Boones Ferry Chiropractic and Massage, PC
Optimum Health Through Alternative Care
30789 SW Boones Ferry Rd., Suite P – Wilsonville, OR 97070 – 503-682-6778 – fax 503-682-6744

Welcome

Patient Information (*Please print*)
Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns; do not hesitate to ask for assistance. We will be happy to help you.

Name_____ SS#_____
First MI Last
Address_____City_____State____ Zip_____

Sex: Female Male Are you: Minor Married Divorced Widowed Single Separated

DOB_____ Age_____ Hm phone# _____ Cell _____

E-mail _____

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

Your employer_____ Occupation _____

Contact person in case of emergency_____ Phone#_____

Whom may we thank for referring you to us?_____

Date of injury _____ Date symptoms began _____

Is this visit today the result of an auto injury? _____ or work related injury? _____

Insurance information
Do you have health insurance? Yes No *(if yes, please present card to front desk so we may place a copy in your file)* If you are not the primary insurance subscriber, please give the subscribers name and date of birth _____
Do you have secondary insurance? Yes No (*if yes, please also give card to front desk for copy*)

Past Health History (*please use the back of page for additional information)
Date of last exam _____
Do you have a history of high blood pressure? Yes No
*Have you ever had any serious illness, surgeries or been hospitalized? If yes, please describe date and illness/ injury_____
*List all serious trauma, accidents, or injuries_____
*What, if any, supplements, prescription, and over the counter medications are you taking?_____
_____
Do you have any allergies?_____
Please list any X-rays with dates when they were taken_____
Have you seen a Chiropractor previously?_____ Who/ When?_____
(Females only)
Are you pregnant?_____ If yes, due date:_____
Do you have any problems with your menstrual cycle?_____
Have you reached menopause?___ Surgical or physiological?_____ Oophorectomy?____
Have you had a Mammogram?_____
Hormone replacement therapy?_____ Contraceptives?_____

Patient Name:_____ DOB:_____ Date:_____

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Family Health History (please use the back of page for additional information)
Are there any serious illnesses, disorders, conditions, or ailments that run in your family?_____
_____

Personal/Social History
Height _____ Weight _____
What is your occupation?_____ Describe your duties_____
What regular exercise do you participate in?_____
What other interests/ hobbies do you enjoy?_____
Do you eat a balanced diet?_____Describe_____
How much water do you drink per day?_____
Do you get enough sleep?_____ If no, is it due to pain?_____ How many hours?_____
Have there been any changes in your bowel or bladder habits?_____
How many alcohol drinks do you consume on average per week?_____ Do you smoke?_____
Have there been any significant stressors in your life lately?_____
How do you handle stress?_____ Has this changed recently?_____

Symptoms
Reason for this visit_____

Health History *(circle any condition you currently have or have had in past)***:**

AIDS/HIV	Cataracts	Hepatitis	Osteoporosis	Suicide Attempt
Alcoholism	Chemical Dependency	Hernia	Pacemaker	Thyroid Problems
Allergy shots	Chicken Pox	Herniated Disc	Parkinsonôs Disease	Tonsillitis
Anemia	Depression	Herpes	Pinched Nerve	Tuberculosis
Anorexia	Diabetes	High Cholesterol	Pneumonia	Tumors, Growths
Appendicitis	Emphysema	Kidney Disease	Polio	Typhoid Fever
Arthritis	Epilepsy	Liver Disease	Prostate Problems	Ulcers
Asthma	Fractures	Measles	Prosthesis	Vaginal Infections
Bleeding Disorders	Glaucoma	Migraine Headaches	Psychiatric Care	Venereal Disease
Breast Lump	Goiter	Miscarriage	Rheumatoid Arthritis	Whooping Cough
Bronchitis	Gonorrhea	Mononucleosis	Rheumatic Fever	Tingling
Bulimia	Gout	Multiple Sclerosis	Scarlet Fever	Numbness
Muscle Weakness	Heart Disease	Mumps	Stroke	Anxiety
Cancer (current or remission)		Headaches	Back/Neck pain	Arm/Leg pain
Blood pressure (high or low)				

Please list anything that is not listed:_____

Authorization
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 chiropractor 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 chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. I understand that my chiropractic 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 benefits on your insurance, we will file your claims for you. You will be charged as we are instructed by your insurance company. 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. Interest won't be charged until 30 days after the first statement has been issued. 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 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 missed chiropractic appointments and $75.00 for missed one-hour massage appointments and $55.00 for missed 30 minute massage appointments. This fee is non-billable to insurance.

NSF Checks _____
Initial
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 between chiropractic health and your overall health, our efforts are intended to make your chiropractic experience not only beneficial but also affordable.

_____ _____
Signature **Date**

Patient Name:_____ DOB:_____ Date:_____

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INFORMED CONSENT FOR CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic Examination

In order to provide appropriate evaluation and treatment recommendations, a doctor will need to obtain a medical history from you and perform an examination. This examination will include palpation, where the doctor uses his hands on your spine, and/or other joints, and the surrounding soft tissue. Palpation allows the doctor to assess joint function and areas of subluxation. Your examination may also include other evaluation techniques such as: assessing your range of motion, orthopedic and neurological testing, imaging studies (like x-rays), obtaining your blood pressure and other relevant vital signs. Some portions of the examination may elicit or aggravate your pain or symptoms. It is important that you communicate all symptoms to the doctor and advise him/her if any portion of the examination causes you pain. All our patients are encouraged to ask questions before, during and after all aspects of the examination and subsequent care.

I _____ (print name), give my consent for examination.

