Welcome to Francis Chiropractic Center !

2593 HWY 2 East, Suite #5 Kalispell, Montana 59901 Phone– 406-756-6868 Fax– 406-756-6870
Dr. John Francis Sr and Dr. John Francis Jr Website– spinaldocs.com e-mail– info@spinaldocs.com

Name: _____ **Date**: _____

E-MAIL is necessary to Communicate Health Information to you:_____

Address / City / State / Zip_____

Home Phone: ( ) _____ **Work** Phone: ( ) _____ **Cell** Phone: ( ) _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex: Male Female

Occupation: _____ Employer's Name: _____

Marital Status: Married Single Spouse's Name: _____ # of Children: _____

MODE OF PAYMENT: CASH INSURANCE CAR ACCIDENT WORK INJURY

Please let us know how you were referred to Dr. John Francis Sr or Dr. John Francis Jr?
Family (Name): _____ Friend (Name): _____
Promotion Other (please describe)_____

MAIN COMPLAINT

What is the **reason for this visit**?

When did this begin and was it **instant or gradual**?

If this was an accident, was it: **Work** **Car Accident** **Other:**
Describe what happened:

Have you had this before? **Yes / No**

How often are you having it? **Constantly** **Daily** **Weekly** **Monthly**

What makes this **feel worse?**

What makes this **feel better?**

What is your pain **today** (Please circle)
NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **EXCRUTIATING PAIN**

Do you have OTHER physical complaints?

HEADACHES? Daily Weekly Monthly **Explain**

NECK PAIN? Explain

BACK PAIN? Explain:

ARM/LEG PAIN? Explain:

ANY NUMBNESS, TINGLING OR WEAKNESS? Explain:

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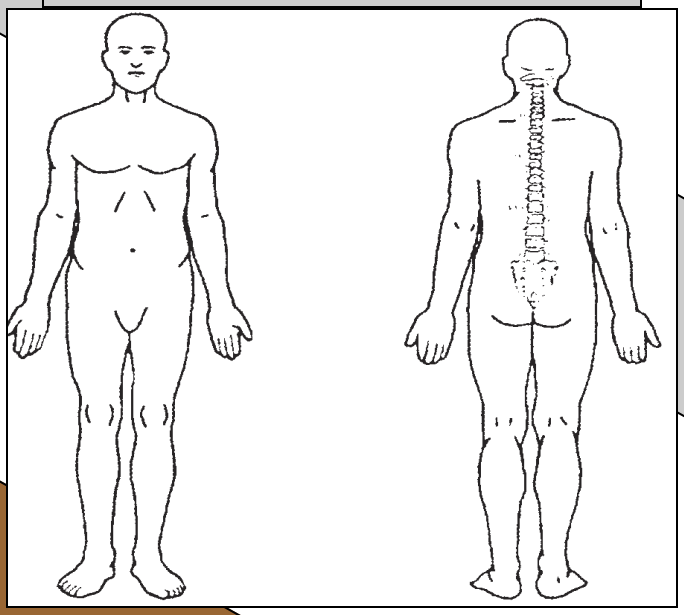
Mark each area of concern



Notes:_____

PAST HEALTH HISTORY

If female, are you pregnant? **Yes No** If **No**, what is the last date of your menstrual cycle: / /

List all **medications** you are taking, include **birth control**, over the counter medications and vitamins.

Have you had broken bones, surgeries or hospitalizations? Yes / No Please list them and give dates:

Have you had an X-ray, MRI, CT scan or other imaging? Yes / No When:

Have you seen an **M.D**. or **Chiropractor** recently? Yes / No Name(s):_____

Do you have a Family Doctor? Yes / No Name(s):_____Phone:_____
May we update this Doctor on your condition? Yes, please do No thank you

PLEASE MARK ANY CONDITIONS YOU HAVE OR HAD

Anemia Chest Pain Depression Diabetes Dizziness Heart Disease High Blood Pressure
Irregular Heart Beat Shortness of Breath Cancer Others:

Do you have, or have you ever had, any diseases or medical problems not listed? If yes, Explain:

Have you **ever** had a: Motor Vehicle Injury Sports Injury Work Injury Slip and Fall Injury
If yes, please give date(s) and explain:

Is there any more information you would like the doctor to know about before beginning care?

Name:_____ **Date:**_____

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Financial Policies

1)We accept the following forms of payment: Cash, Personal Checks, Debit Cards, and Visa, MasterCard and discover.

2) Payment is expected at the time of service.

3) We will bill your insurance company as a **courtesy** to you, but please be advised that the patient is always responsible for the payment of their care. An insurance contract is between the Insurance Company and the Patient.

4) Your insurance company determines benefits when they receive our bills. Any statements or verification made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company. You will be responsible for your account regardless of your insurance policy. All deductible payments must be made prior to insurance submittal.

5) Insurance coverage is **NEVER** guaranteed! If there are any problems between the insurance company and the patient, the patient may file a grievance directly with their insurance company. This office will provide treatment records to your insurance company as needed in order to process your claims.

6) Our Financial Manager will provide you with a payment plan that will fit your needs.

7) Any Pre-Paid visits/Discounted Payment Plans will be charged the full amount for the visits used and refunded the remaining balance if care is discontinued.

