

Patient's <u>LEGAL</u> Nam	e	aka/Nicknam	e	Date
Date of Birth	Soc. Sec. #	Male	Female _	Marital Status
Cell Phone:		Home Phone:		***************************************
		edical information at the co		
(mark one) Yes		*If "No", to remain HIPAA Co	ompliant, we	will be required to leave a vaque eccive any medical information.
Email Address:		(used for	appointment	reminders and Patient Passport Syst
Residence Address (p	hysical address)		••	The second of the second of the system of the system of the second of th
City		State	Zip C	ode
		State		
If patient is a minor, p	arent/guardian's nam	ne		
		Work Phone Numb		
		State		
Address (if different fr	om above)			
City		State	Zip C	Code
In Case of Emergency,	Whom Should We No	otify?	•	
		Relatio		
		Alternate Pho		
How did you learn of o				
Doctor Referral (w	hich physician?)			
		imply Family / T.V. / Rimrocl		
Other (please desc	ribe)		_	
		t the time of service as we d		
		ot cash, check and all major		-
Yellowstone Naturopa However, if your circur	thic Clinic will verify t nstances change, it is	this contact information wh syour responsibility to give	enever you us your new	come in for an appointment. contact information.
Signature			Date	
Rev. 11/2019				



The term 'health care provider(s)' in this form means Yellowstone Naturopathic Clinic, Oasis Health Spa, their physicians, employees and members of the medical staff who provide care to patients.

CONSENT TO TREAT

I give permission to all health care providers involved in my care to administer such examination, treatment, testing and procedures as they deem necessary in the course of my care.

RELEASE OF INFORMATION

I understand that as part of my health care, health care providers create and maintain health records that may include my health history, symptoms, examination and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as a basis for planning my treatment and care and is a tool for routine health care operations including assessing quality and reviewing competency of our staff and/or other health care providers.

FINANCIAL RESPONSIBILITY

I agree to pay all charges for my health care treatment. If charges to my account are not paid after reasonable notice, the account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

Print Patient Name: DOB:
You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.
If you have any objections to this form, please ask to speak with our HIPAA Compliant Officer. You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.
Patient's Representative(s): (the following must be filled out, even if the answer is none) This person is a family member or friend who may call our office on your behalf. Unless their name is listed below, we will not be able to speak with them about your medical concerns.
* I hereby authorize the following individuals to have access to my healthcare information
, Relationship to Patient
, Relationship to Patient
, Relationship to Patient
Рнотодгарн
I authorize YNC to take a photograph of me for my file. A photo helps us improve medical care. Photos prevent identification errors and (in conjunction with written records) prompt our physicians in recalling your needs, concerns and medical issues. This image will not be shared outside of Yellowstone Naturopathic Clinic. The confidentiality of this image will be maintained in accordance with the productions.
HIPPA regulations. TERM
This consent will be in effect for one year from the date signed.
Printed Name of Patient Date
Signature of Patient or Responsible Party
Responsible Party's Relationship to Patient
Witness Date
** If you would like a copy of this form, once signed, please ask the receptionist **

Patient Compliance Assurance Notification

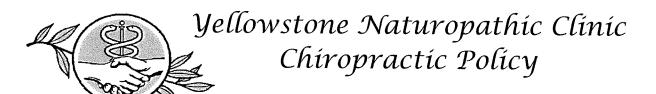
To our valued families and patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you, for being one of our highly valued patients!



Clinical Pain Picture

Patient's Name:		DOB:		
Mark the area on the diagram w Use the appropriate symbols an	which corresponds with the p d include all affected areas.			
			Pai Nu	the following symbols: n
What problem is your primary co	ncern?			
Please describe your pain (achy, r	numb, sharp, etc)			
How severe is your pain? (Mark to	he line below with an X)			
No Pain			~~~~~	Max Pain
How often do you experience this				
Do you have any additional comp				
Signature:			Date:_	



