welcome

Personal Information

Name: _____ Today's Date: _____
Last First Mi Mr Mrs Ms Dr

Home Address: _____
Street City State Zip

Telephone: (____)_____ Social Security #: _____ Driver's License #: _____

Age: _____ Birthdate: ____/____/____ Sex: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Number of Children: _____

Occupation: _____ Employer: _____ Wk#: (____)_____ Years Employed: _____

Spouse Name: _____ Occupation: _____ Employer: _____ Social Security #: _____

Person Responsible for this account: _____ Health Plan: _____

Subscriber's Name: _____ ID #: _____ Group #: _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____ _____

_____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?	☐ Intermittently	☐ Occasionally	☐ Frequently	☐ Constantly
Describe your current pain/symptoms:	☐ Sharp/Stabbing	☐ Throbbing	☐ Aches	
	☐ Dull	☐ Soreness	☐ Weakness	
	☐ Numbness	☐ Shooting	☐ Gripping	
	☐ Burning	☐ Tingling	☐ Other _____	
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change	
What makes the problem better?	☐ Nothing	☐ Lying Down	☐ Walking	
	☐ Standing	☐ Sitting	☐ Movement	
	☐ Exercise	☐ Inactivity/Rest	☐ Other _____	
What makes the problem worse?	☐ Nothing	☐ Lying Down	☐ Walking	
	☐ Standing	☐ Sitting	☐ Movement	
	☐ Exercise	☐ Inactivity/Rest	☐ Other _____	
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all	
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all	
Describe your job requirements:	☐ Mainly sitting	☐ Light Labor	☐ Heavy Labor	
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all	
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High	

What treatment(s) have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic) _____

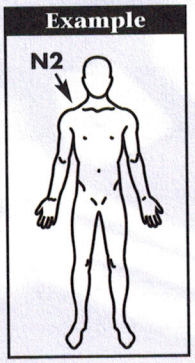
_____

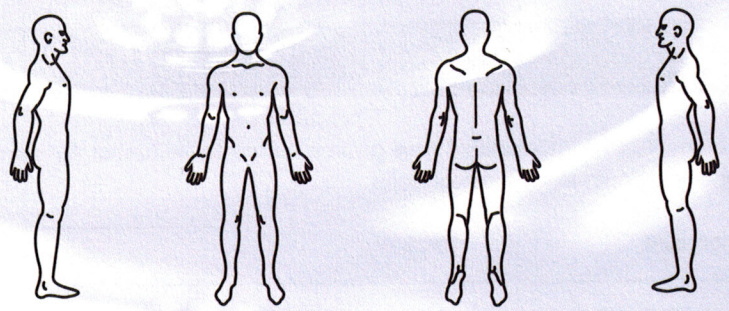
Have you had X-rays, MRI or other tests for this condition? What tests and when? _____

_____

Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness	N
Pins & Needles	P
Burning	B
Aching	A
Stabbing	S





CONTINUED ON BACK

Present Weight _____ **pounds** **Height** _____ **feet** _____ **inches**

Current Medications _____

_____

Hospitalizations/Surgical Procedures _____

_____

Do you have a permanent disability rating? ☐ Yes ☐ No

Location _____

Date rating received _____/_____/_____

Rating percentage _____ %

Medical History

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *present* column. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Neck pain
☐	☐	Shoulder pain (R _____ L _____)
☐	☐	Pain in upper arm or elbow (R _____ L _____)
☐	☐	Hand pain (R _____ L _____)
☐	☐	Wrist pain (R _____ L _____)
☐	☐	Upper back pain
☐	☐	Lower back pain
☐	☐	Pain in upper leg or hip (R _____ L _____)
☐	☐	Pain in lower leg or knee (R _____ L _____)
☐	☐	Pain in ankle or foot (R _____ L _____)
☐	☐	General fatigue
☐	☐	Depression
☐	☐	Dermatitis/eczema/rash
☐	☐	Asthma
☐	☐	Chronic cough
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Chronic sinusitis
☐	☐	Difficulty in swallowing
☐	☐	Excessive thirst
☐	☐	Diabetes
☐	☐	Headache
☐	☐	Jaw pain
☐	☐	Tinnitus (ear noises)
☐	☐	Visual disturbances
☐	☐	Dizziness
☐	☐	Abdominal pain
☐	☐	Bladder infection
☐	☐	Frequent urination
☐	☐	Painful urination
☐	☐	Prostate problems
☐	☐	Kidney disorders (by condition)
☐	☐	Kidney stones
☐	☐	Loss of bladder control
☐	☐	Constipation/irregular bowel habits
☐	☐	Irritable colon
☐	☐	Colitis
☐	☐	Hepatitis

