

***1618 J Street***

***Springfield, OR 97477***

***Phone: 541.341.1414***

***Fax: 541.653.8570***

***Jared Wilson, DC, CCSP***

**Patient Registration**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (complete mailing)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit (routine/accident/illness, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

€ Workers Comp € Auto Insurance € General Insurance € OHP (trillium) € Medicare € Private Pay

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID/claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber name & DOB if not yourself \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(applies only to MVA/pip & workers comp patients):*

Claims Adjuster\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State where injury occurred \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark region(s) of complaint Please indicate region(s) of complaint**

€ Headache

€ Neck

€ Upper/Mid Back

€ Shoulder/Elbow/Wrist/Hand/Finger

€ Hip/Thigh/Knee/Ankle/Foot/Toe

€ Rib/Abdomen/Chest

€ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: 541-341-1414 \* Fax: 541-653-8570

Core Strength Chiropractic \* 1618 J Street \* Springfield OR 97477

**Patient Condition**

*Check symptoms apparent since your accident (applies only to MVA/pip & workers comp patients):*

€ Dizziness € Chest pain € Jaw problems € Nausea

€ Memory loss € Irritability € Arm/Shoulder pain € Mid back pain

€ Headache € Fatigue € Numb hands/fingers € Low back pain

€ Blurred vision € Tension € Difficulty sleeping € Back stiffness

€ Buzzing in ears € Neck pain € Shortness of breath € Leg pain

€ Ringing in ears € Stiff neck € Upset stomach € Numb feet/toes

*(applies to all patients)*

When did your symptoms first appear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition getting worse? € Yes € no

What seemed to be the initial cause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your pain constant, or does it come and go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you have this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with: € work € sleep € daily routine € recreation € other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activities that are painful to perform: € sitting € standing € walking € bending € other\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience any of the following symptoms?

€ Belching or gas € Bloated abdomen € Pain over stomach

€ Constipation or diarrhea € Gallbladder trouble € Vomiting

€ Difficult digestion € Nausea € Vomiting of blood

**Medical History**

Date of last physical exam\_\_\_\_\_\_\_\_\_\_\_\_ Previous chiropractic treatment? If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise frequency? € moderate € daily € heavy Currently pregnant? € yes € no Due date\_\_\_\_\_\_\_\_\_

€ Arthritic condition € High blood pressure € Recreational drugs

€ Cancer € Vascular condition € Tobacco use how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ Diabetes € Lung problems € Alcohol use how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ Heart problems € Unusual childhood diseases € Birth control

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: 541-341-1414 \* Fax: 541-653-8570

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Please list any medications, allergies, surgeries, hospitalizations, or prior auto accidents and work injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list past/present health issues of IMMEDIATE family members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to release medical information/financial agreement**

 I UNDERSTAND AND AGREE THAT REGARDLESS OF INSURANCE COVERAGE, I AM LIABLE FOR ANY CHARGES INCURRED AS A RESULT OF SERVICES RENDERED TO ME AT CORE STRENGTH CHIROPRACTIC. IF THIS ACCOUNT IS ASSIGNED TO AN ATTORNEY FOR COLLECTION AND/OR SUIT, THE PREVAILING PARTY SHALL BE ENTITLED TO REASONABLE ATTORNEY’S FEES AND COST OF COLLECTIONS. I AUTHORIZE RELEASE OF PATIENT MEDICAL RECORDS TO THIRD PARTIES REQUIRING THESE RECORDS FOR DETERMINATION OF FINANCIAL LIABILITY.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy**

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help patients experience good health and we wish to spend our time and energy towards that end. Therefore, I would like you to know about our financial policy:

• Payment is due and payable at the time of your visit, unless satisfactory arrangements have been made in advance.

 • We accept only cash, check or visa/master card (for patients with a co-pay, co-insurance, deductible or cash pay).

**PLEASE NOTE:** There is a $35 fee for all checks returned due to Insufficient Funds. I understand this Financial Policy and agree to abide by these conditions.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Cancellation/Missed appointment**

We require a minimum of a 24 hour notice for cancellation or rescheduling of an appointment. We do understand that things sometimes come up that cannot be helped, to which we will do our best to work with our patients on. If an issue arises in missed appointments, a fee of $50.00 will be charged if continuous missed appointments, etc. Thank you for your consideration.

Signature­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Consent Form To Our Patients**

Chiropractic examination and therapeutic procedures (including spinal adjustment, laser therapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this office to inform our patients about them. These complications included, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These include injury to the arteries in the neck, which may be associated with stroke & serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5-2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side effects, complications and effectiveness of spinal adjustments is available upon request.

***I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for specific cure or results.***

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to treat a minor**

As a parent or legal guardian, I hereby authorize treatment for the following:

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Notice of HIPAA Privacy Policies and Patient Rights**

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your personal health information is extremely important to us. As mandated by federal and state regulation, your personal health information must be protected. As part of these regulations, we are required to ensure you are aware of our privacy policies and legal responsibilities, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

**Privacy Policies**

**The Federal Trade Commission has developed the “Red Flags Rule” to prevent identity theft and medical fraud. Because of this, we will be asking for your picture ID on your first visit. We will also be taking a copy of your picture ID for your chart.**

**Protected Health Information Use and Disclosure**

 Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

**Treatment**

Use and disclosure of your protected health information may be provided to a physician or other healthcare practitioner providing treatment to you. However, this information will only be given with your authorization.

**Payment**

Your protected health information may be used and disclosed to obtain payment for services we provided to you.

**Your Authorization**

 At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation. Your protected healthcare information may be used and disclosed to you as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

**Person Involved In Care**

In order to accommodate the notification of your location, your general condition, or severe illness, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person’s involvement in your healthcare.

**Marketing Services or Other Third-Party Disclosures**

Your protected health information will not be disclosed to any third –party without your written authorization, except as required by law or otherwise described in this notice.

**Required By Law**

Your protected health information may be used/disclosed, if required by any federal, state or local law

**Abuse or Neglect**

As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

 **Patient Rights**

**Access**

You have the right to review and obtain a copy of your protected health information with limited exceptions. Your request to obtain access to your information must be in writing. We may need to charge you a reasonable cost-based fee for the costs of copying, mailing or other costs incurred by us in complying with your request. You may request access by submitting a letter to: Core Strength Chiropractic, Jared Wilson, 1618 J Street, Springfield, OR 97478

**Restrictions**

You may request that we apply additional restrictions to any disclosure of your healthcare information. We are not required to agree to the application of these additional restrictions; however we will make every effort to do so. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

**Alternative Communication**

Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication.

**Amendment**

You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation of why the information should be amended. Certain conditions may exist where we may reject your request.

**Questions and Complaints**

If any time you are unsure of concerned that your personal health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information, or in the response to a request you made to amend the use or disclosure of your protected health information, or to have us communicate to you by an alternative means or at a alternative location, you have the right to bring this issue forward.

**Privacy of your protected health information is extremely important and we are committed to ensuring your privacy. We are available to assist you with the questions, concerns or complaints. You have the right to obtain a paper copy of this notice.**

Patient name (printed) & date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian signature & date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_