WELCOME

What to expect:

First Visit: ***Consultation / *Exam X-Rays (if indicated)**

Second Visit: ***Brief Video and report of health findings**

***Chiropractic adjustment, customized treatment plan and recommendations**

PATIENT INFORMATION

NAME_____GENDER: FEMALE____ MALE____DATE_____

ADDRESS _____CITY_____ STATE_____ ZIP_____

PHONE: HOME (____) _____WORK (____)_____CELL (____)_____

DATE OF BIRTH_____ AGE_____ HEIGHT_____ WEIGHT_____

RACE: NATIVE AMERICAN AFRICAN AMERICAN WHITE ASIAN OTHER DECLINE

ETHNICITY: HISPANIC NON HISPANIC

EMAIL:_____

EMPLOYER_____ ADDRESS _____

SOCIAL SECURITY NUMBER_____ MARITAL STATUS: S M D W

SPOUSE'S NAME_____ D.O.B._____SPOUSE'S EMPLOYER_____

WORK PHONE (____) _____ IF CHILD PARENTS' NAMES_____

IN CASE OF EMERGENCY CONTACT _____ PHONE (____) _____

WHO REFERRED YOU TO OUR OFFICE? _____

MAJOR COMPLAINT _____

PAIN OR COMPLAINT STARTED ON _____IS THIS DUE TO AN ACCIDENT? _____

DATE AND TYPE OF ACCIDENT? _____

PAINS ARE: SHOOTING SHARP STABBING BURNING NUMB/TINGLING THROBBING ACHING

FREQUENCY: OCCASIONAL INTERMITTENT FREQUENT CONSTANT

IS THIS CONDITION INTERFERING WITH: WORK? SLEEP? ROUTINE?

OTHER DOCTORS SEEN FOR THIS CONDITION? _____

ANY AT HOME REMEDIES? _____

INJURIES/SURGERIES YOU HAVE HAD	DESCRIPTION	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred method of communication for patient reminders (please check one)

- ☐ Email: Email address _____
- ☐ Text: Cell Phone Number (____) _____
- ☐ Cell phone provider needed for text: Verizon AT&T Other
- ☐ No reminder

Other Symptoms:

___ Headache
___ Migraines
___ Neck Pain
___ Sleeping Problems
___ Upper Back Pain
___ Lower Back Pain
___ Nervousness
___ Tension
___ Irritability
___ Chest Pain
___ Dizziness
___ Face Flushed
___ Neck Stiff
___ Heavy Feeling of Head
___ Hip Pain (Right)
___ Hip Pain (Left)
___ 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
___ Sensitivity to Light
___ Blurred Vision
___ Double Vision
___ Loss of Memory
___ Eye Difficulty
___ Hyperactivity
___ Ear Infections
___ 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
___ Heartburn
___ Constipation
___ Cold Sweats
___ Loss of Balance
___ Buzzing in Ears
___ Decrease in Hearing
___ Sinus Difficulties
___ Recurrent Infections
___ Reproductive Difficulties

For women only: Are you pregnant? No Yes Due Date _____

Are you currently taking any medications? (*we can make a copy of med list)*

MEDICATION NAME: **DOSAGE & FREQUENCY (i.e. 5mg once a day):**

_____ _____

_____ _____

Do you have allergies? Yes No Allergies to Medications?

MEDICATION NAME:	**REACTION:**	**ONSET DATE:**	**ADDITIONAL COMMENTS:**
_____	_____	_____	_____
_____	_____	_____	_____

Are there any hereditary health issues that you know about? _____

_____

EXERCISE:
__None
__Moderate
__Daily
__Heavy

WORK ACTIVITY
__Sitting
__Standing
__Light Labor
__Heavy Labor

HABITS
__Smoking
__Alcohol
__Coffee/Caffeine
__High Stress

Have you ever smoked?____
Packs/Day?_____
Drinks/Week?_____
Cups/Day?_____

INSURANCE INFORMATION: Do you have any insurance? Y N (Please give card to staff)

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

Insurance Company's Name:_____Policy Holder's SS#_____

ASSIGNMENT AND RELEASE:

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 to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I give authorization to Dr. Linda Matz and or Dr. Ben Olson for my treatment.

Responsible party signature:_____

Relationship:_____ Date:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how our protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we leave a message on your answering machine at home or on your cell phone?
___Yes ___No

May we discuss your medical condition with any member of your family?
___Yes ___No

If YES, please name the family members allowed: _____

This consent was signed by (PLEASE PRINT YOUR NAME): _____

Signature: _____ Date: _____

Bloom Chiropractic and Wellness Center, Dr. Linda Matz PC & Dr. Ben Olson
3700 S. Russell St. #115, Missoula, MT 59801

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or patient listed below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures and give my consent for treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (PLEASE PRINT YOUR NAME): _____

Patient Signature: _____ Date: _____
(Or signature of legally responsible party)

Bloom Chiropractic and Wellness Center, Dr. Linda Matz PC & Dr. Ben Olson
3700 S. Russell St. #115, Missoula, MT 59801

MINOR CHILD CONSENT (If applicable)

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: _____

Patient Compliance and 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 operation.

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 preserve 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 healthcare that is in your best interest.

We also want you to know that, per our witten 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 healthcare 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 all parts of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA 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.

PLEASE PRINT YOUR NAME: _____

Signature: _____ Date: _____ DOB:_____

Acknowledges Receipt of Notification.

Bloom Chiropractic and Wellness Center, Dr. Linda Matz PC & Dr. Ben Olson
3700 S. Russell St. #115, Missoula, MT 59801