PATIENT HEALTH INFORMATION

Dear Patient,
Your answers to these questions will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Date:______________________

PATIENT INFORMATION

Name:____
(First, Middle Initial, Last)

Address: ______________________________________

City: ____________________ State:____ Zip: ________

Home Phone: (_______) ____________________________

Alternate Phone: (_______) _________________________

Email Address:___________________________________

Social Security #: _______________________________

Date of Birth: ______________________ Age: ________

Employer: _____________________________________

Emp. Address: __________________________________

City: __________________ State: ____ Zip:________

Bus. Phone: (________) ___________________________

Occupation: ____________________________________

Marital Status: **M S W D** Children at home:________

Referred by: ___________________________________

SPOUSE INFORMATION

Spouse's Name:__________________________ MI:____

Social Sec. #: ___________________________________

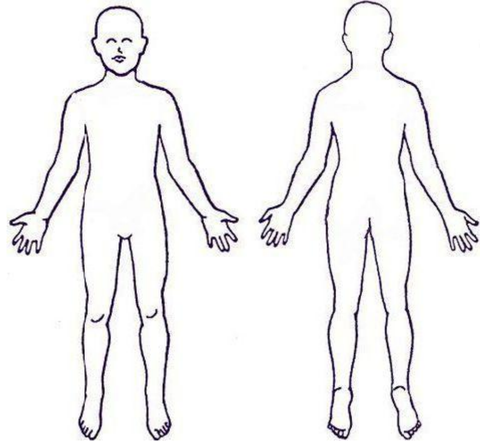
Date of Birth: ___________________________________

Employer: ______________________________________

City: ________________ State: ______ Zip: _________

Bus. Phone: (________) ___________________________

Please mark your areas of pain on the figure below.



GUARANTOR INFORMATION FOR MINOR

Name: ____

Address: _______________________________________

City: ______________________ State: ___ Zip: _______

Home Phone: (_______) ____________________________

Social Sec. #: ____________________________________

Date of Birth: ______________________ Age: ________

Employer: ______________________________________

Emp. Address: ___________________________________

City: ___________________ State: ____ Zip:_________

Bus. Phone: (________) ____________________________

CONSENT TO TREAT A MINOR CHILD: I hereby authorize the Doctor to administer chiropractic care as deemed necessary to:

____
(child's name and relationship to you)

Date: ____________________________

Signature: ____

HEALTH INFORMATION

Have you had previous chiropractic care?______If yes, who did you see, and when?______________________________

What is the reason for your visit today?______________________________

How long have you had these symptoms?______________________________

Have you had this or similar conditions in the past? ☐**Yes** ☐**No** Is this condition getting progressively worse? ☐**Yes** ☐**No**

How would you describe the frequency of your symptoms? ☐ Constant ☐ Comes & Goes

Please list any other health concerns: ______________________________

List the names of your doctors: ______________________________

Do you smoke or use tobacco? ☐**Yes** ☐**No** If yes, what type, how much and how often? ______________________________

Do you drink alcohol? ☐**Yes** ☐**No** If yes, how much and how often?______________________________

Surgical history with dates: ______________________________

____

Current illness (heart disease, lung disease, cancers, high blood pressure, diabetes, etc.).______________________________

____

Current medications, including prescription, over-the-counter, and nutritional supplements). ______________________________

____

____

Allergies: ______________________________

Have you been in an auto accident? ☐ Yes ☐ No If yes, in what year(s)? ______________________________

Please list all other major past injuries (work injuries, falls, etc.), including the years. ______________________________

____

What is your height? _________ Weight? _______ Do you exercise routinely?_________

Would you like information about any of the following?: **foot pain / orthotics** **pillow / bed** **weight loss / fitness**

FAMILY HEALTH HISTORY: Please list **all** health conditions for your close family relatives (parents, siblings, grandparents). Many conditions are hereditary and this information is helpful in providing your care.

NAME	**RELATION**	**HEALTH PROBLEMS**	**DECEASED?**

WOMEN ONLY: X-RAY CONSENT: X-rays can be harmful to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to x-rays.

