Columbia Gorge Chiropractic

233 E Hist. Columbia River Hwy
Troutdale, OR 97060

(503) 491-9266

Patient Information:

Date _____

Patient Name _____

SS# _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Email _____

Cell _____ Home _____

Sex: ☐ Male ☐ Female Age _____

Are you pregnant? _____ Due: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Divorced ☐ Separated ☐ Partnered

Height: _____ Weight: _____

Number of Children: _____

Spouse Information:

Name _____

SS# _____ Birthdate _____

Phone _____ Work _____

☐ Full Time ☐ Part Time ☐ Homemaker ☐ Unemployed

Occupation _____

Employer/School _____

Employer Address _____

Work Activity: ☐ Sitting ☐ Standing ☐ Heavy Labor

Supervisor Name: _____

Supervisor Phone: _____

How did you hear about us? (Specify)

☐ Current Patient _____

☐ My Doctor _____

☐ The Internet _____

☐ Mailing _____

☐ Other _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Cell _____ Work _____

Insurance Information

Is the patient responsible for this account? ☐ Yes ☐ No

If no, who is responsible for it?

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Relationship to Patient _____

Primary Insurance

Insurance Company _____

ID # _____

Group # _____

Subscriber Name _____

Does the patient have additional insurance?

☐ Yes ☐ No

Secondary Insurance

Insurance Company _____

ID # _____

Group # _____

Subscriber Name _____

Accident Information

Is your visit due to an accident? ☐ Yes ☐ No

(If so, please fill out the rest of this section.)

Date of Accident _____

Type: ☐ Auto ☐ Work ☐ Home ☐ Other

Have you reported your accident? ☐ Yes ☐ No

Insurance Company _____

Claim # _____

Attorney Name _____

Attorney Phone _____

Patient signature: _____ Date: _____

For your first visit, please provide your ID and insurance card (if applicable).

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Patient Name: _____

Pain Questionnaire:

Reason(s) for appointment: _____

What is the main area of complaint? _____

When did your symptoms first appear? _____

How did this occur? _____

Is it getting worse? ☐ Yes ☐ No ☐ Unsure

What time of day is the worst? ☐ Morning ☐ Mid-Day ☐ End of Day

What have you done for this condition? _____

What medications are you taking for the pain? _____ How often? _____

Have you had X-Rays, MRI, or other tests for this condition? What tests, when and where?

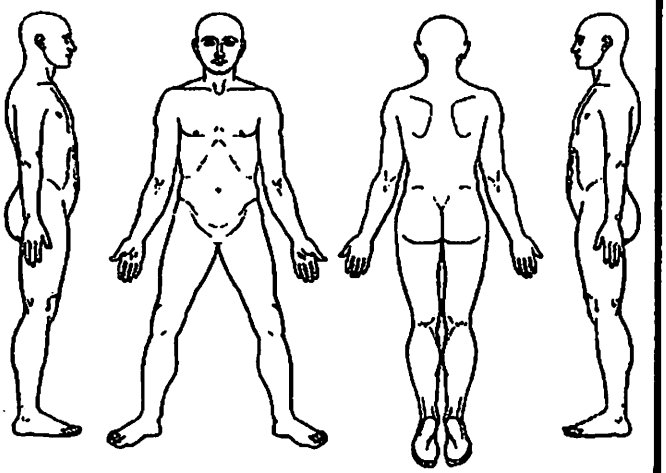
Rate your current pain by circling the corresponding number.

0 = No pain 10 = Pain that would send you to the ER

0 1 2 3 4 5 6 7 8 9 10

Pain level at your best: _____ Worst: _____

Mark on the picture where you have pain, numbness, tingling, etc.



What type of pain is it?

☐ Sharp ☐ Dull ☐ Throb ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling

How often is the pain? _____

Is the pain constant or does it come and go? _____

Does your pain interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Social History: Please check the appropriate box.

