Cascade Spine & Injury Center
Chiropractic, Massage, and Acupuncture

5253 NE Sandy Blvd, Portland, OR 97213
Phone: (503) 893-5131 Fax: (503) 914-0923

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

1. LAST NAME _____ FIRST NAME _____ 3. MI _____
4. ADDRESS _____
5. CITY _____ 6. STATE _____ 7. ZIP_____
8. HOME (_____) _____ 9. WORK (_____)_____ 10. CELL (_____) _____
11. AGE ____ 12. DATE OF BIRTH ____/____/_____ 13. SEX ☐ M ☐ F 14. EMAIL _____
15. MARITAL STATUS ☐ S ☐ M ☐ D ☐ W 16. SPOUSE'S NAME _____
17. PRIMARY CARE PHYSICIAN:_____
FACILITY/ADDRESS:_____
MAY WE SEND PROGRESS REPORTS TO YOUR PRIMARY CARE PHYSICIAN? IF YES, INITIAL HERE _____

WORKERS COMPENSATION / SCHEDULED LOSS INFORMATION

1. EMPLOYER & OCCUPATION _____
2. ADDRESS _____
3. CITY _____ 4. STATE _____ 5. ZIP _____
6. BUSINESS PHONE # (_____) _____ 7. FAX # (_____)_____
8. **(SCH. LOSS EXAMS)** DO YOU HAVE: ☐ SURGICAL REPORTS ☐ X-RAY REPORTS ☐ MRI REPORTS

AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. INSURANCE TYPE: ☐ AUTO ☐ WORK ☐ LIEN ☐ _____
2. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____
3. DATE OF INJURY _____
4. IF AUTO INJURY, WERE YOU? ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐_____
5. # OF PEOPLE IN YOUR VEHICLE? _____
6. DID AIRBAG INFLATE ☐ NO ☐YES
7. NAME OF AUTO INS. CO. _____ 8. INS. PHONE (_____)_____
9. INS. CO. ADDRESS _____
10. POLICY # _____ 11. CLAIM # _____ 12. WCB #_____
13. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY _____
_____
_____
_____
_____
_____

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. INSURED'S NAME _____ 2. INSURED'S SS# _____/_____/_____
3. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____
4. NAME OF HEALTH INS. CO. _____
5. ADDRESS _____
6. INSURANCE PHONE # (_____)_____ 7. POLICY # _____
SECONDARY INSURANCE 8. INSURED'S NAME _____ 9. SS # _____/_____/_____
10. NAME IS INSURANCE CO. _____
11. ADDRESS _____
12. INSURANCE PHONE # (_____) _____ 13. POLICY # _____

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Functional Loss Assessment

Name:_____ **Date:**_____ **Date of Accident:**_____

A common item is **memory and/or cognitive** (ability to function mentally) **loss**. Please complete the form in complete sentences if possible.

As a direct result of my accident, I have the following problems that I didn't have before the accident:

PERSONAL LIMITATIONS: Since the accident I can no longer do the following as I did prior to the accident:

_____

_____

_____

_____

_____

_____

bathing	grooming	cooking	cleaning	vacuuming	yard work	groceries	shopping
sexual difficulties		watching TV	reading	shaving	driving	shoveling	sleeping

SOCIAL LIMITATIONS: Since the accident I can no longer do the following as I did prior to the accident:

_____

_____

_____

_____

_____

_____

dancing	movies	theater	walking	running	bicycling	concerts	sports
gardening	mowing	painting	exercising	child care	swimming	decorating	shopping

WORK LIMITATIONS: Since the accident I can no longer do the following as I did prior to the accident:

_____

_____

_____

_____

_____

_____

lifting	carrying	bending	pulling	pushing	pinching	gripping	sitting
standing	bending	twisting	phone time	computer	focusing	awareness	climbing

_____

Patient Signature

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Healthcare Laws Require Us To Have Written Consent In The Following Areas

Authorization to Release Information

I authorize this healthcare facility to release all information related to the care I receive, to my primary care physician, other providers to whom I may be referred, my insurance company or other/third party payor, attorney, or their designee, as may be necessary for the coordination of care, payment of my bill, determining benefits, or for quality review.

Privacy and Confidentiality

I understand that this healthcare facility is making extensive effort to protect my personal privacy and information. I understand that there are some treatments and procedures that are not in a private setting such as, therapy tables and exercise rehabilitation. If I am uncomfortable with that setting then I will notify the staff and they will try to accommodate me as much as possible. I also give permission for the office to leave voicemail messages, send emails, or send text messages regarding future appointments and information related to my care. Federal and State laws (HIPAA) requires all healthcare facilities to adhere to their policies regarding the release and disclosure of medical records. Records and x-rays are the property of this facility. Copies of records may be received only by authorization of the patient or guardian, request must be in writing and payment of those copies follow the usual/customary costs. Up to 30 days may be required to process this request. I have received a copy of the privacy protection policy.

