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.

NOTE on 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

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

_____
City, State and Zip E-mail Address _____
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) _____

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 _____

Springwater Chiropractic
1659 NE Market Dr. 97024

Vladislav Kostin, DC

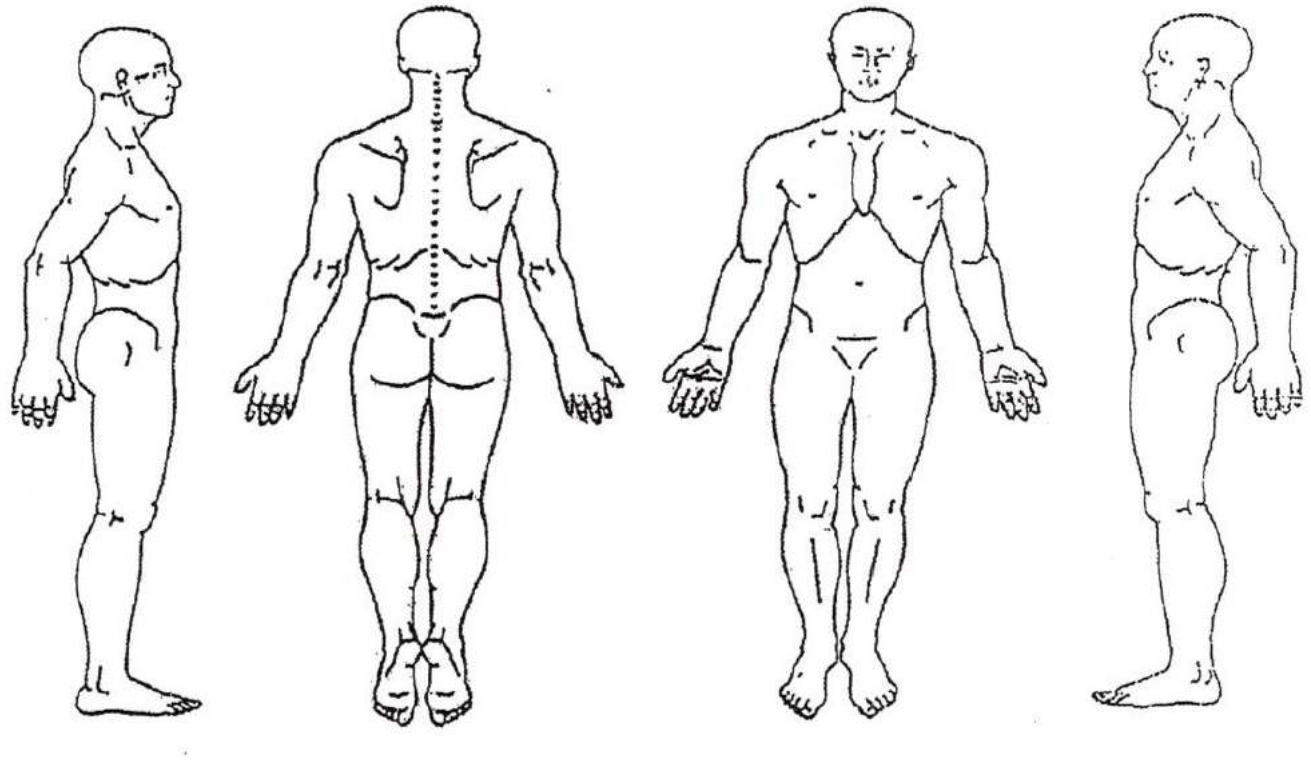
Current Symptoms

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 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 Health / Family History

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.

( ) AIDS/HIV
( ) Arthritis
( ) Breast Lump
( ) Depression
( ) Broken bone
( ) Hepatitis
( ) Herpes
( ) Osteoporosis
( ) Prosthetics
( ) Tumors, growths
( ) Steroid use
( ) Alcoholism
( ) Asthma
( ) Bruise easily
( ) Diabetes
( ) Hearing problems
( ) Hernia
( ) High blood pressure
( ) Pacemaker
( ) Pregnancy
( ) Venereal disease
( ) Surgical Implants
( ) Allergies
( ) Bleeding disorders
( ) Cancer
( ) Drug addiction
( ) Headaches
( ) Herniated disc
( ) Migraines
( ) Pinched nerve
( ) Suicide attempt
( ) Gout

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	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

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 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. 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.
- We will call your insurance company to verify coverage and we encourage you to call your insurance also to confirm your coverage percentage and limits.
- You are responsible for any difference between the billed amount and what we receive from your insurance company.
- All co-pay amounts are due at the time of service.

Initial here _____

No Chiropractic Insurance

- We offer time-of-service discounts 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

- Due to the overwhelming bureaucracy we will no longer accept new patients with Medicare part B coverage.
- Federal law does not allow us to treat any Medicare part B patient as an uninsured patient.

Initial here _____

Revised 12/1/05

Springwater Chiropractic Vladislav Kostin, DC
1659 NE Market Drive (P) 503-465-9100
Fairview, OR 97024 (F) 503-665-2290

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 rehabilitee 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 the above, explanation of the Chiropractic adjustment and related treatment, read to me. I have discussed it with Dr. Vladislav Kostin 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