_____ _____
Signature of Patient or Guardian Date

Chiropractic Treatment

Procedure: Chiropractic adjustment or manipulation is a manual procedure where the doctor uses his/her hands ï or an instrument ï to manipulate the joints of the body to restore or enhance joint function and mobility. You may hear an audible ñpopò or ñclickò or feel or sense movement. Chiropractic care may include any of the following depending on your condition: chiropractic adjustments of the spine or other joints, manual muscle work such as massage, traction, ultrasound therapy, electric muscle stimulation (EMS), heat or cold therapy, the use of therapeutic exercise, cold laser light therapy and the use of nutritional counseling and supplementation. Your doctor will discuss with you a proposed treatment plan, which may at times be carried out by other doctors in the clinic or trained staff.

Risks: Chiropractic care, as in the practice of medicine and all healthcare, carries some risk during examination and treatment. Patients may experience temporary muscle soreness, inflammation, dizziness, worsening of symptoms with treatment, therapies or physical examination. Soreness following treatment, like that following exercise, should resolve within 24-48 hours. While the chances of experiencing serious complications are rare, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, burns or skin irritation from heat or other therapies, sprains/strains, disc injuries, dislocations or rib fractures following any manual technique. More serious complications are extremely rare. Vertebral artery dissection is associated with many neck movements, including chiropractic adjustments of the cervical spine. Current research indicates vertebral artery dissection is not caused by, but is associated with, cervical adjustment. According to some authorities, the association between cervical adjustments and vertebral artery dissection is one in a million (1 in 1 million). Vertebral artery dissections can lead to medical complications, including stroke. Additional information on side effects, risks and complications is available upon request. If you have any unusual symptoms following treatment, you should immediately advise your doctor and seek care.

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INFORMED CONSENT FOR CHIROPRACTIC EXAMINATION AND TREATMENT

Patient Participation: In order to provide you with the best recommendations and evaluate contraindications to care, it is critical you provide us with complete and accurate information about your medical history, symptoms, medications and changes in condition or symptoms. In some instances, it is important we coordinate your care with your other providers, and/or refer you to other specialists.

Alternatives: In addition to the alternative therapies offered by this clinic, other treatment options for musculoskeletal conditions may include rest, over-the-counter analgesics, prescription medications, injection therapies, acupuncture, physical therapy and surgery. Each of these actions carry their own sets of risks, some significant, and should be discussed in detail with your other healthcare providers. Remaining untreated may result in the formation of adhesions and reduced mobility, which can complicate future treatment and rehabilitation.

DO NOT SIGN BELOW UNTIL YOU HAVE MET WITH THE DOCTOR

I hereby acknowledge that I have provided complete and accurate information regarding my health history, medication and symptoms and will notify my doctor if there are any changes to same. I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I understand there is no guarantee or warranty for a specific cure or result. I hereby give my full consent to treatment.

Patient Name: _____Guardian Name:_____

_____ _____
Signature of Patient or Guardian Date

PARQ and discussion completed with patient:

Doctor Name: _____ Interpreter if applicable: _____

_____ _____
Signature of Doctor Date

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

A patient, and/or the patientôs legal representative, has the right to:

- Receive complete and current information and answers to questions about diagnosis, treatment and prognosis.
- Participate in decisions about care and provide informed consent for procedures.
- Refuse treatment and accept potential consequences of that decision.
- Receive considerate and respectful care in an environment that permits reasonable privacy.
- Know the identity and professional status of individuals providing service and know who has primary responsibility for coordinating care.
- Have another person present during examination and/or treatment.
- Expect reasonable safety with regard to the health care environment.
- Be fully advised of and accept or refuse to participate in any research project and/or experimental procedures.
- Expect that all communications and records pertaining to care will be subject to appropriate confidentiality.
- Examine and receive an explanation of charges for services rendered.
- Expect not to be denied care solely on the basis of race, gender, national origin, religion or sexual preference.
- Express grievances regarding any perceived violation of rights to the institution and to appropriate regulatory agencies.

Patient Responsibilities

A patient, and/or the patientôs legal representative, has the responsibility to:

- Provide accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, and any other matters related to his/her health.
- Report in a timely manner any new incident, trauma, or changes in health condition.
- Acknowledge and consider instructions and recommendations provided by health care providers and/or office staff.
- Request clarification about any aspect of care not fully comprehended.
- Keep scheduled appointments or give adequate notice of delay or cancellation.
- Assure that the financial obligations related to his/her health care are fulfilled as promptly as possible.
- Treat members of the health care community with respect and courtesy.

_____ _____

Signature Date

Patient Name:_____ DOB:_____ Date:_____

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ACKNOWLDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form represents documentation that Boones Ferry Chiropractic and Massage Notice of Privacy Practices was given to the patient or their personal representative.

By signing this form, you acknowledge receipt of Boones Ferry Chiropractic and Massage Notice of Privacy Practices. The notice provides information about how we may use and disclose your protected health information. You are encouraged to review the notice carefully.

I acknowledge receipt of Boones Ferry Chiropractic and Massage Notice of Privacy Practices.

Signature_____ Date_____
(Patient or personal representative)

If you are signing as a personal representative, please complete the following:

Parent/Guardian/Personal representativeôs name:_____

Relationship to patient:_____

Boones Ferry Chiropractic and Massage Use Only:

☐ Inability to obtain acknowledgement

To be completed only if a signature is not obtained. Describe the efforts made to obtain the individualôs acknowledgement and the reasons why the acknowledgement was not obtained.

_____

_____

☐ Notice already given
Location:_____ Date:_____

Signature of Boones Ferry Chiropractic and Massage representative:

_____ Date:_____

Patient Name:_____ DOB:_____ Date:_____