BUTLER CHIROPRACTIC HEALTH CLINIC, PC

CONFIDENTIAL PATIENT INTAKE INFORMATION

Welcome! Please complete all questions. Bring **PHOTO ID & INSURANCE INFORMATION** to all appointments.

Name_____ Date_____

Address_____ Home Phone_____ Cell Phone_____

City_____ State_____ Zip_____ E-mail address_____

Employer_____Occupation_____

Work Address_____Work Phone_____

City_____ State_____ Zip_____ May we contact you at work? Yes No

Birthdate_____ Age_____ Sex M F Social Security_____

Marital Status S M W D Spouse's Name_____ Spouse's Birthdate_____

Emergency Contact_____ Phone_____

Person Responsible for Payment_____ Phone_____ Birthdate_____

Children's names and ages _____

Are you here for ___Chiropractic ____Massage Therapy ____Allergy Testing ____Orthotics ____Other

Which Doctor do you want to see? ____Dr. Don Butler ____Dr. Lynn Butler ____Massage Therapist

Current Health Concerns & Reasons for Consulting Our Office by Priority

1)_____ How long have you had this condition?_____

Have you had this or similar problem(s) before? Yes No If so when?_____

What do you believe is wrong with you?_____

Is this the result of an auto accident? Yes No Is this the result of a work accident? Yes No

Any family members with similar problem?_____

2)_____ How long have you had this condition?_____

Have you had this or similar problem(s) before? Yes No If so when?_____

What do you believe is wrong with you?_____

Is this the result of an auto accident? Yes No Is this the result of a work accident? Yes No

Any family members with similar problem?_____

3)_____ How long have you had this condition?_____

Have you had this or similar problem(s) before? Yes No If so when?_____

What do you believe is wrong with you?_____

Is this the result of an auto accident? Yes No Is this the result of a work accident? Yes No

Any family members with similar problem?_____

Other doctors or health care providers you have seen for these problems?

- _____
- _____
- _____

Injuries or accidents you have had?

- _____
- _____
- _____

Surgeries you have had?

- _____
- _____
- _____

Medications & Supplements you currently take?

- _____ For what?_____ Dosage?_____
- _____ For what?_____ Dosage?_____
- _____ For what?_____ Dosage?_____
- _____ For what?_____ Dosage?_____
- _____ For what?_____ Dosage?_____

Do you use ____a wheel chair ____a walker ____a cane ____Do you need assistance

Do you wear ____arch supports ____prescription orthotics ____braces

____prosthetics (specify)_____

Have you been diagnosed with cancer? Yes No If so, what kind(s) and what surgeries or treatment did you have?_____

List anything you are allergic to_____

Do you exercise? Yes No Activity_____ Hours per week_____

How much water do you drink?_____

Do you smoke? Yes No How many years?_____ Quit smoking? Yes No

Height_____ Weight_____

Is there pain when you cough, sneeze or strain? Yes No If so, where_____

Are you diabetic? Yes No Type I Type II

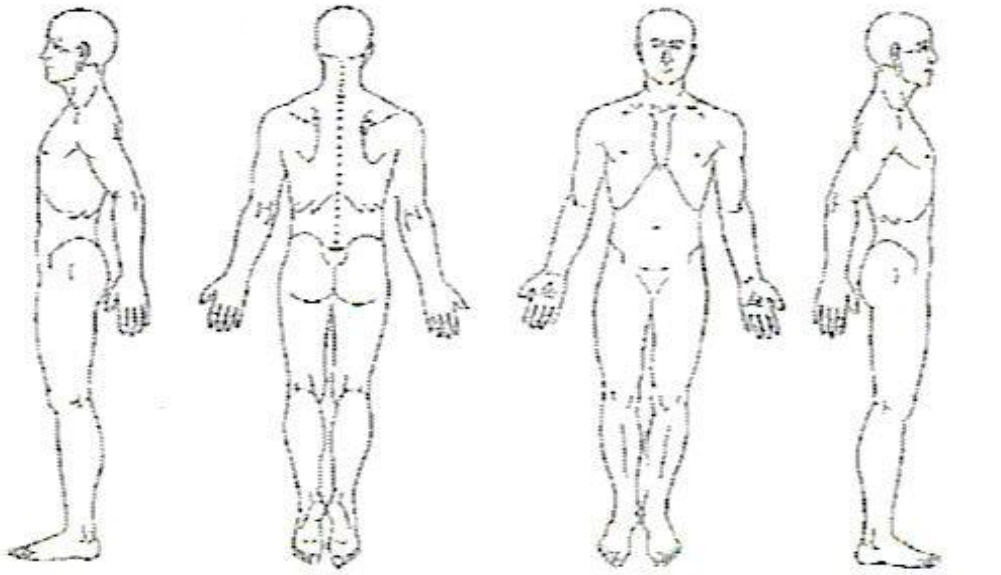
For women: Are you pregnant? Yes No If yes, # weeks pregnant_____

Are you nursing? Yes No Date of Last Menstrual Period_____

Description of Condition

Mark any area(s) on the Person below where you have the following:

Ache Burning Sharp Pain Dull Pain Shooting Pain Stiffness Numbness/Tingling



Left Back Front Right

On a scale of one to ten how intense are your symptoms?

Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

Have you ever been to a chiropractor before? Yes No If so, who_____

Address_____

City_____ State_____ Zip_____

Medical History Health Questionnaire

Please indicate if you have had the conditions below in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
		Abdominal pain			Ear ringing or noises			Loss of consciousness
		Allergies			Elbow pain			Low back pain
		Ankle or Foot pain			Fainting			Lung problem
		Anemia			Facial pain			Mid-back pain
		Arm pain			Fatigue			Motion sickness
		Arthritis			Gall bladder problems			Multiple Sclerosis
		Anxiety			Gastroesophageal reflux			Nausea
		Asthma			Gynecologic problems			Neck pain
		Balance problems			Hand/wrist pain			Numbness/tingling
		Bedwetting			Headache			Panic attacks
		Blackouts			Heartburn			Prostate problem
		Bladder Infection			Heart condition			Seizures
		Blurred vision			Hepatitis			Sinus problems
		Buttock pain			High blood pressure			Short of breath
		Cancer			Hip pain			Shoulder pain
		Chest pain			Hives			Sleep Apnea
		Concussion			HIV positive/AIDS			Sleeping problems
		Constipation			Infertility			Stiffness
		Depression			Jaw pain			Stroke
		Dermatitis/Eczema			Kidney infection			Swelling
		Diahrrea			Kidney stones			Thoracic outlet syndrome
		Difficulty concentrating			Knee pain			TMJ problem
		Dizziness/Lightheaded			Leg pain			Upper back pain
		Ear infections			Liver problems			Ulcers
		Ear pain			Loss of bladder control			Vision problems
		Ear plugging			Loss of bowel control			Vomiting

Family History. Please tell us about any of the above conditions you have in your family.

_____

_____

_____

_____

How did you hear about our office? ____Personal Referral ____Professional Referral ____Website

____Web search ____Other Who referred you to our office?_____

Patient signature_____ Date_____

AUTHORIZATION, ASSIGNMENT & CONSENT FOR TREATMENT

To Don R. Butler, D.C. Lynn Butler, D.C. Karen Fisher, LMT
In your consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursements of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequences thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

TO_____(Name of attorney and/or insurance company)
In consideration of the chiropractic services rendered and to be rendered by him, I authorize and direct the payment to the doctors name above of any sum I know or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services. If my current policy prohibits direct payment to the doctor, then I hereby also construct and direct you to make out the check to me and mail it as follows:

c/o _____
_____
_____

CONSENT FOR TREATMENT

By signing below, I give my consent for examination and the performance of any test or procedures needed. If patient is a minor, by signing, I give consent for examination, tests and procedures for the above minor patient.

Patient Signature: _____ Date_____

Witness: _____

FINANCIAL AGREEMENT

We offer several methods of payment for your chiropractic care. Please read carefully and choose the plan which best fits your needs. This information will enable us to better serve you and help avoid problems in the future.

Our main concern is your health and well being--- we will do our best to provide you with the help you need.

***Butler Chiropractic reserves the right to hire a 3rd party should your account become delinquent. In this instance, all 3rd party, attorney & court fees will be your responsibility**.

1._____ CASH/CHECK/CREDIT CARD: Payment due at time of service.

2._____INSURANCE: We will contact and submit to your insurance carrier for benefit coverage, however, we are not responsible for your insurer's final payment and benefit determinations. **Your co-payments are due at the time of service**.

3._____WORKERS COMPENSATION CLAIM: We will need all necessary information for filing with your workers compensation carrier; date of accident, injury information, carrier address and phone number. **You will be responsible until your claim has been approved.**

4._____PERSONAL INJURY: If you are in an accident, we will render care and send the bill to the designated insurance company. You will receive monthly statements so you are aware of when and if the insurance is paying. **If the insurance agency denies or delays payment, you will be responsible for keeping your account current.**

5._____SPECIAL ARRANGEMENTS: If none of the above applies or you feel that your situation is unique, please feel free to discuss financial options with our Office Manager.

Patient Name Date

Signature of Responsible Party Date

BUTLER CHIROPRACTIC HEALTH CLINIC, P.C.

FINANCIAL RESPONSIBILITY

In all cases, financial responsibility is yours. Payment by insurance companies **cannot** be guaranteed. Should you have any questions, do not hesitate to speak with our office manager.

Professional services are rendered to you, the patient, and not to the insurance company. We will send claims to your insurance company and follow up in every possible way to make sure your claims are processed. But **again, you are ultimately responsible for keeping your account current.**

MEDICARE: Patients with Medicare are responsible for their deductible and non covered services. Medicare **only covers chiropractic manipulations. ALL** other services (exams, x-rays, ultrasound & muscle stim are **NOT COVERED** by Medicare.

