**Bailey Chiropractic & Rehabilitation Center**
**1190 Cross St SE**
**Salem, OR 97302**
**503-363-6793**

## REGISTRATION

Patient________________________________________Cell Phone ____________________
First Name Initial Last Name
HomePhone________________WorkPhone____________________Email______________________________
StreetAddress________________________________________________________________
City______________________________State____________________Zip________________Sex [ M ] [ F ]
Age________ Birth date______________________ [Single] [Married] [Widowed] [Separated] [Divorced]
Driver's License #______________________ Social Security #______________________________
Emergency Contact (Name and Phone #)______________________________________________
How and where did you learn about us?

| | |
|---|---|
| **PATIENT INSURANCE INFORMATION** | Please list any and all insurance and/or employee health care plan coverage you or your spouse may have<br>Insurance Company or Health Care Plan Name____________________<br>Policy/Group #:____________________ID #:____________________<br>Name of Subscriber:____________________ID #:____________________<br>Relationship To Insured [Self] [Spouse] [Child] [Other]______________ |
| **AUTO/WORK COMP** | 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:________<br>If you answered yes, please fill out an accident specific form, available at the front desk. |
| **PARENT/ SPOUSE** | Name____________________________________<br>Last Name First Name Initial<br>Birth date____________________Social Security #____________________<br>Address________________________________Phone______________<br>City State Zip |
| **EMPLOYER** | Company Name____________________ Occupation____________________<br>Address________________________________City______________<br>State Zip Phone [Full-time] [Part-time] |
| **ATTORNEY** | Law Firm________________________________________<br>Address________________________________________<br>Attorney Telephone |
| **PATIENT AGREEMENT**<br><br>**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.<br>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.<br>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.<br><br>________________________________ ________________<br>Signature of Insured / Guardian Date |

# INFORMED CONSENT for TREATMENT and PRIVACY

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

______________________, hereby states that by signing this Consent, I acknowledge
(Patient Name or legal representative) and agree as follows:

**PRIVACY**

If requested, 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 disclosures of my protected health information ("PHI").

The disclosure of my PHI includes a variety of information including appointments and treatment that will be sent to me, my insurance company, billing service, or law office associated with my treatment or with the Practice, including digital and paper communication. 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.

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

**TREATMENT**

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctors will use that procedure to treat you. They may use their hands or a mechanical instrument upon your body in such a way as to move your joints.

As a part of the analysis, examination, and treatment,
you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion tests
- orthopedic tests
- basic neurological tests
- muscle strength tests
- postural analysis tests
- rehabilitative exercises
- other (please explain) ______________________________________________

___Patient (or guardian) should initial indicating they are consenting to the entire list above

**The RISKS**

There are certain complications which may arise during chiropractic manipulation and other therapies provided by this office. These complications include but are not limited to: fractures, disc injuries, bruises, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, some patients feel stiffness and soreness following the first few days of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone.

Some manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke and/or arterial dissection. This topic has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is

extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

**CONSENT TO TREATMENT (MINOR)**

I hereby request and authorize Bailey Chiropractic and Rehabilitation Center to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter:

______________________________________________________.

This authorization also extends to all other doctors and office staff members.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**
**PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

**I have read [ ] or have read to me [ ] the above notice and explanation of the chiropractic adjustment, related treatment and my expected privacy. I have had my questions answered to my satisfaction. I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to that treatment.**

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***.

______________________________________________________

Name of Individual (Printed) Date:

______________________________________________________

Signature of Patient or Legal Representative Relationship

# OFFICE POLICIES

The following is an explanation of our clinic's office policy. We will be happy to answer any questions you may have regarding our office policy, your account or insurance coverage.

## PATIENT PAYMENT POLICY

-Our office accepts cash, checks, money orders and most credit cards.

-Payment of any deductible, co-pay, co-insurance, or non-covered service is expected as services are rendered, unless special arrangements are made.

-Any special arrangements that are made, are with the anticipation that your account will be paid in full within 12 months.

-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 after a written request for refund.

