INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT.**

Today's Date _____

Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Your Employer _____ Occupation _____ Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Your Social Security # _____ Driver's License # _____

Do you have Health Insurance? Yes_____ No_____
If yes: Name of Company_____
Policy #_____ Group # _____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Name of Spouse or Guardian _____ Their Birthdate _____
Spouse Employed By _____ Occupation _____Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Office Phone # _____ Spouse's SS# _____

Emergency Contact: Name of a friend or relative NOT living with you: _____
Address: _____ Phone: _____
Relationship: _____

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Type of Insurance _____Auto _____Workman's Comp _____Health Insurance
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

How did you hear about our office? _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

OFFICE FINANCIAL POLICY

1. If you have insurance, we will gladly verify insurance coverage. We accept assignments with Allegiance and Blue Cross Blue Shield and regulations provided that we have prior certification from your insurance company. If we are not an In-Network provider with your insurance, we will print you a superbill to submit to your insurance.

2. We accept assignment as an in-network provider for BCBS and Allegiance as a courtesy to you. **We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.**

3 Whenever you receive any worksheets from your insurance company, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any overpayment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account if any balance is due.

4. Any services not covered or coverage reductions by your insurance will be the patient's responsibility as well as all deductible amounts.

5. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services, and you will be expected to pay such charges on a timely basis.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we must refer your account to the small claims court of Yellowstone County, you agree to pay all court costs, which consist of filing fees and service fees. If we must refer the collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Yellowstone County, Montana.

LATE ARRIVING/MISSED APPOINTMENTS:

Late appointments: As a courtesy to others, we reserve the right to reschedule your appointment if you are going to be more than 10 minutes late.

Missed appointments: We appreciate 24-hour notice if you will be missing any appointment. If you are unable to give 24-hour notice, please call as soon as you know you are unable to make that day's appointment.

RETURNED CHECKS: There is a fee (currently $30.00) for any checks returned by the bank.

I have read and understand the Financial Policy and agree to abide by these terms.

_____ _____

Patient Signature Date

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

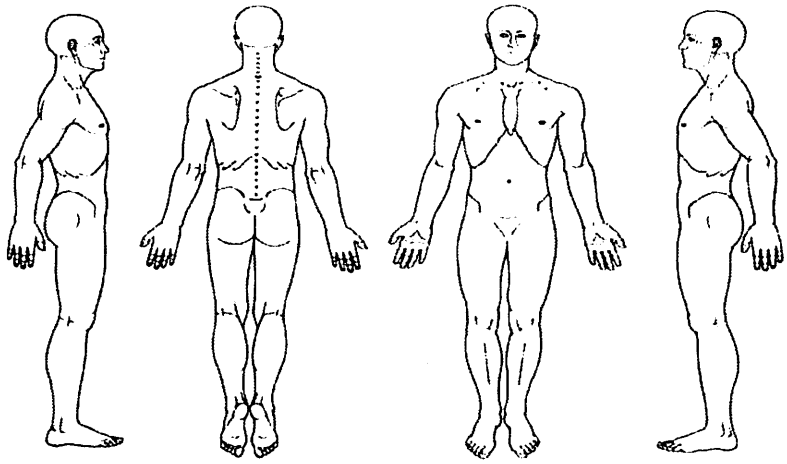
_____

_____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

☐ No One ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

11. What is your occupation?

_____

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again
☐ Resume/increase activity ☐ Learn how to take care of this on my own ☐

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ☐None ☐Light ☐Moderate ☐Strenuous

What is your height and weight? Height ☐☐☐ (*Feet* *Inches*) Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Use Tobacco Products
						☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain				☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite	***Females Only***		
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Birth Control Pills
☐	☐	Joint Swelling/Stiffness	☐	☐	Ulcer	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	
☐	☐	General Fatigue	☐	☐	Cancer	***Other Health Problems/Issues***		
☐	☐	Muscular Incoordination	☐	☐	Tumor	☐	☐	
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	
☐	☐	Dizziness	☐	☐	Chronic Sinusitis	☐	☐	