Alcohol	Daily	Weekly	Monthly	Never
Diet Food Products				
OTC Stimulants				
Homemade Food				
Soft Drinks				
Water				
Caffeine				
Drugs				
Exercise				
Processed Food				
Tobacco				

Patient signature: _____ Date: _____

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Patient Name: _____

Medical History:

Last Physical Exam: _____ Primary Physician: _____ Physician Phone #: _____

Physician Address: _____

Have you seen any other doctors recently? Explain: _____

Health Conditions: _____

Health History:

Have you had any of the following? Please check the appropriate box.

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ Irregular Menstrual Cycle	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Loss of Memory	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Taste	☐ Loss of Balance
☐ Loss of Smell	☐ Polio	☐ Nosebleeds
☐ Pacemaker	☐ Sciatica	☐ Poor Posture
☐ Prostate Trouble	☐ Sinus Infection	☐ Shortness of Breath
☐ High Blood Pressure	☐ Stroke	☐ Insomnia
☐ Spinal Curvatures	☐ Thyroid Condition	☐ Swelling of Ankles
☐ Swollen Joints	☐ Varicose Veins	☐ Tuberculosis
☐ Ulcers	☐ Sexually Transmitted Disease	☐ HIV/AIDs
☐ Broken Bones	☐ Falls	☐ Head Injuries
☐ Dislocations	☐ Surgeries	☐ Sprain/Strains
☐ Hospitalizations	☐ Loss of Consciousness	☐ Eating Disorder

☐ Family Health History: _____

Medications	Allergies	Vitamins/Herbs/Supplements

Any other concerns or information you would like the doctor to know? _____

Patient signature: _____ Date: _____

For your first visit, please provide your ID and insurance card (if applicable).

Financial Policy

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well. In order to attain the level of achievement we both desire, a care plan must be followed. We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes.

Massage No Show/Missed Appointments: Massage times are reserved especially for you, and if patients do not show up for their appointments, we do not have time to fill the hour with patients who need it. It also takes money from the massage therapist as they are only paid for massage hours. We understand that emergencies come up, so please call our office as soon as possible to notify us and to reschedule your appointments. For all "No Shows" or cancellations with less than 24 hours notice, a $35 missed massage fee will be applied to your account.

In order to file your claims in a timely manner, we need current and accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it does not. Should your our-of-network insurance carrier determine that any or all of our services are ineligible for payment or subject to your deductible, you will be billed directly.

You will receive a statement showing your patient balance if your balance exceeds $5.00. Account balances over 60 days old (after your insurance processes) will be considered "past due". Account balances 90 days old are considered delinquent. Late payment for non-covered services, deductibles, missed massage fees, and co-pays/co-insurances may be subject to a $10 re-billing fee. If it becomes necessary to turn your account over to an outside collection agency or send it to small claims court, a non-negotiable fee of $100 will be added to your account balance. This will ensure that our responsible patients are not penalized to cover costs incurred by those who do not pay on time. If you have any questions about our financial policies, please ask to speak to our billing specialist.

Your health insurance does not pay for everything, even some care that your or your healthcare provider have good reason to think you need. We expect your health insurance will not pay for supplements or any chiropractic care deemed "maintenance" or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services. Signing below signifies that you have received and understand this notice.

I authorize Columbia Gorge Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to Columbia Gorge Chiropractic, of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me based in whole or in part upon the charges made for services received.

I hereby appoint Columbia Gorge Chiropractic the authority to cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Columbia Gorge Chiropractic.

If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs, including helping you make payment arrangements.

Signature:_____ Date:_____

Patient HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosure. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in the treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations, such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Authorization for Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various models of physical therapy, electrostimulation of the muscles, ultrasound, and laser therapy.

I further understand that such chiropractic services may be performed by the physician at Columbia Gorge Chiropractic and/or other licensed staff who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Simons and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based on the facts then known.

I have read, or have had read to me, the above consent, I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intent to consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Date:_____ Print Patient Name:_____

Signature:_____

Full name of spouse, family member, emergency contact, or physician who should have access to your medical information as well as the ability to pay your bill on your behalf:_____