Welcome

Thank you for choosing ChiroHealth for your chiropractic care.

Our goal is to provide you with quality patient care. Please complete the enclosed patient information and return to our office. We appreciate receiving the information in advance of your appointment so we can begin your medical record. Once the information is received, we can schedule your new patient appointment.

Our office is contracted with many insurance carriers. To avoid any confusion, please contact your insurance carrier to confirm that ChiroHealth is contracted with them.

The Staff at ChiroHealth look forward to meeting your chiropractic needs.

Please return paperwork to our office:

214 NE Outlook Ave

Grants Pass, OR 97526

Patient Information

Last Name____________________________First_____________________Middle_____________

Date of Birth____________________SS#_____________________Cell Phone_______________

Primary Language_____________________ Home Phone______________

Email______________________________________ Work Phone______________

May we leave medical and appointment information on your cellphone/answering machine?
❑ Yes ❑ No

Mailing address____

City_________________________________ State_____________ Zip______________________

Employment
❑ Full time ❑ Part time ❑ Not employed ❑ Student ❑ Retired

Place of Employment_______________________________Occupation_____________________

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑Domestic Partner

Spouses Name________________________Date of Birth_____________ Phone_____________

OHRP Information (required by the State)

Ethnicity ❑Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Decline
❑ Asian ❑ Black/African American ❑ American Indian
❑ Alaskan Native ❑ Hawaiian/Pacific Islander ❑ White/Caucasian

Emergency Contact
Name______________________________________Relationship____________________

Address____Phone__________________

If patient is a child, parent's name___________________________Phone__________________
Insurance

Primary_____________________________ Secondary_______________________________

Subscriber name______________________ Subscriber name___________________________

Date of birth__________________________ Date of birth______________________________

ID#_______________ Group#____________ ID#____________________ Group#___________

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize ChiroHealth to provide my insurance companies with all information necessary to process insurance claims and assign payments to ChiroHealth all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as a valid as the original.
I have read and understand all of the above.

Signature____ Date______________________

Who is your Primary Care Provider?___________________________________

Medications

Preferred pharmacy_______________________________________

Allergies and Reactions (please include medications, foods, latex, dye, etc.)

____

____

Current Medications (list all medications, including prescriptions, vitamins, over-the-counter, herbs and supplements)

Medication	Dose	Frequency	Reason for taking

Patient Name:_______________________________ Date____________________

Please mark areas on the body guide which you feel best represent the pains or sensations you are experiencing. PLEASE INCLUDE ALL AREAS.

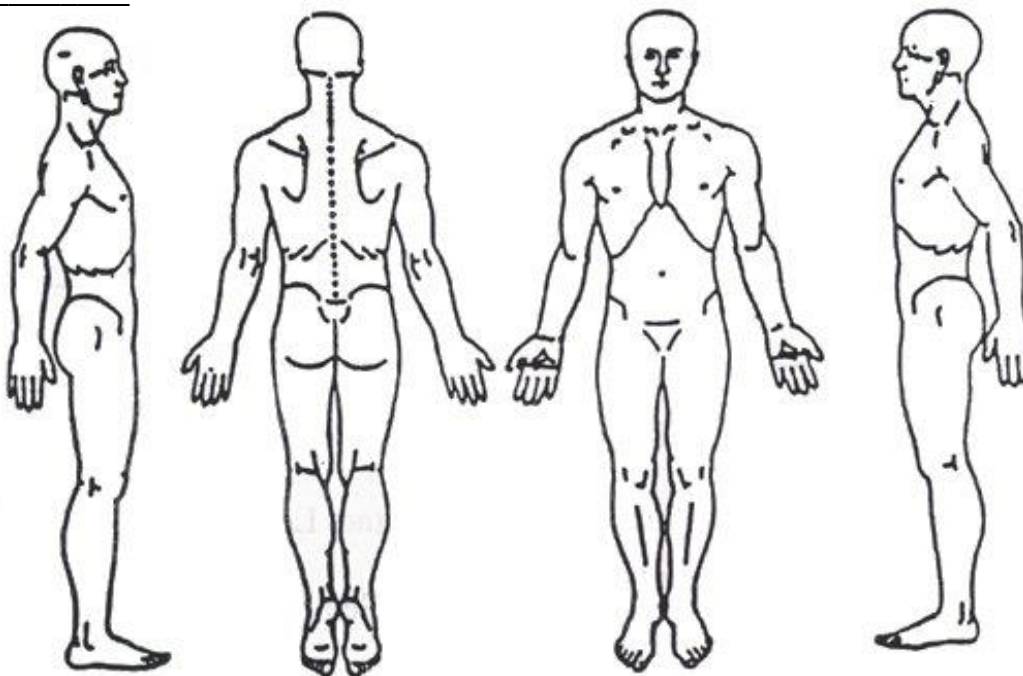
Use the symbols provided below.