-For rehabilitation and chiropractic visits, missed appointments will incur a $50 fee unless notice is given, 24 hours in advance. (insurance will NOT cover this fee)

## NO SHOW/LATE CANCEL POLICY

If you miss an appointment without 24hrs notice, we can accept a fee of $50 for the unattended appointment time UNLESS you have Medicaid/OHP. With this insurance we cannot accept a fee for missed appointments and therefore any appointment canceled same day or missed will result in discharge from our office, with no acceptances. We always keep a record of other in-network providers and will be happy to provide you with a list of other clinics and capable providers.

## PRIVATE HEALTH INSURANCE

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. You should receive a monthly statement from your insurance company with all of your charges itemized, our office won't send you a bill on any regular basis. Please review your insurance documents for accuracy and retain them for your records. If you feel there is an error on your account please contact our office immediately.

## AUTOMOBILE INSURANCE

Under Oregon State law, if you are injured in an automobile accident, you are covered under the terms of your automobile 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 so that we can file the proper forms.

## WORKERS COMPENSATION INSURANCE

If you are injured on the job, you are eligible for workers compensation insurance. If you have been injured on the job, please notify us immediately so that we can file the proper forms.

## 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 90 days. If you have made it this far and read our paperwork in full, please see the front desk for a goodie. If collection is made by suit or otherwise, the 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

# Patient Health Questionnaire

**Patient Name**________________________________________

**Date**_________________

**1. Describe your symptoms**

______________________________________________________________________

______________________________________________________________________

**(a)** When did your symptoms start?

______________________________________________________________________

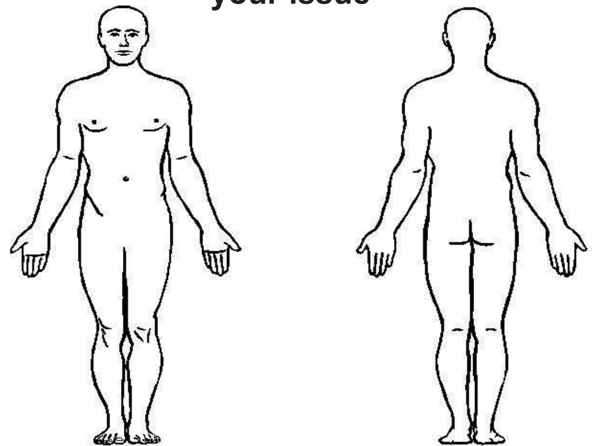
**(b)** How did your symptoms begin?

______________________________________________________________________

**2. How often do you experience your symptoms?**

**(a)** Constantly (76-100% of the day)
**(b)** Frequently (51-75% of the day)
**(c)** Occasionally (26-50% of the day)
**(d)** Intermittently (0-25% of the day)

**Indicate where you have your issue**



**3. How are your symptoms changing?**

**(a)** Getting Better **(b)** Not Changing
**(c)** Getting Worse

**4. What describes the nature of your symptoms?**

**(a)** Sharp **(d)** Shooting
**(b)** Dull ache **(e)** Burning
**(c)** Numb **(f)** Tingling

**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)*

**(a)** All of the time **(b)** Most of the time **(c)** Some of the time
**(d)**A little of the time **(e)** None of the time

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

**(a)** Excellent **(b)** Very Good **(c)** Good **(d)** Fair **(e)** Poor

**8. Who have you seen for your symptoms?**

**(a)** No one **(b)** Chiropractor **(c)** Medical Doctor **(d)** Physical Therapist **(e)** Other

**1.** What treatment did you receive and when?

______________________________________________

**2.** What tests have you had for your symptoms and when were they performed?

**(a)** X-rays date: ____________ **(b)** MRI date: _____________

**(c)** CT Scan date: ___________ **(d)** Other date: ____________

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

If you have received treatment in the past for the same or similar symptoms, who did you see?

**(a)** This Office **(b)** Chiropractor **(c)** Medical Doctor

**(d)** Physical Therapist **(e)** Other

**10. What is your occupation?**______________________________________

**(a)** Professional/Executive **(b)** Laborer **(c)** Tradesperson **(d)** Homemaker

**(e)** White Collar/Secretarial **(f)** FT Student **(g)** Retired **(h)** Other

If you are not retired, a homemaker, or a student, what is your work status?

**(a)** Full-Time **(b)** Self-employed **(c)** Off work

**(d)** Part-Time **(e)** Unemployed **(f)** Other

**Patient Signature** ________________________________