Date: ______________________________ Signature: ______________________________

Please list the *first* day of your most recent menstrual cycle:______________________________

Ontario Chiropractic

200 SW 2nd Avenue ~Ontario, OR 97914 ~ (541) 889-7797

Acceptance of Terms

Statement of Acknowledgement of Financial Responsibility

_____I understand that I am responsible for any charges incurred at this office, including co-pays, deductibles, and any services denied or not covered by my insurance company. The filing of insurance claims is a courtesy that we extend to our patients; however, all charges are strictly your responsibility. **I agree to be personally and fully responsible for payment of any denied or non-covered charges.**

_____I understand that it is my responsibility to know the coverage for chiropractic care provided by my specific insurance company and plan, including deductibles, co-pays and non-covered services. (Although we are contracted with several insurance companies, it is your responsibility to know the benefits for your specific health plan, including deductibles, co-pays, etc. We will assist you in any way we can to help make this process as smooth as possible, but we do not guarantee insurance coverage.)

_____I authorize the release of my records as necessary for billing purposes.

_____At the time of service, you will be responsible for any fees, co-pays, co-insurance, deductibles and non-authorized or non-covered services. For your convenience, we accept cash, checks, Visa and MasterCard. Special payment arrangements may be made by contacting the office manager. You will receive a monthly statement if there is a balance owed. A 1.5% monthly interest may be applied to all past due accounts that become uncollectible. In the event of nonpayment to Ontario Chiropractic, the balance may become due and payable in full and may be referred to a collection agency or to an attorney for legal action. By signing, you agree to pay for any reasonable court costs, attorney's fees and other applicable costs of collection. Any claim filed for the purpose of collection will be filed under the jurisdiction governing claims for the address of Ontario Chiropractic indicated above.

Auto & Work Related Injuries:

_____ Billing will be submitted to the appropriate insurance provider. In the event that my claim is rejected, I understand that I will be liable for all charges and expenses related to my care. (If your injury claim is rejected, Ontario Chiropractic agrees to bill your personal health insurance provider for compensation.)

Use and Disclosure of Health Care Information:

_____Ontario Chiropractic may collaborate with other providers to coordinate, manage and provide optimal care. This consent may include the release of written records, electronic health records (EHR), x-rays and x-ray reports, diagnoses (including sensitive information, such as HIV or sexually transmitted diseases, substance abuse, mental health information, etc.). I agree that Ontario Chiropractic may use and disclose my health information for a range of purposes such as: treatment, eligibility verification, collection, communications with payors (including your insurance, Workers' Compensation programs, etc.), quality of care assessment (such as internal reviews or insurance reviews, audits, etc.), and public health and health oversight services (when reporting is required by state or federal law).

_____I consent to Ontario Chiropractic's request for health information from other providers of care, whether written, verbal or electronic, for the uses described above.

_____I understand that a copy of the written Privacy Policy for Ontario Chiropractic is available upon request.

Signing below indicates that you have read and understand your obligations for payment for all services provided by the doctors and staff of Ontario Chiropractic.

____

Patient Name (please print)

____

Patient Signature *Date*

INSURANCE INFORMATION

<u>Personal Insurance:</u> *Please note that we do not provide billing to secondary insurance companies. If you have a secondary insurance provider, please ask the receptionist how to collect reimbursement for your care.*

Patient's name:____________________ Policy Holder:____________________

Employer of Policy Holder:____________________ Employer Phone #:____________________

Employer Address:____________________ City:__________ State:______ Zip:________

Insurance Co.:____________________ Ins. Phone #:____________________

Insurance Address:____________________ City:__________ State:______ Zip:________

Ins. ID / Policy #:____________________

<u>Workers Compensation Insurance:</u> Date of Accident / Injury:____________

Patient's name:____________________ Employer:____________________

Work Comp Carrier:____________________ Ins. Phone #:____________________

Insurance Address:____________________ City:__________ State:______ Zip:________

Ins. ID / Policy #:____________________ Claim #:____________________

<u>Auto Injury Insurance:</u>

Patient's Insurance Information

Patient's name:____________________ Policy Holder:____________________

Insurance Co.:____________________ Ins. Phone #:____________________

Insurance Address:____________________ City:__________ State:______ Zip:________

Ins. ID / Policy #:____________________ Claim #:____________________

Date of Accident: ______________ Location of Accident (State): ____________________

Other Party's Insurance Information (if applicable)

Policy Holder:____

Insurance Co.:____________________ Ins. Phone #:____________________

Insurance Address:____________________ City:__________ State:______ Zip:________

Ins. ID / Policy #:____________________ Claim #:____________________

. . . .

