Vincent J. Maddio D.C. • Michael C. Morris D.C. • Jeffrey Fife D.C. • Sheridan Jones D.C.
827 North Last Chance Gulch – Helena, MT 59601 - **Motion Is Life**
Phone: (406) 449-4445 Fax: (406) 495-0259 www.helenatcchiro.com

PATIENT INFORMATION

Date: _____ Primary Phone: _____ Other Phone: _____

Patient Name: _____ Social Security #: _____
Last Name First Name M.I.

Mailing Address: _____
City State Zip

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Email address: _____@_____

Employer: _____ Occupation: _____ Phone #: _____

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE 18 OR A STUDENT

Parents Name: _____ Phone #: _____

Address: _____
City State Zip

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Phone #: _____ Relationship: _____

CASH PATIENT FINANCIAL RESPONSIBILITY

Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our Time of Service rates when their account is paid in full on each visit. If your account is not paid in full at each visit the discount will NOT be applied. _____
Please Initial

PATIENT PRIMARY INSURANCE INFORMATION

We will need a copy of all insurance cards. Chiropractic care is covered by most insurance companies. However, you will want to verify your chiropractic coverage with your insurance company. YOU have the contract will your insurance company, NOT this office. Co-Pays are due at time of service. _____
Please Initial

Primary Insurance Company Name: _____ Name of Primary Insured: _____
Date of Birth: _____ Employer: _____

Workers Compensation Injury? ☐ Yes ☐ No Date of Injury: _____
Auto Accident? ☐ Yes ☐ No Date of Accident: _____

IMPORTANT INFORMATION PLEASE READ

I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agrees that all proceeds of insurance are assigned to this office where applicable.

I understand that any check returned to us for NON-SUFFICIENT FUNDS (NSF) will result in a $20.00 service fee.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

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

_____ _____
Patient or Guardian Signature Date

PATIENT HEALTH QUESTIONAIRE

Patient Name: _____ **Date:** _____

For each of the following conditions listed below, please check the past or present column, or both if applicable.

Musculoskeletal

Past/Present

- ○ ○ Headaches
- ○ ○ Neck Pain
- ○ ○ Mid Back Pain
- ○ ○ Low Back Pain
- ○ ○ Hip/Upper Leg Pain
- ○ ○ Knee/Lower Leg Pain
- ○ ○ Ankle/Foot Pain
- ○ ○ Shoulder Pain
- ○ ○ Elbow/Upper Arm Pain
- ○ ○ Wrist Pain
- ○ ○ Rib Pain
- ○ ○ Jaw Pain
- ○ ○ Joint Swelling/Stiffness
- ○ ○ Arthritis
- ○ ○ Rheumatoid Arthritis

Neurological

Past/Present

- ○ ○ General Fatigue
- ○ ○ Muscular Incoordination/Weakness
- ○ ○ Visual Disturbances
- ○ ○ Dizziness
- ○ ○ Depression
- ○ ○ Epilepsy

Family History:

- ○ Heart Disease
- ○ Cancer: Type _____
- ○ Diabetes
- ○ Other _____

Females Only:

- ○ Birth Control Pills
- ○ Pregnancy # _____

Social Habits:

Past/Present

- ○ ○ Tobacco Use
- ○ ○ Alcohol Dependence

Employment:

Company: _____

Occupation: _____

Exercise Habits:

- ○ None ○ Light
- ○ Moderate ○ Strenuous

Height: _____ **ft** _____ **inches**

Weight: _____ **lbs**

Other Health Issues Not Listed:

_____

_____

_____

List any medications you are currently taking:

Medication Name	Purpose of Medication (if known)

**********PLEASE SEE REVERSE SIDE FOR FURTHER INFORMATION AND SIGNATURE**********

List all surgical procedures you have had and times you have been hospitalized: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please read the following statement: Chiropractic examination and therapeutic procedures, (including spinal manipulation, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, burns and temporary worsening of symptoms; more serious complications are extremely rare. Additional information on side effects and complications can be discussed with your provider.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee of warranty for a specific cure or result.

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

Signature: _____ **Date:** _____

Signature of Legal Guardian or Personal Representative _____

Print Name: _____ **Date:** _____

Town Center Chiropractic
827 N. Last Chance Gulch
Helena, MT 59601
406-449-4445

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

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

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

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

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native 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. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date:_____

For office use only

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

TOWN CENTER CHIROPRACTIC, 827 N. Last Chance Gulch, Helena, MT 59601 (406)449-4445

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices

Signature: _____ **Date:** _____

Print Name: _____

Personal Representative. If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your PR.

Signature of Personal Representative or Legal Guardian: _____

Print Name: _____ Date: _____

FINANCIAL/HEALTH DISCLOSURE MATTERS

If you would like us to discuss your health or billing information with someone else, such as a parent or personal representative, please provide us with the contact information for that person.

Name of Contact Person: _____
Address: _____
Phone # or E-mail Address: _____

PATIENT MESSAGING CONSENT

By supplying my phone number, email address and any other personal contact information, I authorize my health care provider to employ a third-party automated messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment or other communications.

Patient Signature: _____ **Date:** _____

Printed Name: _____