

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

*List any history of connective tissue disorders, vascular conditions including, but not limited to: fibro-muscular dysplasia, Vascular Ehlers-Danlos Syndrome, Marphans Syndrome, etc.:

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

Do you have any allergies? _____

Please list any X-rays and/or MRI's with dates when they were taken _____

Have you seen a Chiropractor previously? Yes No

Name: _____ When? _____

(Females only)

Are you pregnant? Yes No If yes, due date: _____

Do you have any problems with your menstrual cycle? _____

Have you reached menopause? Yes No Surgical or physiological? _____ Oophorectomy? _____

Have you had a Mammogram? _____

Hormone replacement therapy? Yes No

Oral contraceptives? Yes No (if not currently, in past? Yes No)

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? Yes No If no, is it due to pain? Yes No 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 currently smoke? Yes No Did you smoke in past? Yes No If yes, when did you quit? _____

Have there been any significant stressors in your life lately? _____

How do you handle stress? _____ Has this changed recently? _____

Patient Name: _____ DOB: _____ Date: _____

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Symptoms

Reason for this visit _____

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

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

Cancer (current or remission)

Blood pressure (high or low)

Please list anything that is not listed: _____

Authorization

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") 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: _____

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 require 24 hours advance notification if you are unable to keep your appointment. We reserve the right to charge a cancellation fee for missed chiropractic and massage appointments at the current rate of the reserved time. We do our best to fill the appointment time if we have ample notice to contact one of the patients on our wait list. This fee is non-billable to insurance.

NSF Checks

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

Initial

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: _____

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), and 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 Legal Guardian

Date

Chiropractic Treatment

Procedure: Chiropractic adjustment or manipulation is a manual procedure where the doctor uses his/her hands, or an instrument, to manipulate the joints of the body to restore or enhance joint function and mobility. You may hear an audible “pop” or “click” 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 health care, 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. Cervical artery dissection is associated with many neck movements, including chiropractic adjustments of the cervical spine. Current research indicates cervical artery dissection is not caused by, but is associated with, cervical adjustment. According to some authorities, the association between cervical adjustments and cervical artery dissection is one in a million (1 in 1 million). Cervical artery dissections can lead to serious medical complications, including stroke. Additional information on side effects, risks and complications is available upon request. If you have any unusual symptoms before, during or following treatment, you should immediately advise your doctor(s) and seek appropriate care.

Patient Name: _____ DOB: _____ Date: _____

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. Do not wait to be seen by our office or leave messages regarding urgent medical conditions. If you are experiencing an emergency, it is important that you go to a hospital or call 911. Please tell us as soon as possible if you presented to urgent care or the emergency room.

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.

Questions: Please list below any specific questions you have about this information or the treatment proposed. If none, please write "none": _____

DO NOT SIGN BELOW UNTIL YOU HAVE MET WITH THE DOCTOR

I hereby acknowledge that I have provided complete and accurate information regarding my (or the patient's) 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 (or the patient's) condition and the treatment plan. I understand the nature of the treatment to be provided to me (or the patient). I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I was provided an opportunity to ask questions, which were answered to my satisfaction by the doctor. I understand there is no guarantee or warranty for a specific cure or result. I hereby give my full consent to treatment to be delivered by BFCM providers and their assistants.

Patient Name: _____

Parent/Legal Guardian Name: _____

Signature of Patient or Legal Guardian with Medical Decision-Making Authority Date

Written informed consent has been obtained and documented in the chart. PARQ and discussion completed with patient:

Doctor Name: _____ Interpreter if applicable: _____

Signature of Doctor Date

Patient Name: _____ DOB: _____ Date: _____

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

A patient, and/or the patient's 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 patient's 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: _____

ACKNOWLEDGEMENT OF RECEIPT—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 representative's 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 individual's 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: _____