BELGRADE BACK & NECK CLINIC

227 Spooner Road · Belgrade, MT 59714

(406) 388-0663 · Fax (406) 388-0664

Dr. S. Clint Bryan
Chiropractic Physician

CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Date _____

Mailing Address _____ Zip Code _____

Street Address _____ Home Phone _____

Age _____ Birth Date _____ Soc Sec # _____

Marital Status M S W D Cell Phone _____

Employer _____ Work Phone _____

Name of Spouse _____ Occupation _____

Spouse's Employer _____ Work Phone _____

Patient's Nearest Relative (not living in the household) _____

Address _____ Phone# _____

Referred by: Yellow Pages Back cover of phone book Other _____

Patient's Name _____

HEALTH INFORMATION:

Have you had previous chiropractic care? YES NO

Where? _____

When? _____

Why? _____

Were x-rays taken? _____

What is your **MAJOR COMPLAINT**? _____

Other Complaints? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

If yes, when? _____

What activities aggravate your condition? _____

What activities relieve your condition? _____

Is this condition getting progressively worse? Yes No Constant Off & On

Is this condition interfering with your: Work Sleep Daily Life Other _____

How long has it been since you really felt good? _____

List surgical operations and years _____

Drugs you now take: Pain killers Muscle relaxants Insulin Birth Control

Others: _____

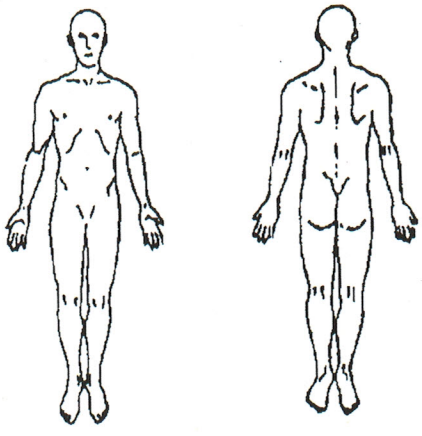
Are you wearing: Heal lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident? Past year Past 5 years Over 5 years None

Describe _____

Date of last Physical Examination _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



HAVE YOU EVER SUFFERED FROM:

Dizziness _____
Backaches _____
Heart Trouble _____
Diabetes _____
Arthritis _____
Headaches _____
Asthma _____
Neuritis _____
Digestive Disorders _____
Nervousness _____
Sinus Trouble _____
Neck Pain _____

INSURANCE INFORMATION: Please provide card for photocopy

Is your condition due to an auto accident? _____ Job related? _____

Do you have health insurance? Yes No **If yes, please provide the following information:**

Name of company _____ Phone# _____

Address of company _____

Policy/ID# _____ Group# _____

Insured's Name _____ Insured's Birth Date _____

Are you covered by Medicare? Yes No If yes, Medicare ID# _____

Supplement Insurance? Yes No If yes, ID# _____ Group# _____

Insured's Name _____ Insured's Birth Date _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Belgrade Back and Neck Clinic 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 the Belgrade Back and Neck Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand if a problem arises with payment of my bill and legal services are required, I will be responsible for all costs and legal fees incurred. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Lastly, I am fully aware that I will have 30 days from the date of visit to pay any amounts due by me or the insurance company if I have failed to complete the necessary requirements requested by them to process my claim.

PAYMENT IS EXPECTED AT THE TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

Patient's Signature _____ **Date** _____

Guardian's or Spouse's Signature _____

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than 1/2 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing

A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from sleeping at all.

SECTION 9--Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms off travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

