Moorhouse Chiropractic
4660 N. Penngrove Way STE 110
Meridian, ID 83646
Phone: (208)938-2992 Fax: (208)938-3476

Patient Name _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Occupation _____ Employer _____

Email Address _____

How did you hear about us? _____

Emergency Contact

☐ Guardian or ☐ Spouse's Name _____

Occupation _____ Phone _____

Health History

What is your reason for seeking chiropractic care? _____

_____

Describe any health problems, including how long you've had them. _____

_____

Are you under the care of a Primary Care Physician? Yes ____ No _____

If Yes, state the conditions you are being treated for

_____

List any current medications _____

List any past surgeries & dates _____

List any past accidents & dates _____

Females Is there a possibility of you being pregnant? Yes _____ No _____

Health Insurance

If you are paying out of pocket, skip this section.

Insured's Name _____ Employer_____

Policy Holder DOB:_____ Relationship to Policy Holder_____

Insurance Company _____

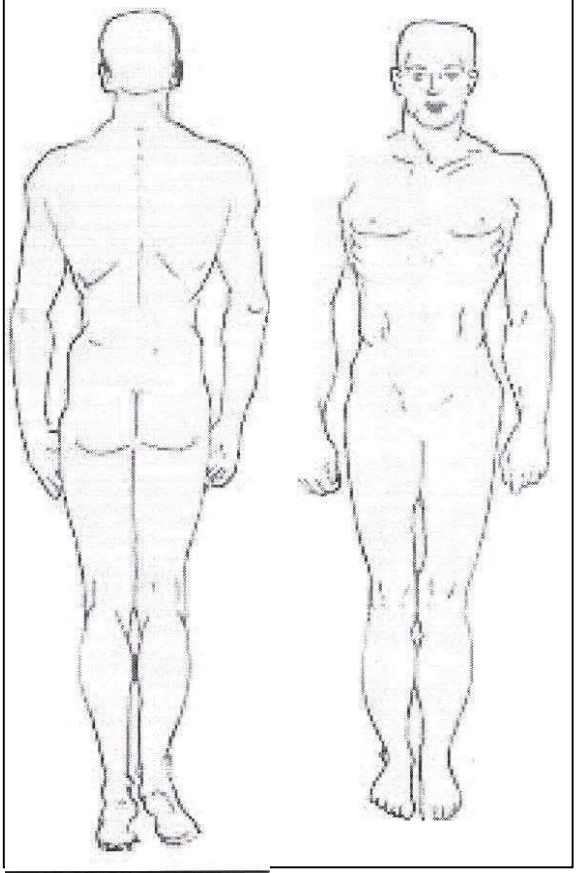
Insured ID Number: _____ Group Number: _____

Please Fill in Below

If you have had the following, or if you suffer From the following, *Please Check*

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	0	0
Migraines	0	0
Neck Pain	0	0
Shoulder Pain	0	0
Arm/Hand Pain	0	0
Mid Back Pain	0	0
Low Back Pain	0	0
Hip Pain	0	0
Leg/Foot Pain	0	0
Disc Problems	0	0
Arthritis	0	0
Other joint pain	0	0
Numbness	0	0
Joint Swelling	0	0
Dizziness	0	0
Nausea	0	0
Weakness	0	0
Fatigue	0	0
Nervousness	0	0
Insomnia	0	0
Heart Problems	0	0
Frequent colds	0	0
Nose Bleeds	0	0
Ringing in Ears	0	0
Earaches	0	0
Hearing Loss	0	0
Cough	0	0
Chest pains	0	0
Menstrual problems	0	0
Allergies	0	0
Asthma	0	0
Cancer	0	0
Osteoporosis	0	0
Diabetes	0	0
Hypoglycemia	0	0
Digestive problem	0	0
Urinary Problems	0	0

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. X-rays may be taken to evaluate your condition. The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used. Exercises may be recommended.

