Rocky Mountain Pain & Joint Center

109 E. 1600 N. North Logan, UT 84341 | 435.563.6363

Patient Information

Full Name_____

Address_____City_____State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Date of Birth_____Email Address_____

Age_____Circle one Sex: M F Circle one: Married, Single, Divorced, Widowed, Seperated

Spouse Information

Full Name_____

Address_____City_____State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Date of Birth_____Email Address_____

Age_____Circle one Sex: M F Circle one: Married, Single, Divorced, Widowed, Separated

Responsible Party Information

Full Name_____

Address_____City_____State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Date of Birth_____Email Address_____

Age_____Circle one Sex: M F Circle one: Married, Single, Divorced, Widowed, Separated

Employer Information

Full Name_____

Address_____City_____State_____Zip Code_____

Phone_____

Insurance Information

Primary Ins._____ID #_____

Secondary Ins._____ID #_____

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Patient History

Have you had previous chiropractic? Y or N. If so who did you see?_____

Why did you discontinue service with them?_____

List any major medical treatment that you have received in the last year as well as any procedures that pertains to your treatment in our office today. _____

Mark all the apply:

_____Surgery, if so explain?_____

_____Car Accidents, if so explain?_____

_____Job injuries, if so explain?_____

_____Fractures or broken bones, if so explain?_____

_____Falls, if so explain?_____

_____Serious Illness, if so explain_____

Family History:

_____Back Problems

_____Cancer

_____Heart problems

_____Arthritis

_____Diabetes

_____Other, if so explain_____

Present symptoms: (Check all that apply)

_____Headache

_____Back pain/stiffness

_____Fainting

_____Vision problem

_____Head seems heavy

_____Neck pain/stiffness

_____Tingling in arms

_____Tingling in legs

_____Tingling in toes

_____Numbness in arm/hands

_____Numbness in legs/feet

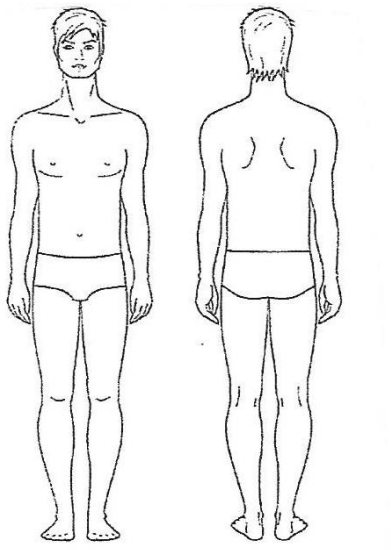
_____Other, explain_____

Recent Date of Injury_____

Describe_____

Patient Name:_____

Mark All Areas of Pain



Patient Signature_____

Date:_____

Current Pain Level

1 2 3 4 5 6 7 8 9 10

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Office Policy & Financial Agreement

We would like to welcome you to our office. We know that chiropractic can and should be an integral part of regaining and maintaining your health and wellness. We believe that a clear definition of our office policy and billing procedures will allow us both to concentrate on the most important issue at hand, which is your health. We are happy to answer any questions you may have regarding our office policies, your account or insurance coverage.

The following financial policies are an attempt to allow you, the patient, to receive that care you need and keep your balance current with the least amount of difficulty.

