

Worker's and Health Care Provider's Report for Workers' Compensation Claims

WCD employer no.:	
Policy no.:	

Note to Provider: Ask the worker to complete this form **ONLY** for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.

Worker or provider	Worker's legal name, street address, and mailing address:	Language preference:	Male/female ☐ ☐	Dept. Use Ins. no.	
	Phone:	Claim no. (if known):	Date/time of original injury:	Occ.	
	Employer at time of original injury — name and street address:	Date of birth:	Occupation:	Last date worked:	Nature
	Health insurance company name and phone:	Part			
	Workers' compensation insurer's name, address:	Event			
	Phone:	Source			
				Assoc. object	

Worker: Check reason for filing this form, answer questions (if any), and sign below.

- ☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)
Have you injured the same body part before? ☐ Yes ☐ No If yes, when: _____

☐ **Request for acceptance of a new or omitted medical condition on an existing claim**
Checking this box initiates claim processing decisions that may affect your benefits. If you have questions, consult with your attorney or the Ombuds Office for Oregon Workers at 1-800-927-1271 (toll-free).
Condition: _____

☐ **Notice of change of attending physician or nurse practitioner**
Reason for change: _____

☐ **Report of aggravation of original injury (actual worsening of a compensable condition)**

Check here if you have more than one job. ☐

Describe accident:

By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)

X

Worker's signature Date

Provider: If worker initiated this report, give worker a copy immediately.

If the worker filed this report for:

- **First report of injury or illness** – Send this form to the workers' compensation insurer within 72 hours of visit.
- **New or omitted medical condition** – Attach chart notes that explain how this condition is causally related to the compensable injury. Send this form to the insurer within five days of visit.
- **Change of attending physician or nurse practitioner** – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. Send this form to the insurer within five days after the change or the date of first treatment. Check the following, if applicable: ☐ I request insurer to send its records.
- **Aggravation of original injury** – Sign this form and send it to insurer within five days of visit.

If filing for progress report, closing report, or palliative care request, check the appropriate box below.

- ☐ **Progress report** OR ☐ **Closing report** (See instructions in Bulletin 239.)
- ☐ **Palliative care request** – Complete remainder of form, except Section b. Attach a palliative care plan; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online:
WorkCompCoverage.wcd.oregon.gov
To order supplies of this form, call 503-947-7627.

Provider	Date/time of first treatment:	Last date treated:	Was worker hospitalized as an inpatient? ☐ Yes ☐ No
	a Next appointment date:	Est. length of further treatment:	If yes, name hospital: Current diagnosis per ICD-10-CM codes:
	b Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown		Medically stationary? ☐ Yes (date): ☐ No (anticipated date):
	Work ability status: ☐ Regular work (job at injury) authorized start (date): ☐ Modified work authorized from (date): ☐ No work authorized from (date):		(Attach findings of impairment, if any.) through (date, if known): through (date, if known):
	c Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).		

Provider's name, degree, address, and phone: (print, type, or use stamp)

- Original and one copy to insurer
- Retain copy for your records
- Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner

X

Provider's signature Date

Notice to worker

Claim acceptance or denial

In most instances, you will receive written notice from your employer's insurer of the acceptance or denial of your claim within 60 days. If your employer is self-insured, your employer or the company your employer has hired to process its workers' compensation claims will send the notice to you. If the insurer or self-insured employer denies your claim, it will explain the reason for the denial and your rights.

Medical care

Health care providers must tell you if there are any limits to the medical services they may provide to you under the Oregon workers' compensation system.

If your claim is accepted, the insurer or self-insured employer will pay medical bills due to medical conditions the insurer accepts in writing, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses up to a maximum established rate. You must make a written request for reimbursement and attach copies of receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with some exceptions. Contact the insurer if you have questions about who will pay your medical bills.

Payments for time lost from work

In order for you to receive payments for time lost from work, your health care provider must notify the insurer or self-insured employer of your inability to work. After the original injury, you will not be paid for the first three calendar days you are unable to work unless you are totally disabled for at least 14 consecutive calendar days or you are admitted to a hospital as an inpatient within 14 days of the first onset of total disability.

You will receive a compensation check every two weeks during your recovery period as long as your health care provider verifies your inability to work. These checks will continue until you return to work or it is determined further treatment is not expected to improve your condition. Your time-loss benefits will be two-thirds of your gross weekly wage at the time of injury up to a maximum set by Oregon law.

Authorization to release medical records

By signing this form, you authorize health care providers and other custodians of claim records to release relevant records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

Caution against making false statements

Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment commits a Class A misdemeanor under ORS 656.990(1).

Palliative care

Palliative care is care that makes you feel better, but does not cure you of an unwanted condition. You must be in the workforce, or in a vocational program, to be allowed to have palliative care.