Benefits of chiropractic treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series a chiropractic adjustments.

Possible Risks: As with any health care procedure, complications are possible following chiropractic treatment. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord . A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. X-rays produce ionizing radiation. There are reported cases of stroke associated with visits to medical doctors and chiropractors. The best quality scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, it indicates that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pain when they are in the early stages of a stroke. The possibility of such injuries occurring in association with chiropractic treatment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare".

Other treatment options which could be considered may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to the stomach, liver, and kidneys, increased cardiovascular risk, and other side effects in a significant number of cases.
2. *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these prescription drugs include all side effects as above, plus patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds additional risk of exposure to medical error, infection and other complications in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

--------- patient initials

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. This informed consent will remain in effect unless there are significant changes in my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

_____	_____	_____
Printed Name	Signature	Date

Financial Policy

Thank you for choosing Moorhouse Chiropractic as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

All payments are due at the time of service. We accept Cash, Check, Visa, MasterCard, Discover and American Express. ***__**Credit Cards incur an additional fee of 3%.**__***

We accept assignment of insurance benefits from your insurance carrier. However, it is the patient's responsibility to ensure that the insurance carrier meets their obligations. The contract is between you and your insurance carrier. We are not a party to that contract. All insurance must be pre-approved by Moorhouse Chiropractic credit department. If your insurance has not paid the bill within 45 days, you will be asked to make a payment on the account to stay in good standing with Moorhouse Chiropractic. We encourage you to contact your insurance company for any discrepancies.

If we are a participating provider, all co-pays and deductibles are due the day of treatment. Verification of insurance must be completed prior to the first visit.

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

CPT Billing Code	Description	Price
99202	Limited Visit	$70.00
98940	1-2 Area Adjust	$50.00
98941	3-4 Area Adjust	$60.00
98943	Extraspinal 1+	$30.00
97014	Muscle Stim-unattended	$25.00
97124	Massage	$35.00/unit
97140	Massage- Manual Therapy	$35.00/unit
97530	Massage-Dynamic Stretching	$38.00/unit
97012	Intersegmental Traction	$25.00
S8990	Wellness Visit- Intro Fee, Cash Pay	$50.00
S8990	Wellness Visit- Cash Pay	$40.00
S8990	Wellness Visit- Cash Pay Medicare age patients (65+)	$30.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and copayments related to my care. I understand that if I have a balance for medical services not paid, after 45 days I will make monthly auto debit payments of 20% of my outstanding balance. If my balance is not paid in a timely monthly fashion, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charge a $25.00 service charge.

I further understand that if my insurance company declines payment, I authorize Dr. Moorhouse to file small claims on my behalf against my insurance company as a method of collection. I also understand that I will be present that the court date if needed.

I have read and fully understand the above financial terms and prices.

Signed _____ **Print** _____ **Date** _____

Moorhouse Chiropractic

Acknowledgement of Receipt of Notice of Privacy Practices

On February, 1, 2005, Moorhouse Chiropractic joined every health care provider in the country in initiating implementation of the Federal *Health Insurance Portability and Accountability Act of 1996*- known as **HIPAA**.

Our practice has always respected the privacy of those who come to us seeking care and healing. While HIPAA may be mandatory, it really is an extension of something we have been doing throughout our entire history. We continually make efforts to "*Respect Privacy."*

In order to make sure that our patients are aware of their rights under HIPAA and how the practice may use and disclose their protected health information, we are making a concerted effort to make sure that each of our patients receives a copy of our Notice of Privacy Practices.

To help us keep track of who has and not received a copy of our Notice of Privacy Practices, please take a moment to complete the information below.

☐ I have received a copy of the practices Notice of Privacy Practices.

☐ I respectfully decline the receipt of a copy of the practice's Notice of Privacy Practices.

_____ _____

Patient Name Legibly Written (First, Middle Initial, Last) Date of Birth

_____ _____

Patient or Guardian Signature Date