balance CHIROPRACTIC

Hermiston Clinic
1155 W. Linda Ave
Hermiston, OR 97838
Phone: 541-289-9966
Fax: 541-289-9976

Confidential Patient Health Record

***Today's Date*:____/____/_____**

How did you hear about us? ☐ **Family** _____ ☐ **Friend** _____ ☐ **Co-Worker** _____
☐ **Close to home/work** ☐ **Dr.** _____ ☐ **Yellow pages** ☐ **Drove by** ☐ **Hospital** ☐ **Insurance Plan**

Personal Information

Title: ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.** ☐ **Dr.**

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III**

Race: ☐ **Caucasian** ☐ **Hispanic** ☐ **Asian** ☐ **African American** ☐ **Decline to answer** ☐ **Other**_____

Ethnicity: ☐ **Caucasian** ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Decline to answer**

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **French** ☐ **Other**_____

I would like my appointment reminders sent to my cell phone via SMS text message. ☐**YES** ☐**NO**

By checking Yes, I am also implying that I understand that standard text message rates will apply and punctual texts are not guaranteed.

Birth Date: ____ /____/_____ **Age:** _____ **Sex: Male / Female** **SSN:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** **Children: #**_____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Home Phone: (_____) _____-_____ **ext** _____ **Cell Phone:** (_____) _____-_____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Employment Information

Business Name: _____

Occupation/Job Title: _____ **Job Description** _____

Insurance Information:

Who Is Responsible For Your Bill? **YOU and… (mark appropriate box(es))** ☐ **Myself ONLY**

☐ **Spouse** ☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Medicare** ☐ **Medicaid** ☐ **Other (be specific):**_____

Personal Health Insurance Carrier: _____ **Health ID Card #:** _____

Policy Holder's Name: _____ **Group #:** _____

Policy Holder's Date of Birth: _____-_____-_____ **Primary Care Physician:** _____

Current Health Condition

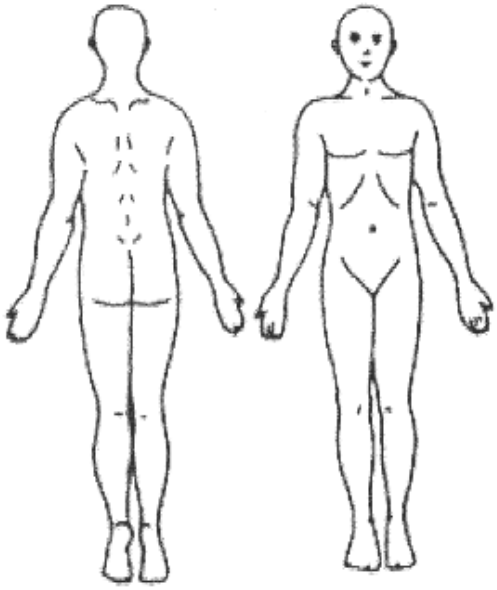
Unwanted Condition (Why you are here today):_____

Patient Name: _____ Date:_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ **Yes** ☐ **No. When?** _____

Is the Condition: ☐ **Auto Related** ☐ **Job Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Explain: _____

_____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

Activities of daily life which increase my symptoms:

☐ Standing ☐ Sitting ☐ Walking ☐ Work ☐ Movement ☐ Sleep ☐ Driving

Other: _____

Treatment Goals:

(What are your expected goals from treatment?)

_____

Allergy: ☐ **I do not have any known allergies to medications**
☐ **I am allergic to the following medication(s):** _____

***Medication*:** ☐ **I am not currently taking any prescription medication**
☐ **I am taking prescription medication and will provide a printed list including all specifications listed on the label.**

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for Same Condition: ☐ **I have not seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? ☐ **Yes** ☐ **No. If yes, Who? (Name)** _____

Type of Treatment: _____ **Was the treatment beneficial in resolving condition?** ☐ **Yes** ☐ **No**

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ **Location:** _____ **Date of Last Visit:** _____

Patient Name: _____ Date:_____

Select all injuries which have occurred in the last TWELVE months:

□ **back injury** □ **head injury** □ **motor vehicle accident** □ **joint injury**
□ **broken bones** □ **industrial accident** □ **soft tissue injury**

Social History:

Tobacco: □ **I have never smoked** □ **I smoke 1-9/day** □ **I smoke 10-19/day** □ **I smoke more than 20/day**
□ **Former smoker**

Alcohol: □ **Never** □ **Social Consumption only** □ **Occasionally** □ **Daily**

Drugs: □ **Deny any illegal drug use** □ **Currently using _____**

Exercise: □ **Yes** □ **No** □ **Occasionally**

Nutrition (please mark all that apply): □ **Regular** □ **Vegetarian** □ **No restrictions** □ **Other**

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information as well as informed consent. I understand that I may request restrictions on specified uses and disclosures of my health insurance information. As such, I hereby restrict the use and disclosure of my health insurance information by or to Balance Chiropractic & Massage.