Indicate if an immediate family member has had any of the following:

☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

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

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

SF-12™ Health Survey

ChiroCare Use Only rev 1/29/99

Patient Name _____ **Date**

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

1. *In general, would you say your health is:* ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. *The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?*

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. ***Moderate activites**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?*	☐	☐	☐
b. *Climbing **several** flights of stairs?*	☐	☐	☐

3. *During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?*

	Yes	No
a. ***Accomplished less** than you would like*	☐	☐
b. *Were limited in the **kind** of work or other activities*	☐	☐

4. *During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?*

	Yes	No
a. ***Accomplished less** than you would like*	☐	☐
b. *Didn't do work or other activities as carefully as usual*	☐	☐

5. *During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home, and housework)?*

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. *These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**....*

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. *Have you felt calm and peaceful?*	☐	☐	☐	☐	☐	☐
b. *Did you have a lot of energy?*	☐	☐	☐	☐	☐	☐
c. *Have you felt downhearted and blue?*	☐	☐	☐	☐	☐	☐

7. *During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?*

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Name: _____ Date: _____

Basic Nutrition Questionnaire

Have you ever been told you have High Cholesterol or Triglycerides? Yes No

Have you ever been diagnosed with high blood pressure? Yes No

Have you ever been diagnosed as diabetic? Yes No

Have you been diagnosed as Pre-Diabetic or Metabolic Syndrome? Yes No

How many days a week do you skip a meal? (3 meals/day) _____

How many "fast food", "refined food", or "pre-prepared" meals do you eat per week?

(None) (1-3) (4-6) (7+)

How many servings of fruit do you eat a day? (0-1) (2-3) (4-5)

How many servings of vegetables do you eat a day? (0-1) (2-3) (4-5)

Do you regularly drink one or more per day of the following: (circle all that apply)

Soda Diet Soda Coffee Juice Milk Alcohol

How many servings of refined sugar do you eat per day? (candy, cookies, cake, etc.)

(0-1) (2-3) (4-5)

Please list all nutritional supplements/vitamins you take regularly.

Supplement Name/Type	Frequency	Brand or where purchased

Maurer Chiropractic
309 1st Avenue, Laurel, MT 59044
(406) 628-9322

Electronic Health Records Intake Form

In compliance with requirements for the government EHR Incentive Program

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

Email Address: _____

Preferred method of communication for patient reminders (circle one): Email / Phone / Mail / Text

Date of Birth: _____ **Gender (circle one):** Male / Female

Preferred Language: _____

Smoking Status (circle one): Every day smoker / Occasional smoker / Former smoker / Never smoked

Smoking Start Date (optional): _____

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 / 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 any regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5 mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional comments

I choose to decline receipt of my clinical summary after each visit (circle one): Yes / No
(These summaries are often blank because of the nature and frequency of chiropractic care)

Patient Signature: _____ **Date:** _____

For office use only:

Height: _____ WEIGHT: _____ BLOOD PRESSURE: _____ PULSE: _____

Maurer Chiropractic
A Family Health and Wellness Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 9/18/2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your protected health information to provide, coordinate or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party. For example, we would disclose your protected health information, as necessary, to a specialist to whom you have been referred to ensure that the specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your chiropractic services. For example, obtaining approval for a third party payment program may require that your relevant protected health information be disclosed to obtain approval for loan status.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this chiropractic practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to chiropractic students or licensed chiropractors that see patients while engaged in training rotations in our office. In addition, we may call you by name in the waiting room when the Doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These include: as Required by Law, Public Health issues required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and organ donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance of Section 164.500.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an

explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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.

If you have any objections to this form, please contact:

Dr. Philip Maurer
Telephone: 406-628-9322 Fax: 406-628-9321
E-mail: maurerchiropractic@gmail.com
Address: 309 1st Avenue, Laurel, MT 59044

Your signature below is only an acknowledgement that you have received this Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date