

# 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 you 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 best 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 \_\_\_\_\_  
Employer \_\_\_\_\_ Full Time Student \_\_\_\_\_ Part time Student \_\_\_\_\_  
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) \_\_\_\_\_

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 \_\_\_\_\_

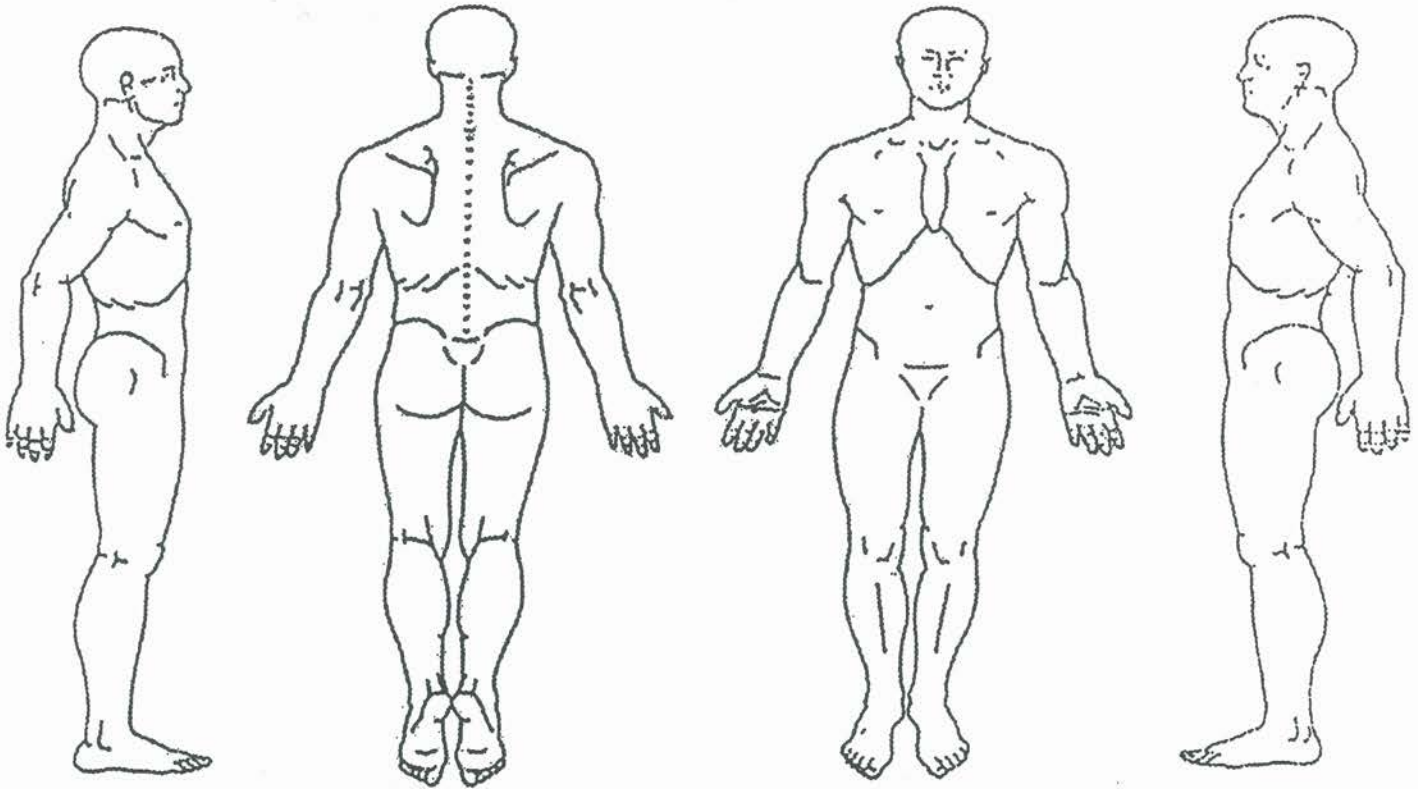
# Current Symptoms

Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Briefly describe any recent injury or any aggravation to current symptoms? \_\_\_\_\_