I authorize the doctor to furnish my attorney and/or insurance company with any necessary documentation related to my treatments at Ontario Chiropractic relating to the injury listed above.

I hereby give a lien to the my treating doctor at Ontario Chiropractic on any settlement, judgment, or verdict as a result of my injury and authorize and direct you, my attorney / insurance provider, to pay directly to my doctor any sums due him/her for services rendered me, and to withhold such sums from any settlement, judgment, or verdict as necessary to protect my doctor adequately.

____

Patient Signature (or guardian) Date

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Informed Consent for Treatment

Informed Consent / Consent for Care

_____I have been informed of the nature, purpose and scope of care to be provided by the doctors of Ontario Chiropractic, the possible limitations and consequences of that care, and the possibility that the care given by Ontario Chiropractic may not help or resolve my complaint, dysfunction or condition.

_____I consent to care and recommendations made by the doctors of Ontario Chiropractic for myself (or my children, if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, adjunctive therapies (including massage, traction, hot or cold application) and rehabilitation.

_____I understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional associations and/or consensus groups.

_____I understand that my treatment will comply with the standard of care defined by the laws in the state of Oregon.

_____I recognize that all health care procedures, including those used in this clinic, have risks associated with them. Risks, although rare, associated with chiropractic adjusting procedures, may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including cerebrovascular accident (stroke) or death through complicating factors.

I hereby accept the risks associated with any care by the doctors and staff of Ontario Chiropractic and release them of any liability for any injury or loss directly related to care I have received at this clinic. In the event of emergency, I grant the doctors and staff of Ontario Chiropractic permission to provide emergency care and any follow-up necessary, including referral to Emergency Medical Services.

I am signing this consent and acceptance of terms after having been fully informed to my satisfaction of the risks and benefits of proceeding with care. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Ontario Chiropractic.

____

Patient Name (please print)

____

Patient Signature *Date*

Ontario Chiropractic

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Advanced Beneficiary Notice for Medicare Patients

Medicare Limits & Responsibilities

_____Medicare will only accept charges and provide payment for manipulation of the spine. Medicare does not accept billing for x-rays, examinations, or other therapeutic services (including massage, traction, hot / cold therapy) when provided by a doctor of chiropractic. Medicare may, at times, determine that your care is not medically necessary and deny payment altogether. Medicare fees may change annually, please ask the receptionist what the current Medicare fees are.

_____The doctors of Ontario Chiropractic do not accept assignment from Medicare. This means that payment from Medicare for your chiropractic treatments will be sent directly to you and *will not* be sent to Ontario Chiropractic. You are responsible for your entire bill.

_____We do not bill secondary or supplemental insurance. Medicare generally forwards billing to your supplemental insurance. Please let us know if Medicare is not doing this for you and we will try to help you resolve this issue. Your secondary insurance may submit payment directly to us or to you.

_____Ontario Chiropractic will bill all charges to Medicare as required by law.

By signing below, you indicate that you have read and understand your obligations for payment of all services provided by the doctors and staff of Ontario Chiropractic.

I agree to accept responsibility to pay for all covered (chiropractic manipulation), non-covered (including examination, x-rays and therapies such as ice, heat, ultrasound, massage, physical therapy procedures, etc.) and any services that Medicare may deny. I understand that Medicare may deny some or all services. If Medicare denies a claim, I agree to be personally and fully responsible for payment. In addition, I authorize the release of my records as necessary for Medicare billing purposes.

____

Name of Medicare Patient – *please print* **Date**

____

Signature of Medicare Patient