Cascade Spine & Injury Center
Jonathan McClaren, DC - Chiropractic Physician
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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Confidential Patient Questionairre

Name: Date:

Major Complaint(s):

CHECK YOUR PRESENT AND PAST SYMPTOMS

Present	Past		Present	Past	
☐	☐	Neck Pain	☐	☐	Excessive Thirst
☐	☐	Middle Back Pan	☐	☐	Chronic Cough
☐	☐	Low Back Pain	☐	☐	Sinus Problems
☐	☐	Headache	☐	☐	Chronic Fatigue
☐	☐	Dizziness	☐	☐	Painful Urination
☐	☐	Convulsions	☐	☐	Frequent Urination
☐	☐	Fainting, Visual Problems, Nausea	☐	☐	Difficulty with Bladder/Bowels
☐	☐	Shoulder Pain	☐	☐	Stomach Pain
☐	☐	Pain in Shoulder, Arms, Elbows	☐	☐	Difficult Swallowing
☐	☐	Pain in Hands	☐	☐	Depression
☐	☐	Pain in Upper Leg	☐	☐	High Blood Pressure
☐	☐	Pain in lower Leg	☐	☐	Angina
☐	☐	Pain in Ankle/Foot	☐	☐	Heart Attack
☐	☐	Swelling/Stiffness in Joints	☐	☐	Stroke
☐	☐	Jaw Pain	☐	☐	Asthma
☐	☐	Ringing in Ears	☐	☐	Cancer
☐	☐	Rapid Heart Beat	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Arthritis
☐	☐	Loss of Appetite	☐	☐	Diabetes
			☐	☐	Ulcers

Please describe your current pain: __ Sharp __Dull __ Aches __Sore __Weak __ Throbbing
__Shooting __Constricting __Burning __Tingling

Was your problem from a: __Car Accident __Work Related Injury __Started Gradually __Slip and Fall __Other

Describe how the problem began:

What treatment have you received for this condition: __Family Doctor __Chiropractic __ Physical Therapy
__Medical Specialist __Surgery __Injections __X-Ray __MRI Other_____

Have you ever had this problem before? __ Yes __No

What makes the problem better? __Nothing __ Lying Down __Walking __Sitting Other_____

What makes the problem worse? __Nothing __ Lying Down __Walking __Sitting Other_____

Are you currently working? __Yes __No
If yes, do you: ___Sit more then 50% of the day ___Light Manual Labor __Heavy Manual Labor

Does Your Problem Affect Your Daily Activities? __ No __Mild __Moderate __Significant Restrictions
Describe:

Do you Smoke? __No __Yes ___Packs per Day

Do you Drink Alcohol? __No __Socially __Habitually

Are you Pregnant? __No __Yes Date of Onset of Last Menstrual Period _____

Are you Currently Taking Medication? ___No __Yes Please List all Medicaltions: _____