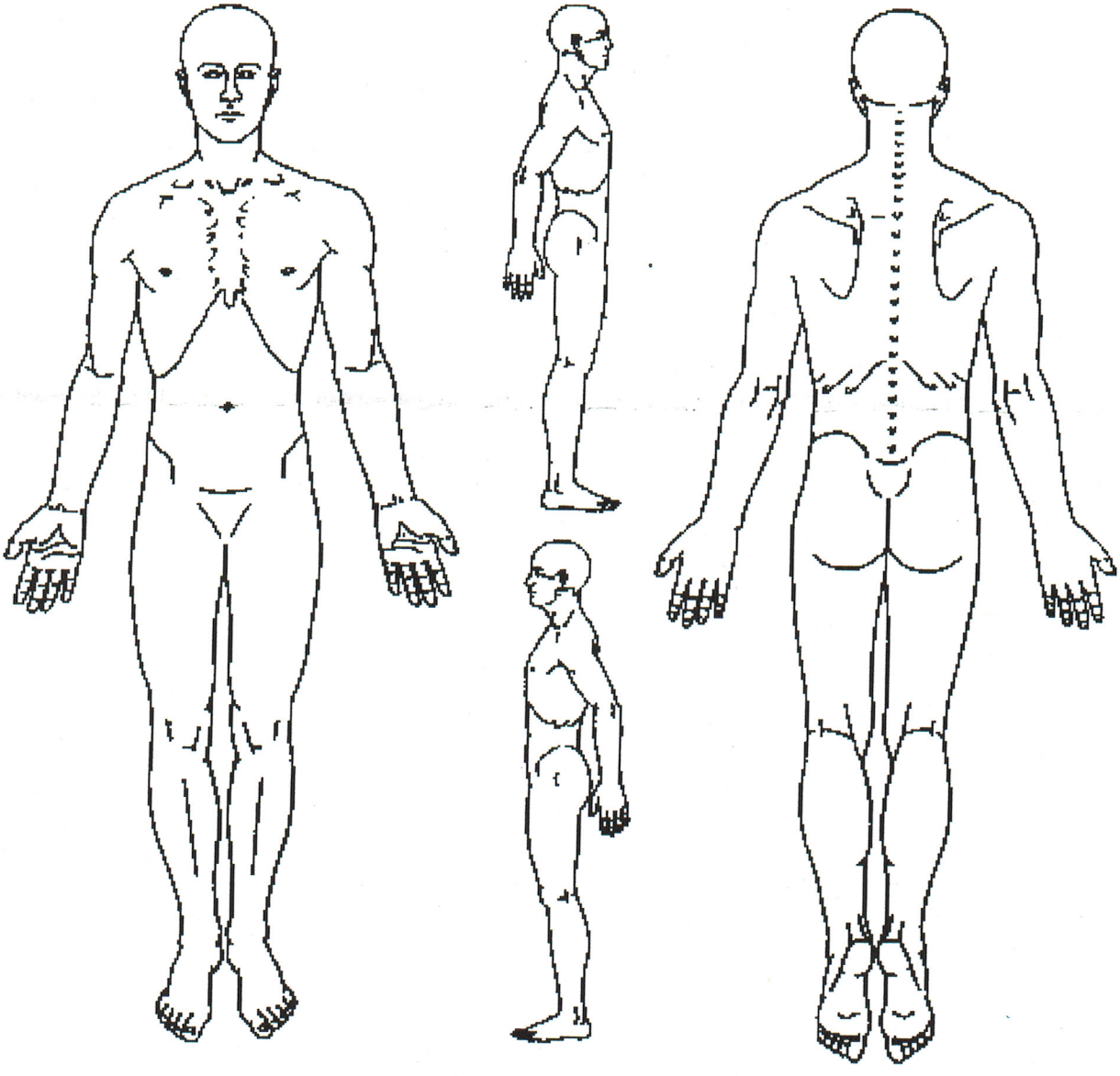
DISABILITY INDEX SCORE: %_____

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

PATIENT PAYMENT POLICY

Patient Name _____

[A] **IF YOU HAVE HEALTH INSURANCE**
which covers chiropractic care, we ask that you pay *100%* of your first office visit and *100%* of all services as they are rendered until your deductible has been met. After your deductible has been met, we ask that your co-payment amount be paid as services are rendered. *Balances on each date of service must be paid within 30 days.* Any balances owed by me that are over 30 days will be considered delinquent and will be handled accordingly. We will gladly process your insurance for your convenience. However, if they fail to pay or have requested information from you, and you have not responded within the allotted time, you will be responsible for the entire balance.

[B] **IF YOU WERE HURT ON THE JOB**
we will bill the liable insurance company directly. Any changes not paid for by the worker's compensation insurance company will be your personal responsibility.

[C] **IF YOU WERE INJURED IN AN AUTO ACCIDENT**
we will bill the responsible insurance company or your attorney directly, Please let our office know as soon as an attorney is involved so we can forward some necessary paperwork to them. Any charges not paid for by the automobile insurance company will be your responsibility.

[D] **IF YOU ARE COVERED BY MEDICARE**
we request that you pay for all non-covered services when the services are rendered or your may make special financial arrangements with the receptionist. We will bill Medicare and any supplemental insurance companies you have.

[E] **IF YOU DO NOT HAVE HEALTH INSURANCE**
which covers chiropractic, we request that you pay when services are rendered or make special arrangements with our receptionist.

WE WILL NOT HOLD BALANCES FOR MORE THAN 30 DAYS. PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE*

I authorize the doctors and staff to examine, take x-rays, treat me and do whatever he deems necessary in accordance with the state statues, for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that BELGRADE BACK & NECK CLINIC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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 for professional services rendered me will be immediately due and payable. I here by authorize the release of my health evaluation, examination and treatment records, and the prognosis to my employer, attorney or insurance company. I also understand if a problem arises with payment of my bill and legal/collection services are required, I will be responsible for all costs and legal fees incurred. PAYMENT IS EXPECTED AT THE TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. I also understand that I will have 30 days from the date of visit to pay any amounts due by me or the insurance company if I have failed to complete the necessary requirements requested by them to process my claim.

I choose plan (circle one): **A** **B** **C** **D** **E**

Signature: _____ **Social Security #:** _____

Effective Date: _____ **Birth Date:** _____

expiration date is 18 months from day of signing*

NOTICE OF PRIVACY PRACTICES

Belgrade Chiropractic Inc., d.b.a.
Belgrade Back & Neck Clinic
227 Spooner Road, #B
Belgrade, MT 59714
(406)388-0663 Fax (406)388-0664

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Signature of Patient of Legal Representative

Witness

Date

Date

OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice.

Payment is due at the time of treatment. We accept cash, check and major credit cards. We also have a payment plan called CareCredit, that allows you to start treatment today and spread payments over time.

Payment Options

1. Cash or Check
2. Major Credit Cards
3. CareCredit

Applying for CareCredit only takes a few minutes and there is no fee to apply.

Please indicate below the form of payment you choose to settle your account: check one

☐ Cash or Check
☐ Major Credit Card
☐ Care Credit (Subject to credit approval.) If credit application is declined, another form of payment listed above is required.

_____ _____

Signature of Patient/Responsible Party Date

Belgrade Back and Neck Clinic
227 Spooner Road, Suite B
Belgrade, MT 59714

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Belgrade Back and Neck Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Belgrade Back and Neck Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Belgrade Back and Neck Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Belgrade Back and Neck Clinic's Privacy Officer at 227 Spooner Road, Suite B Belgrade, MT 59714.

With my consent, Belgrade Back and Neck Clinic may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Belgrade Back and Neck Clinic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Belgrade Back and Neck Clinic may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Belgrade Back and Neck Clinic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Belgrade Back and Neck Clinic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Belgrade Back and Neck Clinic may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian