Optimum Health & Wellness, PLLC

Phone: (406) 317-1014 **Fax:** (406) 552-1811
1001 SW Higgins Ave Suite 102 Missoula, MT 59803
www.optimumhealthmissoula.com

Paying for your care is easy here!

Mark which one is you:

☐ **No Insurance**	• Easy! Our care plans and simple payment arrangements have helped many and will work great for you too!
☐ **Health Insurance**	• These days, insurance pays very little if anything for natural drugless care to get you healthy, so we make it easy! • We will verify any benefits you may have and submit your claims to the insurance for you. • If they pay anything after your deductible is met, we will accept payment directly from them. • You are responsible for any deductible, co-insurance, co-pays and unpaid visits. • Of course, you can use your HAS, HRA, and Flex dollars here. • For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.
☐ **Auto Injury**	• Auto-related injuries are typically covered at 100% in Montana, even if you were at fault or were a passenger. You can get the care you need, and it typically costs you $0.00! Great for you! • All we need is your claim number and insurance information.
☐ **Work Injury**	• Work injuries are typically covered at 100%! • It costs you nothing. • All we need is your claim number, work comp info., and a letter of pre-authorization (usually for 6-12 visits initially).
☐ **Medicare**	• Medicare pays for most of your care making it quite easy. • We simply need a copy of your Medicare card, and any supplementary/secondary insurance information. • Medicare *does not* cover examinations, x-rays, or any therapies.

You have made a great decision to get care here!

Our goal is to be your family chiropractor for life!

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Acct #_____ W: _____ H: ____'____"

Name:	Birthdate:	Today's Date:	
Mailing Address:	City:	State:	Zip:
Phone:	Email:		
Marital Status:	Gender:		
Employer:	Insurance Company:		
Emergency Contact:	Emergency Contact Phone:		

Who may we thank for referring you? _____
Have you ever received Chiropractic Care? YES NO If yes, when? _____
Name of most recent Chiropractor: _____
Is there a chance you could be pregnant (women only)? YES NO

1. Reasons for seeking chiropractic care:

Primary reason:
_____

Secondary reason:
_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):
_____
_____

3. Past Health History:

A. Please indicate if you have a history of any of the following (select all that apply):
□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's
□ Other _____ □ None of the above

B. Previous Injury or Trauma:
_____

Have you ever broken any bones? Which?
_____

C. Allergies:
_____

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D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females / Pregnancies and outcomes (if there are more please list on an additional page):

Pregnancies/Date of Delivery	Outcome

4. Family Health History:
   Do you have a family history of? (select all that apply)
   □ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
   □ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
   □ Other _____ □ None of the above

Deaths in immediate family: _____

Cause of parent's or sibling's death	Age at death

Social and Occupational History:

A. Job description:
   _____

B. Work schedule:
   _____

C. Recreational activities:
   _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):
   _____

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Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn
□ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____
□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____
□ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
□ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

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NEW PATIENT HISTORY (*Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.)*

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (select all that apply):
  Bending neck forward bending neck backward tilting head to left tilting head to right turning head to left turning head to right bending forward at waist bending backward at waist tilting left at waist tilting right at waist twisting left at waist twisting right at waist sitting standing getting up from sitting position lifting any movement driving walking running nothing other: _____
- What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication muscle relaxers nothing
  Other: _____
- Describe the quality of the symptom (select all that apply):
  Sharp dull achy burning throbbing piercing stabbing deep nagging shooting stinging
  Other: _____
- Does the symptom radiate to another part of your body (select one): YES NO
  If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (select one)
  Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (select all that apply):
  Bending neck forward bending neck backward tilting head to left tilting head to right turning head to left turning head to right bending forward at waist bending backward at waist tilting left at waist tilting right at waist twisting left at waist twisting right at waist sitting standing getting up from sitting position lifting any movement driving walking running nothing other: _____
- What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication muscle relaxers nothing
  Other: _____
- Describe the quality of the symptom (select all that apply):
  Sharp dull achy burning throbbing piercing stabbing deep nagging shooting stinging
  Other: _____
- Does the symptom radiate to another part of your body (select one): YES NO
  If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (select one)
  Morning Afternoon Evening Night Unaffected by time of day

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Is there anything else in your past medical history that you feel is important to your care here?