MISSED APPOINTMENTS: (NO SHOW)

24 hour advanced notice is required if you are unable to make your scheduled appointment time.

Our office policy regarding a missed appointment is as follows: A fee of $25 will be added to your account for **missed appointments with Dr. Don and/or Dr. Lynn.**

In regards to missed appointments for **MASSAGE**: A fee of 50% of the appointment charge will be accessed.

Any insurance or settlement check you receive is due to this office within three (3) days of receipt (unless your account is paid in full).

Interest on accounts receivable will be calculated at 1% per month (12% per annum) or $1.00 per statement charge (whichever is greater) on all accounts when payment is not made within 30 days of invoice.

Should your personal account exceed $250.00, a meeting with our office manager will be set up to discuss payment arrangements.

I have read and agree to the policies outlined above. I understand that insurance coverage cannot be guaranteed and I am ultimately financially responsible for care received at Butler Chiropractic Health Clinic, P.C.

Signature _____ Date _____

Witness _____ Date _____

Butler Chiropractic Health Clinic, P.C.
1802 Dearborn Ave.
Missoula, MT 59801
406-728-5114

BUTLER CHIROPRACTIC HEALTH CLINIC, PC
Privacy Policy

This notice is required by law (Federal regulation 45 CFR Parts 160 & 164) and describes how health information about you may be used and disclosed and how you can get access to this information.

This notice is in effect on and after April 14, 2003 and applies to Butler Chiropractic Health Clinic, PC.

Uses and Disclosures of Health Information

We use health information about you for treatment (diagnostic testing, referral, etc.), to obtain payment (submit claims and/or encounters to billing services and/or clearinghouses, and/or collection agencies, etc.), for healthcare operations (reporting, utilization management, etc.) and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for other purposes such as auditing and research studies when the research has been approved by an institutional review board. As required by law, we may disclose your health information to public health or legal authorities charged with prevention or controlling disease, injury, or disability.

Your Health Information Rights

- You have the right to inspect and obtain a copy of your health record with a signed authorization as provided in 45 CFR 164.524.
- You have the right to request in writing that we restrict and/or not use or disclose your protected health information as provided in 45 CFR 164.522 but we do not have to agree to accept your restrictions.
- You have the right to request in writing that your physician amend your protected health information as provided in 45 CFR 164.528
- You have the right to request in writing to receive confidential communications from us by alternative means or at an alternative location as provided in 45 CFR 164.522
- You have the right to obtain a list of instances (accounting of disclosures) where we have disclosed your protected health information for purposes other than treatment, payment or health care operations as provided in 45 CFR 165.528
- You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken as provided in 45 CFR 164.508

Our Responsibilities

- We are required by law to maintain the privacy of your health information.
- We are required by law to provide you with this notice about our privacy practices.
- We are required by law to follow the privacy practices that are described in this notice; however, we reserve the right to change or modify our practices and to make the new provisions effective for all protected health information (PHI) we maintain. Should our information practices change, we will post the revised privacy notice.

Questions and Complaints

If you have questions or if you are concerned that we have violated your privacy rights, you may contact the privacy officer. You may also file a complaint with the U.S. Secretary of Health and Human Services. There will be no retaliation against you for filing a complaint.

Privacy Officer Telephone: (406) 728-5114
Mailing Address: Medical Record Department, 1802 Dearborn Ave., suite 101, Missoula, MT 59801

Name:_____Date:_____

BUTLER CHIROPRACTIC HEALTH CLINIC, PC

Privacy Practices Acknowledgment: HIPAA

As of April 2003, all health care providers are required by law to provide you the patient with a Notice of Privacy Practices. The privacy of your protected health information (PHI) is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. You are being provided a Notice of Privacy Practices which explains how we may use and share PHI about you. If, at any time, you have questions or concerns related to your protected health information, please feel free to speak with any one of our staff.

Signature on file form

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all insurance companies related to my care at Butler Chiropractic Health Clinic, PC.
- I authorize release of all medical/health information from any other provider I have used previously to Butler Chiropractic and any agent working on their behalf.
- I authorize Butler Chiropractic Health Clinic, PC and any agent working on their behalf to obtain payment from my insurance company and/or attorney.
- I authorize payment to be made directly to Butler Chiropractic Health Clinic, PC.
- I permit a copy of this authorization to be used in place of the original.
- I permit Butler Chiropractic and any agent working on their behalf to contact me by means of the home, work and/or cell phone numbers I have provided on any patient information form(s).
- I permit Butler Chiropractic Health Clinic, PC and any agent working on their behalf to contact me via written communication to my home address given on any patient information form(s).

I have received and reviewed the Notice of Privacy Practices and the Signature on file forms.

Signature:_____Date:_____