What activities are difficult to perform? ( )sitting ( )standing ( )walking ( )bending ( )lying down  
( )sleeping ( )my job ( )concentrating ( )other, please list \_\_\_\_\_

**Draw on the figures below to show your current areas of pain or other symptoms.**



What is your pain level now? 0 1 2 3 4 5 6 7 8 9 10 At it's 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? \_\_\_\_\_

01/13/12

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 \_\_\_\_\_

cc 2011 10/30/11

Springwater Chiropractic and Massage  
1659 NE Market Drive  
Fairview, OR 97024  
503-465-9100

**Consent to use PHI**

**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Springwater Chiropractic and Massage or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received or been offered a copy of the Notice of Patient Privacy Policy. \_\_\_\_\_ Patient Initials

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Notice of Treatment in Open or Common Areas**

Describe and Notify private areas available upon request

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

_____ Patient or Legally Authorized Individual Signature	_____ Date
_____ Print Patient's Full Name	_____ Time
_____ Witness 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. If we have to re-bill you for an unpaid balance to your account you will be responsible for a re-billing charge of \$5 and interest of 5% annually for all unpaid bills. 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**

- All 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 are a non-participating provider with Medicare part B coverage, and we do not accept assignment. Only Chiropractic adjustments are covered with Medicare. All other services must be paid for at the time of service. What this means is that you are responsible for your entire bill on the day of service. We will bill Medicare, but it is up to them what they will reimburse you.
- Federal law does not allow us to treat any Medicare part B patient as an uninsured patient.

*Initial here* \_\_\_\_\_

Revised 05.17.11

**Informed Consent**

When a patient seeks Chiropractic health care, it is essential for both patient and doctor to be working toward the same objective. A Chiropractic adjustment is the primary treatment used by doctors of Chiropractic and will most likely be part of your care. Other treatments are offered in our clinic and explained below.

**Chiropractic adjustment and possible risk.** The doctor will use his hands or an instrument device upon your body in such a way as to move your joints. That may cause an audible “pop”, like when you “crack” your knuckles. This sound is from the release of gas bubbles in the joint capsule when it is gapped. You may feel or sense movement. As with any health care procedure, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to: muscle strain, costovertebral strains and separations, fractures, disc injuries and cervical myelopathy. Some types of manipulations to the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying there is, at most, a one-in-a-million chance of such an outcome. The exact risk of stroke is unknown, but is extremely unlikely. Fractures are rare occurrences and generally result from some underlying bone weakness, which we check for during the taking of history and during examination and/or x-ray. Some patients will feel some stiffness and soreness and temporary worsening of symptoms following the first few days of treatment. The other complications are also generally described as “rare”. During the examination, it is necessary to touch/palpate areas of concern. Certain orthopedic and neurological tests require touching or bending the spine and/or lifting extremities. This may result in pain or discomfort.

**Physiotherapies:** Your care might include therapeutic massage, electric muscle stimulation, laser therapy, ultrasound, hot/cold packs and/or mechanical traction. Therapies will help to increase blood flow, relax muscle spasms, increase ranges of motion, decrease pain and decrease fibrotic tissue formation. Adverse side effects may result which may include, but are not limited to muscle spasm, increased pain, muscle weakness and possible exacerbation of symptoms existing prior to treatment.

**Other treatment options and their possible risks.** Outside of this clinic you may get treatment with over-the-counter medications, prescription pain medications, prescription muscle relaxants or surgeries. All these common types of traditional medicine approaches have significant risks to a much higher degree than Chiropractic care.

**Risks and dangers to remaining untreated:** Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilee is very high.

**PARQ:** To gain informed consent, Oregon health care practitioners are required to utilize a Procedures, Alternatives, Risks and Questions (PARQ) conference. I have acknowledged the conference has been explained by my physician of the following: (a) in general terms the procedure of treatment to be done; (b) that there may be alternative procedures or methods of treatment; and (c) that there are risks, if any, to the procedure or treatment.

I have read, or have had read to me the above explanation of the Chiropractic adjustment and related treatment. I have discussed it with Dr. Steven Prom or another doctor at this clinic and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature. (If minor, then Parent or guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date