720 North 30th Street Billings, MT 59101 (406) 259-5096 Phone (406) 545-0044 Fax

Print Patient Name:	DOB:	(406) 545-0044 Fax
Appointments: Your appointment time has been reserved for you. If you can so that we may give this time to another patient. Failure to result in a charge to your account. Your first visit will be soly you in depth about your health concerns, pertinent past physicians may be requested at this time. Your doctor may visit.	provide us with 24 hours notice of appointment heduled for 60 minutes. During this time your d medical history, etc. Medical records of prev	nt cancellation will loctor will talk with rious care by other
Fees, Insurance and Accounts Receivable: Fees for initial visits with the Chiropractor are charged at a rextended and range from \$50.00* to \$275.00* per visit. We extended and range from \$50.00* per visit. P	xpect payment at the time of visit unless prior a nic accepts VISA, Discover, MasterCard and Ar receipt that includes all the appropriate proced laim. If you need old invoices reprinted after anies do cover chiropractic services. We are N tarantee that your insurance plan will cover	arrangements have merican Express. If lure and diagnostic the date of service, OT an in-network these charges. We
Phone Consultations and Questions: Please feel free to discuss with us any questions you may h understand your treatment program. If you have any questi staff. The staff will relay your questions promptly to your dable to answer your questions directly or immediately. Eit possible. Should you have a number of questions regard appointment so that we may properly meet your needs.	ions please address them with the Yellowstone Noctor. The Chiropractor maintains a full scheduther the doctor or a staff member will get back	Naturopathic Clinic ule and may not be to you as soon as
Emergencies: One of our doctors is on-call 24 hours a day. Calls to automatically transferred to our answering service, who we medical emergencies, please call 911.	the Clinic at 406-259-5096, outside regular by vill then contact the doctor and your call will	usiness hours, are be returned. For
Acknowledgements: We hope that you will find your visit with us pleasant, as well	ll as beneficial. Our goal is to help you in buildi	ng better health.
**Signing this form acknowledges that you understand and *Fees subject to change.	accept the policies of the Yellowstone Naturop	pathic Clinic.*

_Date: _

Signed_



Informed Consent for Dry Needling

What is Dry Needling? Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger (painful knots in muscles), tendons, ligaments or around nerves in order to stimulate a healing response in prusculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicine; that is, it does not have the purp altering the flow of energy ("Qi") along traditional Chinese meridians for treatment of disease. In fact, dry needlin modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shiplints, plantar fascilow back pain. Dry needling is a valuable and effective treatment for musculoskeletal pain. Like any treatment, their possible complications. While complications are rare in occurrence, they must be considered prior to giving consenteratment. Risks: Drowsiness, tiredness, or dizziness occurs after treatment in a small number of patients (1-3%) and if affected are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is consist normal. Temporary pain during needling occurs in 60-70% of treatments. Existing symptoms can get worse treatment in less than 3%; however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (particularly at the first treatment session when needling head or neck regions. The most serious risk with yn needling informed well in advance, if this were to occur, it may likely require a chest x-ray and no further treatment. The sym of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization an inflation of the lung. Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure well as the possibility of side effects. Multiple treatment sessions may be beneficial, thus this consent fivil coverteatment as well as consocutive treatments by this facili			DOB:
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well as the possibility of side effects. Multiple treatment sessions may be beneficial, thus this consent will cover treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form understand that I should not sign this form until all items, including my questions, have been explained or answered to satisfaction. With my signature, I hereby consent to the performance of this procedure. You have the right to either consent or refuse a proposed treatment at any time prior to its performance. You may reyour consent at any time during the treatment at which point the treatment will be terminated. Alternatives to this therapy can include physical therapy, exercises, manipulation, drug therapy, other types of inject and taking no action. Please answer the following questions: Are you pregnant? Yes-or-No Are you immunocompromised? Yes-or-No Are you taking blood thinners? Yes-or-You read and understand the information provided on this form and agree to the above. You received all the information and explanation you desire concerning the procedure. Print Name Signature Signature	normal. Temporary treatment in less the particularly at the first accidental puncture informed well in adversion of shortness of breathers.	pain during needling occurs in 60-7 an 3%; however, this is not necessarist treatment session when needling her of lung (pneumothorax) in .01%. This pance, If this were to occur, it may likely	of treatments in 15-20% of treatments and is consider 0% of treatments. Existing symptoms can get worse at ly a "bad" sign. Fainting can occur in certain patients (.39 ad or neck regions. The most serious risk with dry needling is only a concern with needling in specific areas. You will
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Please answer the following questions: Are you pregnant? Yes -or- No	Alternatives to this th		
Are you pregnant? Yes -or- No Are you immunocompromised? Yes -or- No Are you taking blood thinners? Yes -or or your signature below means: 1. You read and understand the information provided on this form and agree to the above. 2. You received all the information and explanation you desire concerning the procedure. 3. You authorize and consent to the performance of the procedure. Print Name Signature	_	following questions:	
 You read and understand the information provided on this form and agree to the above. You received all the information and explanation you desire concerning the procedure. You authorize and consent to the performance of the procedure. Patient/Representative: Print Name Signature			ad? Vos er No. Amana Ala
Patient/Representative:Print Name Signature	our signature below 1. You read and 2. You received	means: understand the information provided or all the information and explanation you	n this form and agree to the above.
			procedure.
		Print Name	Signature
		* *************************************	-
	Patient/Representativ		licate relationship:
	Patient/Representative Pate:	If signed by a representative, inc	licate relationship:lure indicated above and its attendant risks and thereof, and has consented to its performance.

Treating Physician Signature: _____ Date: ____

Rev. 10/19