_____

_____

Clinic and Patient Policies (initial next to each)

____ **Insurance Policy and First Visit Fees**

For patients with health insurance we will happily submit for reimbursement on your behalf. However, the patient will be responsible for any co-pays, deductibles, or uncovered services by your insurance carrier. Any quoted benefits by your insurance are **NOT** a guarantee for reimbursement and may leave the patient responsible for out of pocket expense. The actual coverage and patient responsibility can only be determined by the Explanation of Benefits statement received from your insurance company after billing, which may take several weeks.

There will be a charge for your first visit which includes exam, doctor consultation, treatment, and any X-rays the doctor deems necessary. If you have insurance, some of this initial fee may be covered. Should you pay the full amount and your insurance reimburses us for the service we will credit the remaining amount to your account.

____ **Medicare and Supplemental Insurance**

We do accept Medicare. However, Medicare will only reimburse for medically necessary treatment and does not cover exams, re-exams, x-ray's, or maintenance care. For this reason, it is important to set a treatment plan and follow it according to Medicare guidelines. Many Medicare beneficiaries also have supplemental insurance. These may or may not cover deductibles, co-pays, examinations, or other services. The patient will be responsible for any fees that are not covered by Medicare or their supplemental plan.

____ **Payment**

All payments for appointments are due at the time of service via cash, check, or credit card. This includes insurance co-pays, deductibles, or time of service fees (cash).

____ **Cancellation Policies**

All new patient and report of finding(s) appointments require 24 hours' notice for canceling and/or rescheduling and all regular appointments require one (1) hour notice for canceling and/or rescheduling.

____ **No Show/Missed Appointments**

Patients who do not show for their appointment(s) without contacting Optimum Health & Wellness prior to their scheduled appointment(s) may be charged a "No Show" fee of $60.00. Patients on treatment plans who do not show for their appointment(s) without properly notifying the clinic will be adhered to the following:

1st No Show:	Forgiven
2nd No Show:	One (1) appointment/treatment will be counted towards plan
3rd No Show:	Treatment plan will be terminated, and patient will be charged regular rate(s) for all previous appointments and forfeit any discounts previously given in the plan

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Optimum Health & Wellness to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Jeff Engel, DC / Optimum Health and Wellness for services performed.

_____

Patient or Guardian Signature Date

INTENTIONALLY LEFT BLANK

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Informed Consent

Patient Name (please print full name): _____

The nature of the chiropractic adjustment.
The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment
Please indicate below any procedures you ***do not*** consent to as part of the analysis, examination, and treatment:

____spinal manipulative therapy
____range of motion testing
____muscle strength testing
____ultrasound
____electric muscle stimulation
____palpation
____orthopedic testing
____postural analysis testing
____hot/cold therapy
____vital signs
____basic neurological
____radiographic studies
____other (please explain) _____
_____

The material risks inherent in chiropractic adjustment
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

The availability and nature of other treatment options.
Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

OVER →

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The probability of those risks occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and/or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and effective the longer it is postponed.

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.

X-Ray Release*:
This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

*Pregnant women: X-rays can be hazardous to an unborn child. Please inform clinic staff if you are or think you could be pregnant.

Date of last menstrual cycle: _____

I have read { } or have had read to me { } the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Jeff Engel and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Patient's Signature

_____
Signature of Parent of Guardian (if a minor)

Dated: _____

_____
Doctor's Name

_____
Doctor's Signature

Optimum Health and Wellness, PLLC. **Jeff Engel, D.C.**

Patient Name: _____ **Date: _____**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

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

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician 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 situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. 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 with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

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