8) In the event that no payment activity has been made on the patients account within 120 days, the account will be placed with an outside collection agency. The patient will be responsible for any collection fees, costs, and interest and/or attorney's fees applied to unpaid balance.

9) Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service, as well as care.

By Signing below, I acknowledge that I understand the policies herein

Patient Signature: _____ Date: _____

Financial Policies

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406-756-6868

Please read and initial next to the policy that applies to you. If you have any questions please don't hesitate to ask!

_____ **Insurance:** We will bill your insurance as a courtesy for you. We will verify your Chiropractic benefits prior to receiving care, however insurance companies will never allow a quote of coverage to be a guarantee of payment. **We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance or unmet deductible you will be responsible for payment at time of service. We do offer services that may not be covered by your insurance and you will be responsible for the balance.** Please note that some patient's policies are written to where they may have a deductible for certain services, and or a copay for certain services. Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits.

_____ **Medicare Part B/Medicare Managed Care/ Railroad Medicare: Medicare plans cover manipulation of the spine ONLY.** All other services are not covered and will be the responsibility of the patient. Medicare Part B and Railroad Medicare patients have an annual deductible which must be satisfied before benefits are payable. In some cases, a patient's Medicare supplemental insurance policy would cover this, as well as any co-payments which may be due. If there is no supplemental policy, the patient will be responsible for any deductible or copays. Once again, these plans cover spinal adjustments only, and any other services performed in the office are payable by the patient.

_____ **Auto Accident/Personal Injury/Workman's Compensation:** Most Personal Injury and Workman's Compensation claims are covered 100%. However it is **YOUR** responsibility to provide our office with the documentation necessary to prove a valid claim, as well as the name(s) of any claims adjuster/attorney, etc. handling the case, claim number and mailing address to send bills. Failing to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt.

_____ **CASH:** Payment is due at the time of service.

Francis Chiropractic Center

Patient Privacy Notice

1) **Objective:** To provide a control for the maintenance and release of patient health information.

2)**Policy:** The health record is the property of Francis Chiropractic and shall be maintained to serve the patient, the health care provider in accordance with legal, accrediting and regulatory agency requirements. The information contained in the health record belongs to the patient, and the patient is entitled to the protected right of his/her information. All patient care information will be regarded as confidential and available only to authorized users.

3) **Data Collection:** All individuals engaged in the collection, handling or disclosure of the patient health information shall be specifically informed of their responsibility to protect patient data and of the penalty for violation of this trust.

4) **Storage:** All primary health records kept on paper shall be housed in physically secure areas. All computerized data records are to be accorded the same high level of confidentiality given to manually kept records and all policies herein stated apply to both. Primary health records (from this office) and secondary health records (from another office) shall be retained according to legal, accrediting and regulatory agency requirement. Original health records may not be removed from the premises, except under a court order, request of the physician, or to be stored in an outside storage unit. Access to areas housing health information records shall be controlled by the office manager with the exception of the physician. Health care records shall not be left unattended in areas accessible to unauthorized individuals.

5) **Access:** All requests for health records shall be directed to the office manager/records custodian. Authorization for access to patient information is based on the need to know in order to provide health care and related services required by the patient. All employees shall maintain patient information in the strictest confidence, sharing it only with others who have a need to know in order to provide services to the patient. Release of information from the health record shall be carried out in accordance with all applicable legal, accrediting and regulatory agency requirements, and in accordance with written institutional policy. All information contained in the health record is confidential and the release of information will be closely controlled. Medical records shall be released when:

A) It is required by law
B) For release to another health care provider currently involved in the care of the patient
C) For medical evaluation

Patient Signature:
_____Date:_____

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Office Policies

1) Please be on time for your appointment. Being late, or last minute cancellations will cause severe disruptions, which can interfere with the quality of care you and other patients receive.
2) Continued cancellations or missed appointments may result in being released from our care.
3) Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times.
4) We may schedule you for multiple appointments. This will help insure convenient appointment times for you, as well as provide you with the highest level of care possible.
5) If you need to spend extra time discussing your health concerns with your doctor, please let our staff know, so we may schedule your next appointment accordingly.
6) Please notify the front desk of any changes in your health status, so your appointment can be scheduled accordingly.
7) Please notify the front desk of any changes in address, phone number or insurance status.
8) Parking is available in front of the building as well as on the side.
9) Please be considerate of other patient's privacy! If someone is being helped at the front desk, please step back from the counter until the patient before you is finished.
10) Please be courteous to other patient's with regard to cell phone use. We ask that you place your phone on silent or vibrate during your treatment time.

By signing below, I acknowledge that I understand the policies herein

Patient Signature _____ Date:_____

Francis Chiropractic Center
Laser Consent Form

Date:_____

Patient Name:_____

Infrared Laser Therapy

Laser Therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or significant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy
3. Mild bruising from vasodilation or direct pressure of laser tip
4. Temporary dizziness
5. Reactions when photosensitizing drugs are used with laser therapy

I understand the risks of laser therapy and agree to the treatment program outlined by the doctor.

Patient Signature: _____Date:_____
Employee Signature :_____Date:_____

Website disclaimer

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