Numbness: N Pins and Needles: P
Burning: B Stabbing and Sharp: S
Dull and Aching: A Stiff and Tight: T

What caused your pain? ________
____
____

Does anything make your issues better? _____________________
____

right side L R R L left side



Started on:____________ Body part:___________

Pain scale
1 2 3 4 5 6 7 8 9 10
mild moderate severe

25% 50% 75% 100%
of the day

Started on:____________ Body part :___________

Pain scale
1 2 3 4 5 6 7 8 9 10
mild moderate severe

25% 50% 75% 100%
of the day

Started on:____________

Body part :___________

Pain scale
1 2 3 4 5 6 7 8 9 10
mild moderate severe

25% 50% 75% 100%
of the day

Started on:____________

Body part :___________

Pain scale
1 2 3 4 5 6 7 8 9 10
mild moderate severe

25% 50% 75% 100%
of the day

Started on:____________ Body part :___________

Pain scale
1 2 3 4 5 6 7 8 9 10
mild moderate severe

25% 50% 75% 100%
of the day

CONSENT TO TREAT

Chiropractic care is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any health care specialty we cannot promise a cure but we give you our best care and will discuss any questions or concerns with you.
Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat or ultrasound may irritate skin. There have been a few cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology (very rare about one is six million chance).
I acknowledge that I have discussed non-surgical chiropractic care and physiological therapeutics and authorize Chirohealth to provide such care.

Signature: ____Date: __________________________

HIPPA Laws Policy and Procedure

I have had a chance to review and have been offered a copy of the HIPPA Laws policies and Procedures.

Signature: ____Date: ___________________________

DISCLOSURE OF FEES AND PAYMENT POLICY

I understand that all fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctor's specific recommendations. I also understand there is one fee schedule for all services rendered in this office. There is a 30% discount if you pay in full at time of service. If I desire, a complete list will be available at any time. All fees are subject to change without notice.

I Authorize Chirohealth to receive direct payment from my insurance company or attorney for all monies due on my account. I understand that I am responsible for insurance deductibles, co-pays and any portion of the bill not paid for by the insurance company due and payable on the day the services are rendered. I authorize My signature, below, to be kept on file and used as "my signature on file" to process all insurance claim submissions. I also authorize the release of medical or other information necessary to process all insurance claims.

I hereby assign all medical benefits to which I am entitled to Chirohealth I authorize any of their employees to sign for me on the back of any draft or check which they receive for services rendered from any insurance company, whether pursuant to medical payments coverage or health insurance coverage, as long as I have an outstanding balance with them. Said amount shall be credited against my account and shall reduce my outstanding balance accordingly. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I fully understand and agree to the above terms and acknowledge that I am ultimately responsible for any and all monies owed to Chirohealth regardless of the outcomes of any court case or denials by an insurance company. Should I receive any payment(s) or settlements for services rendered, I will forward those on to Chirohealth within 5 days, or be immediately responsible for the entire amount billed.

Signature____Date________________

No Show Policy

A “no show” is someone who misses an appointment without canceling it 24 hours in advance. No shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in our schedule as a “no show”. The first time there is “no show”, you will be sent a letter alerting you to the fact that you have failed to show up for an appointment and did not cancel the appointment. If you have three “no shows” in one year, you will be dismissed from ChiroHealth.

In order to be respectful of the medical needs of all our patients please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of all our patients.

If it is necessary to cancel your appointment, we require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

To cancel and reschedule your appointment, please call our office: 541 474-5665.

Late cancellations are considered a “no show”.