte, MT 59701 406-728-2557

PATIENT COMPLIANCE ASSURANCE NOTIFICATION

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for use and disclosure of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment, or health care operations in order to provide health care that is in your best interest.

We also want you to know that, per our written policy, we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for the purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Protected Health Information (PHI). If you choose to give consent in this document, at some future time, you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and to revoke consent in writing after you have reviewed our privacy notice.

Patient Name _____ DOB _____

Patient Signature _____ Date _____

Acknowledges Receipt of Notification

NOTE TO PATIENTS

To Our Valued Families and Patients:

The Misuse of Protected Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with governmental rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

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INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes altercation of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

Adjustments commonly referred to as spinal manipulations can occur in both the spine and/or extremities. The spine/extremity can take time to properly hold the adjustments based on the environmental factors that are applied to the body by each patient. Complications that can occur from chiropractic care range from but are not limited to: fractures, dislocations, muscle strains, costovertebral separations, disc herniation, stroke, and cervical myelopathy. Some patients may feel pain and stiffness for a few days after their adjustment. We will make every reasonable effort at our office to ensure that you get the best results with the lowest amount of risk by doing detailed evaluations to screen for any contraindications for care. It is your responsibility as a patient to inform the doctors about any kind of pre-existing conditions prior to starting care to minimize any side effects from any kind of care at our office.

By signing this document, you are authorizing *Highland Family Chiropractic, P.C.* and its staff to perform the following treatments, as seen fit by your chiropractor.

Physical exam	Chiropractic adjustments	Rehab training	Massage therapy
X-rays	Soft tissue techniques	Laser therapy	
Consultation	Tractions therapy	Heat therapy	
Cryotherapy	Interferential therapy	Ultrasound therapy	

There are also dangers to not having spinal issues taken care of. If untreated for prolonged periods of time, patients will develop adhesions and therefore limit mobility. This will complicate treatment and prolong the recovery time. Sticking to the care plan, given to you by your chiropractor, is necessary to not only ensure you are recovering but to make sure you can prevent further injury from happening,

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction.

I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Minor Child CONSENT NEXT PAGE

Minor Child Consent (continued)

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Guardian Signature Date