Past	Present	Condition
☐	☐	Liver/gallbladder problems
☐	☐	Ulcer
☐	☐	Muscular incoordination
☐	☐	Swelling, Stiffness of joint(s)
☐	☐	Arthritis
☐	☐	Rheumatoid arthritis
☐	☐	Heartburn/indigestion
☐	☐	Angina
☐	☐	Heart attack (date) _____
☐	☐	Aortic aneurysm
☐	☐	Chest pains
☐	☐	High blood pressure
☐	☐	Rapid heart beat
☐	☐	Stroke (date) _____
☐	☐	Loss of appetite
☐	☐	Abnormal weight ☐ Gain ☐ Loss
☐	☐	Anorexia/Bulimia
☐	☐	Blood disorder
☐	☐	Tumor, explain _____
☐	☐	Cancer, explain _____
☐	☐	HIV/AIDS
☐	☐	Epilepsy
☐	☐	Fainting
☐	☐	Convulsions
☐	☐	Other _____
☐	☐	Coffee/tea/caffeinated soft drinks: cups/cans per day _____
☐	☐	Drug or alcohol dependence
☐	☐	Tobacco, frequency _____
☐	☐	Alcohol, frequency _____
☐	☐	Birth control pills, type _____
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Irregular menstrual flow
☐	☐	Profuse menstrual flow
☐	☐	PMS
☐	☐	Endometriosis
☐	☐	Number of births _____
☐	☐	Number of pregnancies _____

If a family member has had any of the following, please mark the appropriate box:

☐	Cancer	Family member _____
☐	Chronic back problems	Family member _____
☐	Chronic headaches	Family member _____
☐	Diabetes	Family member _____
☐	Heart problems	Family member _____
☐	High blood pressure	Family member _____
☐	Lung problems	Family member _____
☐	Lupus	Family member _____
☐	Rheumatoid arthritis	Family member _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

NEW PATIENT CONTACT AND CONSENT FORM

Name (please print) _____

Please mark which is the best way for us to reach you:

Home # _____ **Work#** _____

Cell # _____ **Cell Phone Provider** _____

Email Address _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Alternate Contact and Numbers: _____

_____

Who may we thank for referring you?_____

I give the following people (list names) permission to view my medical records if necessary (this does not apply to other medical facilities):

_____

_____

Signature _____ **Date** _____

****Thank you for helping us keep your information private****

Disclosure and Consent

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

The nature of the chiropractic adjustment

The primary treatment used by the chiropractor is chiropractic manipulative therapy, also know as an adjustment. The chiropractor will use their hands or mechanical device upon your body to adjust a joint which may produce a pop or a click, referred to as an audible.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures to be performed by the chiropractor, and/or other licensed chiropractors and those working with or associated with the clinic.

__Spinal or extremity manipulative therapy
__Vitals
__Range of motion
__Orthopedic test
__Muscle strength testing
__Palpation
__Heat/cold
__Ultrasound
__Electric muscle stim
__Light wave therapy
__Postural analysis
__Gait Analysis
__Radiographs
__Basic neurology testing
__Other_____

Patient: please initial each procedure you are consenting to

The material risks inherent in chiropractic adjustment

As with any healthcare procedures, certain complications may arise during the chiropractic manipulative therapies and examination. These include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, vertebral basilar artery insufficiency, and/or burns. Some patients will feel some stiffness and soreness following the first few days of treatment. 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 his/her attention, it is your responsibility to inform the doctor.

The probability of those risk occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which the doctor checks for during the discussion of your history, during examination, and possibly X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include self-administered, over-the-counter analgesics and rest; allopathic care and prescription drugs such as muscle relaxants, pain killers, and anti-inflammatory drugs; hospitalization, and surgery.
If you chose to use one of the above noted "other treatment" options, you should be aware that there are possible risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set 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.

I have read or had read to me the above consent/explanation of chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent.

_____ _____
Patient print name Date

_____ _____
Patient signature Parent or guardian if patient is underage

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

Facility _____
Phone _____
FAX _____

The information you may release subject to this signed release form is as follows:

❑Complete Records ❑History & Physical ❑Progress Notes ❑Care Plan
❑Lab Reports ❑Radiology Reports ❑Treatment Record
❑Medication Record ❑Other (please specify below)

_____

_____

Release my protected health information to the following physician/person/facility/entity:

Name: King Chiropractic Clinic

Address: 4515 SW Corbett Ave.

City: Portland State: OR Zip Code: 97239

The purpose/reason for this release of information is as follows:

_____

Expiration Date of Authorization: This authorization is effective through ___/___/_____ unless revoked or terminated by the patient or the patient's personal representative.

Signature:

_____ _____
Patient Name Signature of Patient or Personal Representative

_____ _____
Patient Date of Birth Printed Name of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

Judicial and Administrative Proceedings
We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures
We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities
We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety
We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)
We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research
We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation
We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS
You have the following rights related to your health information.

Restrictions
You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications
You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information
You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Acknowledgment
Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Effective Date:_____

Valerie King, D.D.S. (503) 224-3464

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with medical care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between health care providers and business office staff. In addition, we may share your health information with other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern health care can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

FINANCIAL & INSURANCE INFORMATION

Patient Name: _____ **Patient Social Security Number:** _____ **Patient Birthdate:** __/__/__

Primary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Chiropractic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: __/__/__ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Chiropractic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: __/__/__ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors.

_____ _____
Signature Date

My method of payment will be: ❑ Cash ❑ Check ❑ Credit Card. Credit Card #: _____ Expiration Date: _____

_____ _____
Signature Date

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I, (We), the undersigned patient and/or responsible party hereby jointly authorize this office, its agents/employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, (We), authorize the release and disclosure of any and all of my medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We) may be entitled. I, (We) authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide patient with the most appropriate medical care.

I, (We), authorize and request that payment of any third-party or insurance company benefits be made to this office for any services furnished to patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

_____ _____ _____ _____
Signature of Patient Date Signature of Insured Date