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. We may use or disclose your PHI for workers compensation and similar programs. We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name. We may contact you by mail, email, text message, or phone, at your residence, work, or mobile phone, to remind you of appointments or to provide information about treatment or other reasons. Unless you instruct us otherwise, we may periodically mail you a postcard to remind you to make an appointment or for other reasons, and we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have: You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions. You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor and supplies associated with your request may be charged.) You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights. You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities

or law enforcement officials as permitted by law. You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager. You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint. This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Authorization for Examination, Diagnostic Testing and Treatment

I authorize the performance of examination, diagnostic tests, procedures and treatment deemed necessary by personnel in this office regarding my care. Necessary procedures can be discussed with the doctor on a case basis. I give the office staff permission to use their best clinical judgment regarding what is necessary to handle my care. I understand that occasionally it may be necessary for another doctor/therapist to treat me.

Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the licensed doctor(s) of chiropractic and/or their chiropractic assistants who now or in the future treat me while employed by, working or associated with or serving for clinical coverage for Cascade Spine & Injury Center, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with a doctor of chiropractic and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, loss of bowel or bladder control, burns with modalities, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

Massage Therapy Informed Consent To Treat

I understand that I may receive massage therapy given to me by a licensed massage therapist who now or in the future treat me while employed by, working or associated with or serving for clinical coverage for Cascade Spine & Injury Center, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not. Massage therapy may be provided for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, or other specific reasons stated by the therapist and/or prescribing doctor.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary

provider (chiropractor, medical doctor, etc.) for any condition I may have. I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

Acupuncture Informed Consent To Treat

I understand that I may receive acupuncture services from the licensed acupuncturist(s) at Cascade Spine and Injury Center, while employed by, working or associated with or serving for clinical coverage for Cascade Spine & Injury Center, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not, treat me. I also authorize him/her/them to perform on me the treatment known as "acupuncture" as his/her/their judgment may indicate, and further authorize him/her/them to use whatever therapeutic methods he/she/they see fit, regardless of whether these methods are commonly and generally accepted and practiced in this community. I understand that acupuncture may include: the non-surgical, non-incisive insertion of disposable needles in specific locations on the body; the use of oriental massage techniques including massage therapy and/or manual therapy; the recommendation of herbal dietary supplements; the recommendation of energy-flow exercises or other prescribed forms of movement; the collection of data and information regarding the functioning of various physical processes, by interrogation, observation, palpation, and other methods specific to the practice of acupuncture; and the use of localized heat and/or electrical stimulation, whether alone or in combination with the other procedures described above.

I have had an opportunity to discuss with an acupuncturist the nature and purpose of the treatment, the risks involved, the collateral hazards, and the possibilities of complications during or as a result of treatment. I understand the meaning of the term "complications", and I give my consent to the treatment. In the event that any unforeseen condition arises in the course of treatment, and in the judgment of the acupuncturist it is advisable to use procedures in addition to or different than this now contemplated, I also request and authorize him/her to perform such treatments, use such procedures, or otherwise act in accordance with his/her professional opinion.

I understand that results are not guaranteed. In the event that my condition is such that treatment is beyond the normal capabilities of the acupuncturist, I understand that I may be referred to other competent practitioners including, but not necessarily limited to, medical physicians or other practitioners.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian:_____ Date:_____

Print Name of Patient or Legal Guardian:_____ Date:_____

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Assignment of Benefits

And

Appointment/Designation as an ERISA/PPACA Representative and Beneficiary

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay: Cascade Spine & Injury Center located at 5253 NE Sandy Blvd., Portland, OR, 97213, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____ _____

Signature of Policy Holder Date

_____ _____

Signature of Authorized Signer or Claimant Relationship to Authorized Signer or Claimant to Patient

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LIEN ASSIGNMENT

I_____(patient name) residing at _____(address) with social security number _____-____-_____ hereby enter into the following agreement with (Cascade Spine & Injury Center), hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay **all** remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken.

I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of benefits.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of benefits.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me OR MY ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby **direct** and **authorize** direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances. This agreement is binding and I hereby relinquish my right to revoke or annul this lien for any reason.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, the new ATTORNEY honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my ATTORNEY, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my ATTORNEY to contact "the provider" prior to disbursement of any funds to ascertain any outstanding balances due and owing to Cascade Spine & Injury Center and Jonathan McClaren, DC.

Dated: _____Patient's Signature: _____

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Date of Request: _____

I hereby authorize _____

_____

_____

and any of its employees to use or disclose my Protected Health Information to Cascade Spine & Injury Center.

I specifically authorize the release of the following records:

_____ Medical records needed for continuity of care
_____ Laboratory records
_____ X-ray(s) and/or imaging including reports (don't send films over 2 years old)
_____ Other: _____

I understand I have the right to: Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization; Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization; Inspect a copy of Protected Health Information being used or disclosed under federal law; Refuse to sign this authorization; Receive a copy of this authorization; Restrict what is disclosed with this authorization. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

_____ _____

Signature or Patient or Patient's Authorized Representative Date