Boones Ferry Chiropractic and Massage, PC
OPTIMUM HEALTH THROUGH ALTERNATIVE CARE
30789 SW Boones Ferry Rd., Suite P ï Wilsonville, OR 97070
503-682-6778 ï fax 503-682-6744

Confidential Client Information

Name: _____ DOB _____ SS# _____

Address:_____

City:_____ State: _____ Zip: _____

Phone: Home _____ Cell _____

E-mail: _____

Would you like appointment reminders by: text _____ or voice mail _____ (home or cell)

Occupation _____ Employer _____

In case Of Emergency_____ Phone _____

Whom may we thank for referring you to us?_____

Insurance Information: Please supply front desk with your insurance information. Please list the primary insurance subscriberôs name _____ and date of birth _____

Is todayôs visit due to auto injury? _____ Work related injury? _____

Date of injury: _____ or Date symptoms began: _____

Symptoms: _____

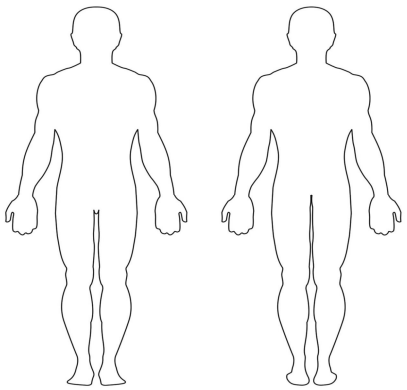
_____

_____

_____

_____

[Please mark symptom area(s)]



Have you had a massage before? _____

How long ago? _____

How much water have you had today? _____

Are you allergic to lotions, oils or scents? _____ If yes, what kinds? _____

Past Health History (*please use the back of page for additional information)
Do you have a history of high blood pressure? Yes No

*Have you ever had any serious illness, trauma, accidents, injuries, surgeries or been hospitalized?
If yes, please describe date and illness/injury: _____

_____

_____

Patient Name:_____ DOB: _____ Date: _____

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*What, if any, supplements, prescription, and over the counter medications are you taking?

_____

_____

(Females only) Are you pregnant? ____ If yes, due date:_____

Do you have any allergies (other than listed above)? _____

_____

Please indicate if you have a history or current problem with the following:

Disc Problems	Recent Hospitalization	Dizziness/Fainting
High Blood Pressure	Cancer (current or remission)	Back Pain
Heart Problems	Circulatory Problems	Joint Pain
Diabetes	Varicose Veins	Bruising/Open cuts
Seizures	Headaches/Migraines	Skin Disorders
Kidney Problems	Gastrointestinal Problems	TMJ
Surgery	Hepatitis	HIV

Authorization:

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during this session, or any future sessions, I will immediately inform the practitioner to adjust the pressure to my comfort level. Massage should not be performed under certain medical conditions. I affirm that I have stated all known medical conditions, and answered all questions honestly and correctly.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment(s), even in the case of pre-purchased package plans.

The Health Insurance Portability & Accountability Act of 1996 (ñHIPAAò) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the massage therapist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Boones Ferry Chiropractic and Massage any insurance benefits regarding my visits. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or parent of a minor) Date

Patient Name:_____ DOB: _____ Date: _____

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FINANCIAL POLICIES STATEMENT

Boones Ferry Chiropractic and Massage would like to take this opportunity to familiarize you with our office financial policies.

Please be sure to update front desk personnel with any changes in address, phone numbers, or insurance information so that billing is done correctly and in a timely manner.

Insurance

For those of you with chiropractic or massage benefits on your insurance, we will file your claims for you. Our staff will call and verify your benefits and coverage; however, this is not a guarantee of payment. Your coverage is determined by the individual policy secured and limitations, you will ultimately be responsible for payment of services you receive.

- It is our office policy to collect all money when services are provided. If we over estimate the amount you owe, you will receive a refund or we can keep the credit on file. If you owe more than what we estimate, you will be balance billed.

Initial

- Interest will accrue at 1.5% on any outstanding balance. If you need to set up a payment plan, we require a credit or debit card on file, and outstanding balances to be paid within 90 days.

Initial

Workers Comp / Auto Accident

We will file your claims for you; however, this is not a guarantee of payment or acceptance of your claim. You will ultimately be responsible for payment of services you receive. Time of service discount is not applicable for these services.

Time of Service Discount

For patients without chiropractic or massage insurance, we offer a time of service discount, which requires payment at the time services are rendered. We honor our senior citizen patients (age 65 and over without insurance coverage) with a discount on their chiropractic adjustment.

Canceled Appointments

We request 24 hours advance notification if you are unable to keep your appointment. We reserve the right to charge a $25.00 cancellation fee for a missed chiropractic appointment, $75.00 for a missed one-hour massage appointment, and $55.00 for a missed 30 minute massage appointment. This fee is non-billable to insurance.

Initial

NSF Checks

Checks returned from the bank will incur a $25.00 processing fee.

The above policies are designed to keep our office running as efficiently as possible. Knowing the importance of the relationship with your overall health, our efforts are intended to make your chiropractic and massage experience not only beneficial but also affordable.

_____ _____

Signature **Date**

Patient Name:_____ DOB: _____ Date: _____

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INFORMED CONSENT FOR MASSAGE THERAPY

Massage therapy is considered a low risk and effective method of care. Occasionally, however, complications may arise. Any procedure intended to help may have a certain level of risk. It is the practice of this office to inform our patientsô about any potential risk, as infrequent as it might be. These may include, but are not limited to, soreness, inflammation, soft tissue injury, bruising, dizziness, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications are available upon request.

Massage cupping and Gua Sha are therapeutic decompression techniques used by Licensed Massage Therapists, Acupuncturists and body-workers for the relief of muscular pain, tension and congestion. These techniques are used to draw out congested fluids and toxins to the surface tissue layers, allowing for fresh blood and lymph circulation. Massage cupping uses negative pressure created within a specialized glass or rubber cup that is applied to the affected body part. Gua Sha is similar to cupping in results, using a round edged tool in strokes of varied pressure to specific areas of muscle pain. There is a **possibility of discoloration** that can occur from the release and clearing of stagnation and toxins in the body. The reaction is the cellular debris, pathogenic factors and toxins being drawn to the subcutaneous layers for dissipation by the circulatory system to occur. The discoloration, or sha, will dissipate in as little as a few hours or up to weeks, usually and in relation to after care activities. It is important to stay hydrated and avoid vigorous activities for 24 hours after treatment. Avoid exposure to extreme temperatures including cold, wet, windy or icy conditions, hot showers, saunas, baths and hot tubs for 24 hours after treatment.

I understand that if I choose to experience cupping or Gua Sha therapy during treatment, I understand the potential side effects and the aftercare recommendations.

I have read, understand and will follow all the information stated above and will not hold the practitioner responsible. I also understand that there is no guarantee of complete cure of any condition.

To be completed by patient:

Completed, if necessary, by patient's Parent/Guardian:

Date: _____

_____ _____

Print patients name **Name of Parent/Guardian /relationship**

_____ _____

Signature of patient **Signature of Parent/Guardian**

Patient Name:_____ DOB: _____ Date: _____