

WELCOME

The doctors and staff of Springwater Chiropractic welcome you. Our goal is to provide the best possible care. Please fill out the following information to the best of your ability. If you need any assistance, please feel free to ask.

INSURANCE

This office will happily process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found however, in some instances, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

PATIENT IDENTIFICATION

_____ Name I prefer to be called in this office _____
Print name

_____ Telephone # _____
Mailing Address Street (Home) _____
(Cell) _____
(Work) _____
OK to call at work? Yes ___ No ___

_____ E-mail Address _____
City, State and Zip OK to send newsletter Yes ___ No ___

Occupation _____ Full Time Student ___ Part time Student ___

Employer _____ School _____

Male ___ Female ___ Date of Birth ___ / ___ / ___ Age ___ Single ___ Married ___ Other _____

Contact in case of Emergency, Name: _____ Phone # _____

Name of parent of minor patient (if patient is under 18 years of age) _____

Social Security # (For Medicare Patients Only) _____

Who may we thank, or how did you hear about Springwater Chiropractic _____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors and therapists of Springwater Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Signature _____ Date _____

Current Symptoms

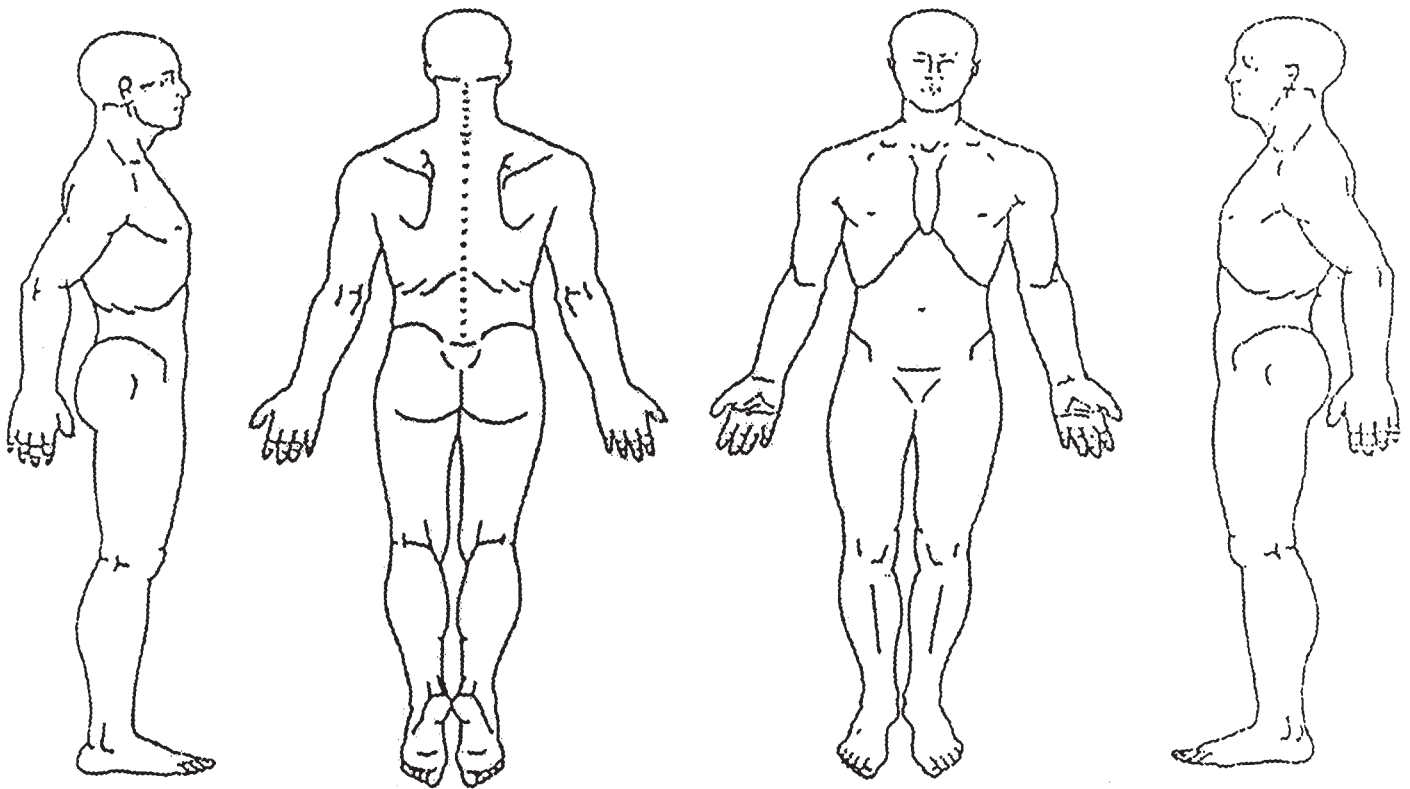
Patient Name: _____ Today's Date: _____

Reason for today's visit _____

When did you first notice the symptoms? _____ Are the symptoms getting worse? _____

What activities are difficult to perform? () sitting () standing () walking () bending () lying down

Please draw on the figures below to show your areas of pain.