The following are **not** palliative care:

- Prescriptions, prosthetics, braces, and doctors' appointments to monitor them
- Diagnostic services
- Life-preserving treatments
- Curative care to stabilize an acute waxing and waning of symptoms
- Services to a permanently and totally disabled worker

If you have questions about your claim that are not resolved by your employer or insurer, you may contact:

(Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

Workers Compensation Division
(División de Compensación para Trabajadores)
P.O. Box 14480, Salem, OR 97309-0405
Salem: 503-947-7585
Toll-free: 800-452-0288

Ombuds Office for Oregon Workers
(Oficina del Ombuds para Trabajadores de Oregon)
350 Winter Street NE, Salem, OR 97301-3878
Salem: 503-378-3351
Toll-free: 800-927-1271

Boones Ferry Chiropractic and Massage PC

30789 SW Boones Ferry Rd., Suite P – Wilsonville, OR 97070 – 503-682-6778 – fax 503-682-6744

Financial Agreement For Workers' Compensation Claim

Date _____ Patient Name: _____ DOB: _____

Workers' Compensation Insurance Company: _____

Employer: _____ HR Contact: _____

Date of injury: _____ Claim # _____

Adjuster: _____ Phone # _____

Fax #: _____ Adjusters E-Mail: _____

Billing Address: _____

Health Insurance (please provide a copy of card):

Insurance Company: _____

ID # _____ Group # _____

Subscriber(if different than patient) _____ DOB _____

Notes: _____

It is our billing policy, as with Oregon Law, to bill the worker compensation insurance carrier. You are expected to provide our office at the time of your first visit with the above information.

Please inform our office of notification from your insurance company to seek care from an MCO (Managed Care Organization). At the date of the notification you will have seven days to continue care with your provider at this office.

If you retain an attorney, please provide our office with the attorney's name and phone number.

It is important to note that Oregon Law allows you to have care with a Chiropractor for 18 visits or 60 days, whichever comes first. The Chiropractor is allowed to authorize work restrictions for 30 days. It is your responsibility to contact the insurance carrier and complete the proper forms for opening a Workers' Compensation claim prior to your appointment with our office.

As a courtesy we will bill your Workers' Compensation insurance carrier listed above; however, ultimately it is your financial responsibility for all charges incurred at this office.

Patient Signature: _____ Date: _____

Claims Address ☐ Claim # ☐ MCO ☐ Adjuster and # ☐ Fax ☐ E-mail ☐

NECK DISABILITY INDEX (NDI) QUESTIONNAIRE

Patient's Name _____ Date _____

PLEASE READ: Answer each of the 10 sections by marking the **ONE BOX** that most applies to your **NECK PAIN**.

SECTION 1: Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2: Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3: Lifting

- ☐ I can lift heavy weights without extra neck pain.
- ☐ I can lift heavy weights but it gives extra neck pain.
- ☐ Neck pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Neck pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4: Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all because of the pain in my neck.

SECTION 5: Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.

- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7: Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 8: Driving

- QUESTION: Driving**
- ☐ I can drive my car without any neck pain at all.
 - ☐ I can drive my car as long as I want with slight pain in my neck.
 - ☐ I can drive my car as long as I want with moderate pain in my neck.
 - ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
 - ☐ I can hardly drive at all because of severe pain in my neck.
 - ☐ I cannot drive my car at all because of the pain in my neck.

SECTION 9: Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10: Recreation

- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly engage in any recreational activities because of pain in my neck.
- ☐ I cannot engage in any recreational activities at all because of pain in my neck.

How Strong is Your Pain?

Please place an "X" on the line below at the point which you feel represents your pain right now.

No Pain ←————→ Excruciating (the worst possible)

BACK -- REVISED OSWESTRY PAIN QUESTIONNAIRE

Patient's Name _____ Date _____

PLEASE READ: Answer each of the 10 sections by marking the **ONE BOX** that most applies to your **LOW BACK PAIN**.

SECTION 1: Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2: Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes me some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing or dressing without help.

SECTION 3: Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me lifting heavy weights off the floor.
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4: Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than $\frac{1}{2}$ mile without increasing pain.
- ☐ I cannot walk more than $\frac{1}{4}$ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5: Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents sitting more than ½ hour.
- ☐ Pain prevents me sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6: Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7: Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of my pain my normal night's sleep is reduced by less than ¼.
- ☐ Because of my pain my normal night's sleep is reduced by less than ½.
- ☐ Because of my pain my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8: Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of my pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9: Travel

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10: Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

How Strong is Your Pain?

Please place an "X" on the line below at the point which you feel represents your pain right now.

No Pain ←————→ Excruciating (the worst possible)

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. If you have no answer to a question please write "none"*)

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 _____

First MI Last

Address _____ Apt # _____

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 provide card to front desk)*

Subscriber Name _____ **DOB:** _____

Do you have secondary insurance? Yes No (if yes, please also give card to front desk for copy)

Subscriber Name _____ **DOB:** _____

Primary Care Physician _____

Specialist _____

Past Health History (*please use the back of page for additional information)

Date of last physical exam _____

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: _____

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.

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 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: _____

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: _____