

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.

Have you been in a car accident or work injury within the last two years? Y/N

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 ___
_____	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) _____	
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

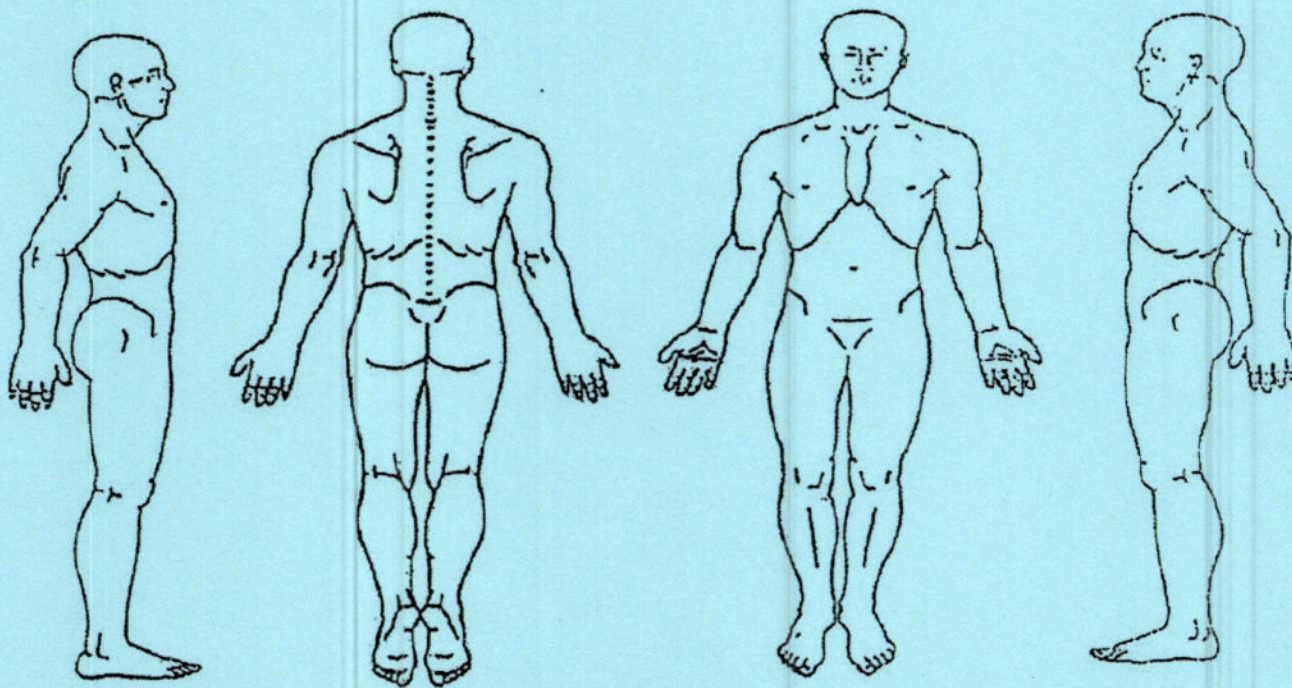
Have you been in a car accident or work injury within the last two years? Yes/No?

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? _____

What makes the pain worse? _____

Does the pain travel down the arms or legs? _____

Headaches? _____

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 | ☐ Alcoholism | ☐ Allergies |
| ☐ Arthritis | ☐ Asthma | ☐ Bleeding disorders |
| ☐ Breast Lump | ☐ Bruise easily | ☐ Cancer |
| ☐ Depression | ☐ Diabetes | ☐ Drug addiction |
| ☐ Broken bone | ☐ Hearing problems | ☐ Headaches |
| ☐ Hepatitis | ☐ Hernia | ☐ Herniated disc |
| ☐ Herpes | ☐ High blood pressure | ☐ Migraines |
| ☐ Osteoporosis | ☐ Pacemaker | ☐ Pinched nerve |
| ☐ Prosthetics | ☐ Pregnancy | ☐ Suicide attempt |
| ☐ Tumors, growths | ☐ Venereal disease | ☐ Gout |
| ☐ 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	☐	☐	☐	☐
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 | _____ |

IMPORTANT!: Previous X-ray, MRI, or CT scans. If so where? _____

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 for Springwater Chiropractic to use and disclose my health information as needed for my treatment.

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

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 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

Worker's and Health Care Provider's Report for Workers' Compensation Claims

OPTIONAL WCD employer no.: Policy no.:
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Note to Provider:	Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.			Dept. Use	
Worker or provider	Worker's legal name, street address, and mailing address:	Language preference:	Male/female ☐ Male ☐ Female	Ins. no.	
		Claim no. (if known):	Date/time of original injury:	Nature	
	Phone:	Date of birth:	Occupation:	Last date worked:	Part
	Employer at time of original injury — name and street address:	Health insurance company name and phone:		Event	
		Workers' compensation insurer's name, address:		Source	
	Phone:			Assoc. object	

Worker	Worker: Check reason for filing this form, answer questions (if any), and sign below.		
	☐ First report of injury or disease (Do not complete or sign if you do not intend to make a claim.) Have you injured the same body part before? ☐ Yes ☐ No If yes, when: _____		Check here if you have more than one job. ☐ Describe accident:
	☐ Request for acceptance of a new or omitted medical condition on an existing claim Checking this box initiates claim processing decisions that may affect your benefits. If you have questions, consult with your attorney or the Ombuds Office for Oregon Workers at 1-800-927-1271 (toll-free). Condition: _____		
	☐ Notice of change of attending physician or nurse practitioner Reason for change: _____		
	☐ Report of aggravation of original injury (actual worsening of a compensable condition)		
	By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)		
	X _____ Worker's signature		_____ Date

Provider	Provider: If worker initiated this report, give worker a copy immediately.		
	If the worker filed this report for: • First report of injury or illness – Send this form to the workers' compensation insurer within 72 hours of visit. • New or omitted medical condition – Attach chart notes that explain how this condition is causally related to the compensable injury. Send this form to the insurer within five days of visit. • Change of attending physician or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. Send this form to the insurer within five days after the change or the date of first treatment. Check the following, if applicable: ☐ I request insurer to send its records. • Aggravation of original injury – Sign this form and send it to insurer within five days of visit.		To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online: WorkCompCoverage.wcd.oregon.gov To order supplies of this form, call 503-947-7627.
	If filing for progress report, closing report, or palliative care request, check the appropriate box below.		
	☐ Progress report OR ☐ Closing report (See instructions in Bulletin 239.)		
	☐ Palliative care request – Complete remainder of form, except Section b. Attach a palliative care plan; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.		
a	Date/time of first treatment:	Last date treated:	Was worker hospitalized as an inpatient? ☐ Yes ☐ No
	Next appointment date:	Est. length of further treatment:	If yes, name hospital:
			Current diagnosis per ICD-10-CM codes:
	Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown		Medically stationary? ☐ Yes (date): _____ (Attach findings of impairment, if any.) ☐ No (anticipated date): _____
	Work ability status: ☐ Regular work (job at injury) authorized start (date): _____ ☐ Modified work authorized from (date): _____ through (date, if known): _____ ☐ No work authorized from (date): _____ through (date, if known): _____		
c	Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).		
	Provider's name, degree, address, and phone: (print, type, or use stamp)		— Original and one copy to insurer — Retain copy for your records — Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner
	X _____ Provider's signature		_____ Date