- We understand that most insurance companies provide chiropractic coverage. We will be happy to call and verify your coverage. However, it is our experience that benefits and limitations vary widely depending on your plan. We will submit and process claims for you. We would like you to understand that the contract you have with your insurance company is between you and them. If there are disputes, or problems with coverage, it is your responsibility to solve the problem with your carrier. Because of our contract with your insurance company, and by federal law, it is your responsibility to pay your annual deductible, required co-payments, and non-covered services; at the time those services are rendered.
- Your co-payment must be paid the day of your visit with Dr. Ferguson
- If you are responsible for paying an annual deductible, we require a minimum payment of $50.00 each visit to go towards your deductible.
- Payment for orthotics, supplements, pillows and other supplies are required at the time of purchase. Special orders must be paid at the time the order is made.
- Patients will be charged a $45.00 fee for all missed appointments unless cancelled 24 hours in advance. An appointment is considered missed if it is more than 15 minutes after your scheduled appointment time. You will not be seen that day and you will need to reschedule your appointment. Insurance companies will not pay for missed appointments; this is the responsibility of the patient.
- Under Utah State Law, if you are injured in an automobile accident, you are covered under the terms of your automobile no-fault insurance for care. This also applies if you are a passenger or pedestrian involved in an accident. If you have been in an automobile related accident, please notify us immediately.
- Any financial arrangements that are made under our hardship agreement will be subject to further policies. Delayed payment, violating your previous agreement, will be subject to interest charges.

Fee Schedule:

Therapies/Treatments	Price	Time of Service Price
New Patient Office Visit	$193	$60
Office Visit (Existing Patient)	$106	$45
1 Hour Massage	$100	$55
30 Minute Massage	$50	$30
Injections (Cost Per Injection)	$100	$50
Ultrasound	$75	$25
Acupuncture	$50	$25
Decompression	$95	These therapies included in the $45 or $60 office visit when paid at time of service
Electrical stimulation	$35	
Mechanical Traction	$50	

I have read and understand the financial agreement in regards to this office's chiropractic charges and policy. In the event that my account should become delinquent or payment arrangements are not fulfilled; I agree to pay all costs of collection including a 50% collection fee, attorney's fee, court costs and interest at the rate 1.5% per month (18% annum)

Printed Name:_____

Signature:_____Date:_____

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Disclosure and Consent for Chiropractic Adjustments and Care, & Use of Health Information

You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedures after knowing the potential risks and hazards involved.

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 the patient named below, for whom I am legally responsible), by Dr. Jace H. Ferguson a licensed doctor of chiropractic. I have had the opportunity to discuss with the doctor, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures or alternatives. I understand and I am informed that with the practice of chiropractic, there are some risks (even though minimal) to exam and treatment, including but not limited to; fractures, disc injuries, strokes, dislocations, sprains, increased symptoms and pain, or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of procedures based upon knowledge which the doctor has at the time and is in my (the patient's) best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we disclose your health information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for diagnosis.
- We may have to disclose your health information and billing records to another party for the collection or payment of services.
- We many need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal information to remind you of your appointments, send you a birthday card, send you a thank you for your referrals, and invite you to participate in patient appreciation days, send you an office newsletter, or send promotional information.
- In our office, there are areas and times when treatment, or rehabilitation, and some ongoing routine details of care are discussed within earshot of other patients and staff. It is our view that the kinds of matters related in an 'open area' environment are incidental matters. In the event you or someone else would not agree with us, a closed room may be furnished.
- We reserve the right to change our privacy practices. If we make a change to our privacy practices, we will notify you in writing when you come for treatment or by mail. Please feel free to call us any time for a copy of our privacy policy.
- We will not provide your health information to any individual, company or organization without your signed consent, except as mentioned above.
- You are entitled to inspect/and or copy your health information at any time upon request for 7 years or for as long as the information remains in our files.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read, or have had read to me, the above consent to care and privacy policy. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan and privacy policy. I intend this consent form to cover the entire course of treatment for my present condition and/or any future condition(s) for which I seek treatment.

Signature:_____Date:_____

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Electronic Health Records Intake Form

To be compliant with the requirements for the government EHR incentive program

In accordance with the affordable care act we are required to collect the following information.

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

Email address: _____ **@** _____

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

DOB: __/__/___ Gender (circle one): Male/ Female **Preferred Language:** _____

Smoking Status (Circle one): Every day / occasional / Former/ Never (less than 100 in a lifetime)

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/Other

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino

Are you currently taking any medications? (Please include regularly used over the counter medications)

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

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature:_____Date:_____

For office use only:
Height:_____ Weight:_____ Blood Pressure: Left Right:_____/_____