Patient Information

Legal First Name: ______________________ MI: ______ Last Name: ______________________

Street: ____ Apt: __________

City: ______________________________ State: ________ Zip: ______________

Social Security #: ____________________ Marital Status: S M W D Spouse: ______________

DOB: ____________ Home Phone: ____________________ Work Phone: ______________

Cell Phone: ____________________ Cell Carrier ________________________

Please check your contact preference: ____Hm ____ Wk ____ Cell ____Email ____ Postal Mail

Email hm: ____________________ Email wk: ____________________

Emergency Contact: ____________________ Phone Number: ____________________

Whom may we thank for referring you to our office? ____________________

Occupation: ____________________ Employer: ____________________

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:

First Name: ____________________ M.I. ________ Last Name: ____________________

Policy Holder's Date of Birth: ______________ Policy Holder's SS#: ______________

Policy Holder's Employer: ____________________

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:

First Name: ____________________ M.I. ________ Last Name: ____________________

Policy Holder's Date of Birth: ______________ Policy Holder's SS#: ______________

Policy Holder's Employer: ____________________

Current Health Concern

1)____

2)____

3)____

When did your concern first appear?____________________

Is this condition getting progressively worse? _____Yes _____No

Rate the severity of your concern on a scale of 1 (least) to 10 (severe) 1 2 3 4 5 6 7 8 9 10

Type of Concern: ____Sharp ____Dull ____Throbbing ____Numbness ____Achy ____Shooting ____Burning/Tingling

Does it interfere with your ____Work ____Sleep ____Daily Routine ____Recreation

Is there pain when you cough or sneeze? **Yes** or **No**? If so, where?____________________

What do you believe is wrong with you?____________________

Is this a result of an auto or work accident **Yes** or **No?** If so, when?____________________

Have you been to a Chiropractor before **Yes** or **No**? If so, when? ____________________

Patient History

Are you seeing anyone else for other problems or health conditions? □ Yes □ No
Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

____
____
____

Past health history

Have you...	Yes	No	If yes, include date & provider seen
...been diagnosed with Diabetes?	□	□	______________
Type I____or Type II_____			
...been treated for hypertension?	□	□	______________

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Injuries/Surgeries you have had:	Description	Date
Head Injuries	______________	______
Broken Bones	______________	______
Surgeries	______________	______
Other	______________	______

Please List any **Medications** you are currently taking: **Vitamins/Supplements:**

____
____
____
____

Please list any Allerygies you have:______________________________

_____I am concerned about relief of a particular symptom
_____I am concerned about relief of a particular symptom and preventing its return
_____I just want to perform at my highest capacity.

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this 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 doctors 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 or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: ______________________________

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice is effective as of April 4. 2003. This notice ,and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed Please)	Signature	Date

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

Personal Representative Printed	Personal Representative Signature	Date

Description of the authority to act on behalf of the patient.

Terms of Acceptance

These are the terms under which all patients are accepted for care in this office:

The **Insured** does not offer to diagnose or treat any disease or condition other than vertebral subluxation or other neuro-musculoskeletal conditions; the **Insured** will advise such patient of any non-chiropractic or unusual finding; and, the **Insured** will recommend that the patient seek services of healthcare provider who specializes in that area if the patient desires advice, diagnosis or treatment of such findings.

Insured: Steven Stanchuk, D.C.

Printed Name_________________________________ **Date**_____________

Signature___________________________________ **Date**_____________

Witness____________________________________ **Date**_____________

Financial Policy

It is the policy of this office that all services rendered are charged directly to you, the patient, and ultimately, you are responsible for all services including those not reimbursed by third party payors. Patient balances may not exceed $150 at any time. Balances over 30 days and returned checks may be subject to additional collection fees and interest charges.

Assignment of Insurance: I hereby assign my rights and authorize and direct my insurance company, or any other liable insurance company, or any other concerned party to make payment directly to Tall Pines Chiropractic P.C. If Tall Pines receives payment from my health benefit provider in the form of a check that is made payable to me I transfer the right to Tall Pines to endorse and deposit the check to use towards the services rendered.

Tall Pines Chiropractic, P.C. makes no representation as to whether or not the chiropractor participates in or accepts assignment for the patient's specific insurance or payor plan.

This assignment and direct payment authorization shall include any payments for services billed by Tall Pines Chiropractic, P.C. in connection with services rendered.

By providing a cell phone number you are allowing Tall Pines Chiropractic to contact you in the way of a phone call or by a text message in conducting business resulting from services provided or products purchased. The number will not be shared with any party other than those in-house or contracted to perform duties resulting from services provided to you by this office.

Financial Agreement: I UNDERSTAND, WHETHER SIGNING AS PATIENT, OR GUARDIAN, THAT THE TERMS OF PAYMENT FOR SERVICES RENDERED ARE DUE IN FULL WITHIN 30 DAYS OF SERVICE. BALANCES REMAINING AFTER INSURANCE HAS PAID ARE DUE WITHIN 30 DAYS OF THE INSURANCE PAYMENT UNLESS OTHER FINANCIAL ARRANGEMENTS ARE MADE. I also understand that I am responsible for all charges incurred regardless of insurance or third party liability. I will pay all services in full until Tall Pines Chiropractic, P.C. "qualifies" my coverage to determine the extent of benefits under my policy. I will pay the account in accordance with the regular rates and terms of Tall Pines Chiropractic, P.C. I agree that I may be responsible for 100% payment of the account.

As a courtesy service, and to assist you in the satisfaction of your responsibility to Tall Pines Chiropractic, if you are not able to pay your balance in full Tall Pines Chiropractic offers several payment options and special programs to assist you. Tall Pines Chiropractic will carry self pay account balances for no longer than twelve (12) months. The 12-month time frame goes into effect the moment your account balance is over $150. Monthly payment amounts must be sufficient to resolve all self pay account balances within the 12-month timeframe.

All accounts that do not have financial arrangements will bear interest on the unpaid balance if not paid in full within 30 days.

Should I not pay this account as due, I will be liable for any court, attorney or collection fees incurred by Tall Pines Chiropractic, P.C. in collection of any balance due on the account for services rendered.

If a commitment was made to a care plan, you will receive a discount if paid in full. If terminated prematurely, you will forfeit your prepaid discount as well as any other accumulated discounts during your care plan.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

The undersigned certifies that he/she has read the foregoing, has received a copy thereof, and is the patient, or is guardian to the patient to execute the above and accept its terms.

Signature________________________________ Date Signed__________________

Printed Name_____________________________ Account#____________________

Witness__________________________________

Tall Pines Chiropractic, P.C.
913 SW Higgins Suite 101
Missoula, MT 59803
406-926-1575