Bailey Chiropractic & Rehabilitation Center
1100 Liberty St SE Suite 2
Salem, OR 97302
503-689-1604

REGISTRATION

Patient_____ Cell Phone _____
First Name Initial Last Name

Date_____ Home Phone_____ Work Phone_____ Email_____

Street Address_____
City_____ State_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Insured Name_____ How and where did you learn about us?_____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Oth

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City State Zip
SPOUSE (PARENT)	Name_____ Last Name First Name Initial Birth date_____ Employer Name_____ Occupation_____ Address_____ Phone_____ City State Zip
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ **Yes** ☐ **No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Phone Number_____ Address _____ City _____ State_____ Zip_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Bailey Chiropractic & Rehabilitation Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent.

The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):
Date Signed ____/____/____ Witness: _____

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OFFICE POLICY

The following is an explanation of our clinic's office policy. We believe that a clear definition of office policy will allow us both to concentrate on the most important issue, **regaining and maintaining your health.** We will be happy to answer any questions you may have regarding our office policy, your account or insurance coverage.

PATIENT PAYMENT POLICY

We feel that the patron's health needs are paramount. Therefore the following payment policy is an attempt to allow you, the patron, to receive the care you need and keep your balance current with the least amount of difficulty.

1. Our office accepts cash, personal checks, money orders and the following credit cards: Visa, MasterCard, American Express, and Discover.
2. Payment of any deductible, co-pay, or non-covered service is expected in a timely manner.
3. Any special arrangements that are made, are with the anticipation that your account will be paid in full within 18 months.
4. Payment for supplies is required at time of purchase. Special orders must be paid for at the time the order is placed. All devices bought are non-refundable.
5. Any refund on services paid in advance will be based on our normal and customary fees for services rendered to date. Refunds will be refunded within 90 days of written request for refund.
6. For rehabilitation/chiropractic visits, missed appointments will incur a $10 fee (which insurance will not cover) unless notice is given, 24 hours in advance.

All records are the property of Bailey Chiropractic & Rehabilitation Center and will not be released to anyone, however copies will be provided when requested.

Most insurance companies provide Chiropractic coverage, however the benefits and limitations vary widely. We will be happy to contact your company to confirm your coverage. We will submit your insurance claims for you, however it will be your responsibility to pay your annual deductible, required co-payments, and non-covered services as services are rendered, unless special arrangements are made. You should receive a monthly statement from your insurance company with all of your charges itemized. Please review these for accuracy and retain them for your records. If you feel there is an error on your account please contact our office immediately.

AUTOMOBILE (NO-FAULT) INSURANCE

Under Oregon State law, if you are injured in an automobile accident, you are covered under the terms of your automobile no-fault insurance for Chiropractic treatment. This also applies if you are a passenger or pedestrian involved in an accident. If you have been injured in an automobile related accident, please notify us immediately. Payment plans are available if your need for chiropractic care exceeds your medical coverage.

WORKERS COMPENSATION INSURANCE

If you are injured on the job, you are eligible for workers compensation insurance to pay for any needed Chiropractic treatment.. If you have been injured on the job, please notify us immediately.

PLEASE READ CAREFULLY

I also agree to pay a minimum finance charge of 1.5% per month or a minimum of $2.00 whichever is more on any amount not paid after 180 days. If collection is made by suit or otherwise, patient and/or responsible party agrees to pay interest until paid, collection costs of 50% of the remaining balance, all attorney fees and court costs.

I understand and agree to the above policies.

_____ _____

Signature Date

_____ _____

Witness Date

Patient Health Questionnaire – PHQ

Patient Name_____
Date_____

1. Describe your symptoms

_____

_____

a. When did your symptoms start?

_____

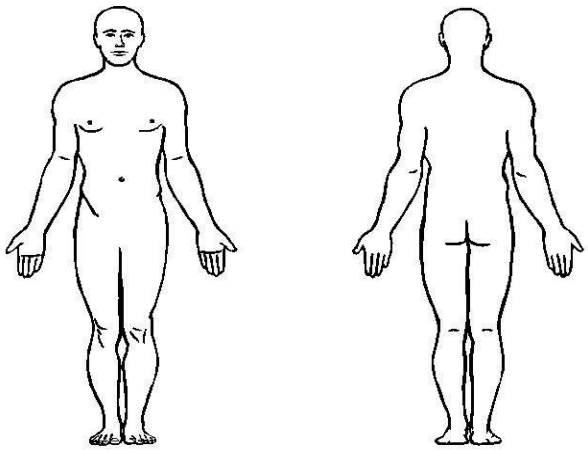
b. How did your symptoms begin?

_____

2. How often do you experience your symptoms?

(1) Constantly (76-100% of the day)
(2) Frequently (51-75% of the day)
(3) Occasionally (26-50% of the day)
(4) Intermittently (0-25% of the day)

Indicate where you have your issue



3. What describes the nature of your symptoms?

(1) Sharp **(4)** Shooting
(2) Dull ache **(5)** Burning
(3) Numb **(6)** Tingling

4. How are your symptoms changing?

(1) Getting Better **(2)** Not Changing **(3)** Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ***Unbearable***

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

(1) Not at all **(2)** A little bit **(3)** Moderately **(4)** Quite a bit **(5)** Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

(1)All of the time (2) Most of the time (3) Some of the time
(4)A little of the time (5) None of the time

7. In general would you say your overall health right now is...

(1) Excellent **(2)** Very Good **(3)** Good **(4)** Fair **(5)** Poor

8. Who have you seen for your symptoms?
(1) No one **(2)** Chiropractor **(3)** Medical Doctor **(4)** Physical Therapist **(5)** Other

a. What treatment did you receive and when?
_____.

b. What tests have you had for your symptoms and when were they performed?
(1) X-rays date: _____. **(2)** MRI date: _____.
(3) CT Scan date: _____. **(4)** Other date: _____.

9. Have you had similar symptoms in the past. **(1)** Yes **(2)** No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
(1) This Office **(2)** Chiropractor **(3)** Medical Doctor **(4)** Physical Therapist **(5)** Other

10. What is you occupation? _____.

(1) Professional/Executive **(3)** White Collar/Secretarial **(5) Trades person** **(7)** Laborer
(2) Homemaker **(4)** FT Student **(6)** Retired **(8)** Other

a. If you are not retired, a homemaker, or a student, what is your work status?
(1) Full-Time **(3)** Self-employed **(5)** Off work
(2) Part-Time **(4)** Unemployed **(6)** Other

Patient Signature _____ Date _____