What is your pain level now? 0 1 2 3 4 5 6 7 8 9 10 At its worst? 0 1 2 3 4 5 6 7 8 9 10

Describe your pain: () sharp () dull () throbbing () aching () shooting () electrical () burning
() numbness () tingling () weakness () cramping () stiffness () swelling () other _____

How often do you experience the pain? () Constantly () Frequently () Occasionally () Infrequently

What makes the pain better? _____

Have you seen other doctors for this condition? _____ If yes, who? _____

What are your goals in seeking care today? _____

Patient Name _____ Today's date _____

Please Note: We protect your confidential information! Everything on this page will remain confidential and will not be sent to your insurance company or your attorney if you choose. To determine your choice please initial any of the following statements that apply. Signing below applies to this Health History/Family History page only.

- _____ Do not send any of this page to my insurance company.
- _____ Yes, you may send this page to my insurance company if they request it.
- _____ Yes, you may send this page to my attorney if he/she requests it.

Health History

Check the conditions that you have had in the past or currently have.

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug addiction |
| <input type="checkbox"/> Broken bone | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Herniated disc |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pinched nerve |
| <input type="checkbox"/> Prosthetics | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Tumors, growths | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Steroid use | | |

Please list any surgeries you have had along with the date: _____

Please list all medications and supplement you are taking currently: _____

Your Daily Habits

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Family History

Has any blood relative had any of the following disorders?
If yes, then whom?

- Alcoholism _____
- Arthritis _____
- Cancer _____
- Diabetes _____
- Osteoporosis _____
- Stroke _____

Springwater Chiropractic Clinic
Steven Prom, DC
1659 NE Market Drive
Fairview, OR 97024
(503) 465-9100 Fax: (503) 665-2290

Consent to Treat

Chiropractic examination and therapeutic procedures (including spinal manipulation, massage, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications.

While the chances of experiencing complications are small, it is the practice of Springwater Chiropractic Clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms.

More serious complications are extremely rare. Additional information on side-effects and complications are available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

I consent to treatment by any Chiropractic Physician or Licensed Massage Therapist at Springwater Chiropractic Clinic. I also give my consent to treatment of my minor child.

Name of patient: _____

Signature of person over 18 years of age: _____ Date: _____

Rights of Privacy

Here at Springwater Chiropractic Clinic, we hold all your information in complete confidentiality. We do not disclose any of your personal information without your written permission, unless required by law. We follow all HIPAA laws. This last section of this form is required by Federal Law.

I, _____ (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Springwater Chiropractic Clinic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Signature _____

Date: _____

Springwater Chiropractic Clinic
Financial Policy

- We do not double book. Your appointment time is reserved for you. We appreciate a 24-hour notice on all canceled appointments. We reserve the right to charge you \$20 for all missed appointments.
- *By initialing here and other sections, I understand and agree to this financial policy.*

Initial here _____ and date _____

Insurance

- As a courtesy we will bill your insurance company for you.
- All co-pay amounts and deductibles are due at the time of service.
- We encourage you to call your insurance company to confirm your coverage percentage and limits. Knowing your insurance benefits is your responsibility.
- We will call your insurance company to verify coverage. What we are told on the phone is not always the same as what they end up paying. You are responsible for any difference between the billed allowable amount and what we receive from your insurance company.

Initial here _____

No Chiropractic Insurance

- We offer special time-of-service fees to anyone without Chiropractic Insurance coverage.
- These fees must be paid at the time of service.

Initial here _____

Motor Vehicle Accidents

- In the state of Oregon motor vehicle accident cases are billed to your auto insurance company.
- An accident claim and appropriate paper work must be filed with your insurance company prior to treatment.
- If you do not file a claim with your insurance company, or are uninsured, all fees will be due at time of service.

Initial here _____

Workers Compensation Claims

- We will bill your workers' compensation carrier, once you have filled out all the proper paperwork with your employer.
- If your carrier does not pay the claim for any reason, you are responsible for prompt payment of your bill.

Initial here _____

Medicare Part B

- We will no longer accept new patients with Medicare part B coverage, unless they have other insurance coverage also.
- Federal law does not allow us to treat any Medicare part B patient as an uninsured patient.

Initial here _____