Do you have Any Allergies to Drugs or Other Products? __No __Yes
Describe: _____

FAMILY HISTORY

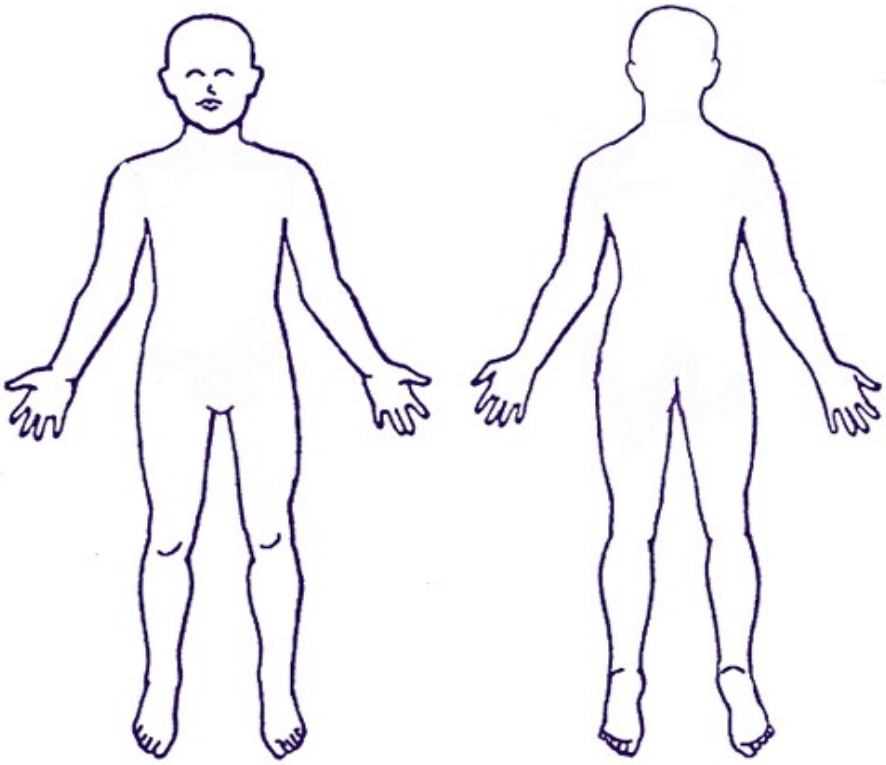
	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other	
Mother	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	
Brother	☐	☐	☐	☐	☐	☐	☐	
Sister	☐	☐	☐	☐	☐	☐	☐	
Grandmother	☐	☐	☐	☐	☐	☐	☐	
Grandfather	☐	☐	☐	☐	☐	☐	☐	

Current Work Status:

- ☐ I Have Not Missed Any Days of Work
- ☐ I Have Missed ___ Days of Work
- ☐ I Have Been Put on Light Duty at Work
- ☐ I Have Had to Change my Job as a Result of my Condition

PAIN / SYMPTOM PICTURE

Please mark with an "X" where you have any symptoms



Patient or Legal Guardian Signature Date

Cascade Spine & Injury Center

Licensed Chiropractic Care, Licensed Massage Therapy, Licensed Acupuncture
5253 NE Sandy Blvd., Portland, OR 97213 Phone: (503) 893-5131 Fax: (503) 914-0923

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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Financial Policy

We strive to provide the highest quality health care, all the while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience at least some out of pocket expense. We are happy to work with you to bill your insurance. Please review our office financial policy below:

Policies For All Insurances

1. It must be fully understood that your insurance policy is a contract between you and your insurance company.
2. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation.
3. If you have a question or concern with your reimbursement, you will need to contact your insurance company.
4. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.
5. All charges incurred are ultimately your responsibility. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment.
6. It is our policy that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays.
7. If your insurance company has not paid a claim within sixty (60) days of submission, you agree to take an active part in the resolution of your claim.
8. If your insurance company has not paid within ninety (90) days of submission, you are responsible for payment of any outstanding balance, unless other arrangements have been made with us beforehand.
9. Overpayments will be refunded to you or your insurance company as applicable, generally within 30 days of receiving the explanation of benefits from your insurance company.
10. While we strive to bill expediently, the insurance billing cycle can last a variable amount of time from weeks to months and depends on many factors. It is not unusual for patients to receive statements months after their visit.

In-Network Health Insurances: If coinsurance payments are expected from your visit, or if we cannot, to a reasonable degree of assurance, verify your expected responsibility for the visit, then we will collect $150/visit for visits where an evaluation/management service is rendered, and $75 for a visit where an evaluation/management service is not rendered.

Out-Of-Network Health Insurances: We will collect, at the time of service, $300/visit for visits where an evaluation/management service is rendered, and $150 for a visit where an evaluation/management service is not rendered for non-participating insurance visits, unless other arrangements have been made.

Patients without Insurance: It is our policy that 100% of the services provided be paid at the time of the visit, unless other arrangements have been made. ChiroHealth USA Discount members must pay on the day the service was performed. We are happy to accept cash, check, and most credit cards. No insurance will be billed.

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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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