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

For Office Use Only

Height:_____ Weight:_____ Blood Pressure:_____/_____ Pulse:_____

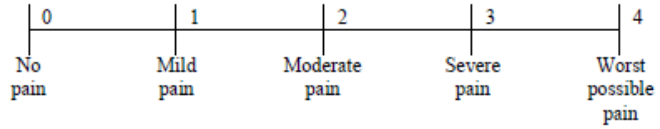
Patient Name: _____ Date:_____

Functional Rating Index

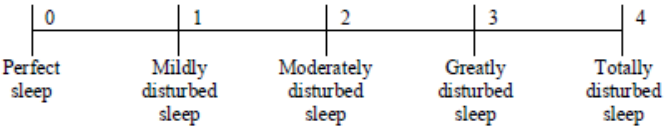
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

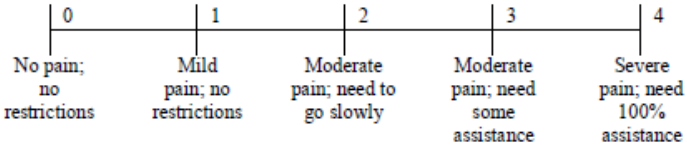
1. Pain Intensity



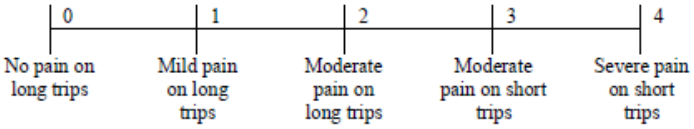
2. Sleeping



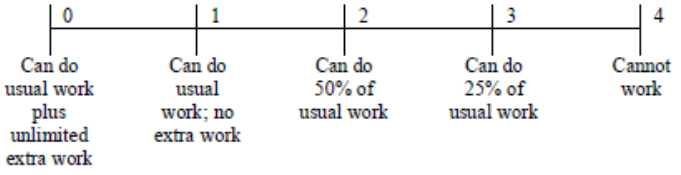
3. Personal Care (washing, dressing, etc.)



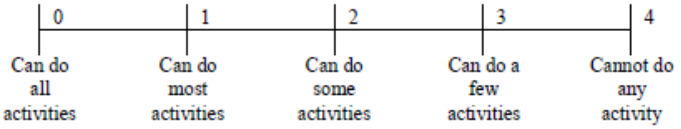
4. Travelling (driving, etc.)



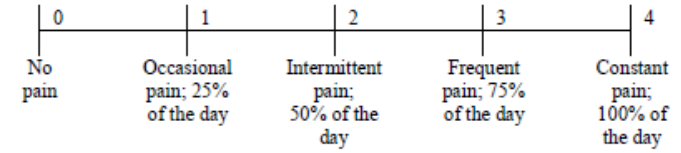
5. Work



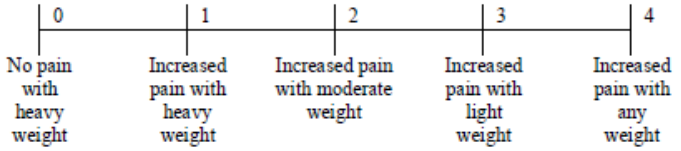
6. Recreation



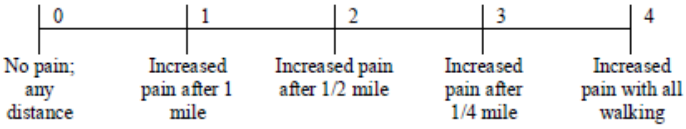
7. Frequency of Pain



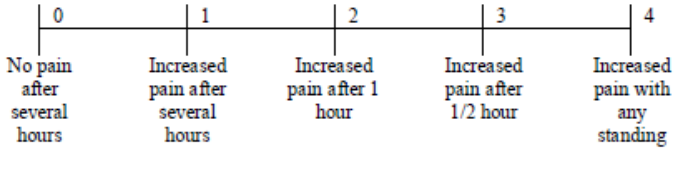
8. Lifting



9. Walking



10. Standing



Patient Signature: _____Date: _____

For Office Use Only: **Patient Score: _____ / 40**

Patient Name: _____ Date:_____

I, (please print name)_____, certify that I have read the notice and privacy practices provided by Balance Chiropractic & Massage, and acknowledge that a copy of this policy is available to me at my request. I understand that my exam, diagnosis, and/or treatment may be conditioned upon my consent as evidence by my signature below.

New patients will be required to pay $50.00 on their initial date of service, until insurance is verified and we have clarification of benefits.

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.
2. You may be entitled to a network or contractual discount under the following circumstances:
    a. We are a participating provider in your insurance health plan.
    b. You are covered by a State or Federal program (Medicare) with a mandated fee schedule.
    c. You are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $39.00 a year and covers you and your dependents. Ask our staff for more information.

PI, AUTO ACCIDENTS, WORKERS COMPENSATION

Medical lien paperwork must be signed and on file. Patients must comply with treatment plan and insurance company requirements. **If your claim is denied, you will be responsible for the full amount billed to insurance for any and all services provided**.

INSURANCE

As a benefit to you we will be happy to bill your insurance. However you are ultimately responsible for the difference between what your insurance pays and the total charges for your care. This includes copays, deductible and co-insurance which are due at the time of service. **The doctors may suggest a treatment plan that may not be fully covered by your insurance.**

****I understand that all appointments cancelled less than 24 hours in advance will be subject to a no-show fee of $25.00 for adjustment and $50.00 for massage.** I understand my account will be charged a $25.00 fee for all returned checks. **This fee and the no-show fee must be paid before any future appointments will be made.**

****I also understand that after my 3rd no-show I will no longer be scheduled at this clinic.**

I have read the Notice of Privacy Practices, Acknowledgement and Consent and the Financial Policy. I understand and agree to these policies and I hereby assign payment of insurance benefits to Balance MBS Chiropractic. **I consent to chiropractic treatment having been informed of treatment procedure, alternative forms of care and risks of treatment, namely injuries (sprain/strains, broken bones, stroke, etc) which may occur during a chiropractic adjustment.**

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Printed name of Responsible Party

** I authorize all my medical information to be released to or discussed with: _____

Name of person or organization