Patient Initials: _____ Date: ____/____/_____

Natural Life Chiropractic
90971 S Willamette St
Coburg, OR 97408
Phone: 833-628-5433

New Patient Intake Form

Whom may we thank for referring you to our office? _____

Patient Information

First Name: _____ Middle: _____ Last: _____

Nickname/Preferred Name:_____

Address: _____

City:_____ State: _____ Zip Code: _____

Date of Birth: ____/_____ /_____ Age: _____ Gender: _____ SSN: _____

Marital Status: _____ Spouse's Name (if applicable): _____

Children's names and ages (if applicable): _____

_____

Primary Phone: _____ Alternative Phone: _____

Email: _____ Preferred contact method: □ Call □ Text □ Email

Would you like appointment reminders? □ No Thanks □ Phone Call □ Text Message □ Email

Your Occupation: _____ Your Employer: _____

Emergency Contact Name: _____ Relationship to you: _____

Emergency Contact Phone: _____

Have you previously seen a chiropractor in the past? □Yes □No If yes, date of last visit: _____

Reason for visit today: _____

Has this condition been previously treated by any other physician? □Yes □No If yes, please state the name of doctor and how you were treated: _____

Have you had any previous diagnostic imaging or testing for this condition? □Yes □No If yes, please describe:

_____

Medical History

Major hospitalizations in the past? : □Yes □No, If yes, please describe: _____

_____

Major illnesses in the past? □Yes □No, If yes, please describe: _____

_____

Surgeries in the past? □Yes □No, If yes, please describe: _____

_____

Major injuries or broken bones, including car accidents, in the past? □Yes □No, If yes, please describe:

_____

_____

When was the date of your last physical exam? _____

Any allergies to medications? □Yes □No If yes, please note medication and reaction: _____

Any other allergies? □Yes □No If yes, please note allergen and reaction: _____

Are you being treated for any other condition by any other physicians? □Yes □No If yes, please state the name of the doctor, the condition, and how you are being treated: _____

_____

Any history of smoking? □Yes □No If yes, from _____ to _____ and frequency:

_____

Medication

Medication Name:	Condition Prescribed For:	Dosage:	Frequency:

Recreational drug use? □Yes □No

Insurance Information (if applicable)

Is the reason for your visit due to: □Auto Accident □Personal Injury □Work Injury □Other

Do you plan to use insurance? □Yes □No

Relationship to insured: □Self □Spouse □Child □Other

Insured's full name (as it appears on policy): _____

Insured's Employer: □ Same as above _____

Insured's SSN: □ Same as above _____-_____-_____ Insured's DOB: □ Same as above _____/_____/_____

Primary Insurance Co: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Co: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Policy Number: _____ Group Number: _____

Patient Initials: _____ Date: ____/____/_____

Review of Systems

Please check any of the following symptoms that you may be experiencing or have experienced in the past.

Constitutional

□ Fever	□ Chills	□ Night Sweats	□ Daytime Fatigue
□ Weakness	□ Malaise	□ Headaches	□ Decreased/Increased Appetite
□ Weight Gain/Loss	□ Difficulty Sleeping		

Allergy

□ Hives	□ Rash	□ Persistent Illness	□ Seasonal Allergies

Eyes

□ Vision Loss	□ Irritation	□ Blurring	□ Discharge/Tearing
□ Light Sensitivity	□ Itching	□ Double Vision	□ Wears Glasses/Contacts

Ear, Nose & Throat

□ Hoarseness	□ Stiff Neck	□ Difficulty Hearing	□ Ringing in Ears
□ Ear Discharge/Pain	□ Sore Throats	□ Swollen Lymph Glands	□ Difficulty Swallowing
□ Dizziness/Vertigo	□ Fainting	□ Loss of Smell	□ Sinus Infection
□ Nosebleeds	□ Head Injury		

Respiratory

□ Asthma	□ Productive Cough	□ Shortness of Breath	□ Wheezing

Cardiovascular

□ Heart Disease	□ Leg Pain/Ache	□ Low Blood Pressure	□ High Blood Pressure
□ Sleep Apnea	□ Ulcers	□ Palpitations	□ Shortness of Breath with Exertion
□ Varicose Veins	□ Heart Murmur		

Gastrointestinal

□ Abdominal Pain	□ Jaundice	□ Black/Tarry Stool	□ Heartburn/GERD
□ Constipation	□ Hemorrhoids	□ Rectal Bleeding	□Loss of Bowel Control
□ Indigestion	□ Diarrhea		

Female Only

□ Birth Control	□ Frequent Urination	□ Vaginal Discharge	□ Abnormal Bleeding
□ Breast Lump/Pain	□ Hormone Therapy	□ Irregular Menstruation	□ Urine Retention/Incontinence
□ Burning Urination	□ Cramps		

I…

□ am currently pregnant	□ currently have menses
□ am NOT currently pregnant	□ do NOT have menses

My menses…

□ are Regular □ are NOT regular

Age of 1st menses _____ Age menopause began _____ Date of last menstrual period _____

Patient Initials: _____ Date: ____/____/_____

Male Only

□ Burning Urination □ Frequent Urination □ Prostate Problems □ Erectile Dysfunction
□ Hesitancy/Dribbling □ Urine Retention/Incontinence

Sexual Health

Do you have any concerns about your sexual health? □ Yes □ No
Have you ever been a victim of domestic violence or sexual abuse? □ Yes □ No

Skin

□ Hair Loss □ Change in Skin Color □ Change in Nail Texture □ History of Skin Disorder□
□ Itching □ Skin Lesions/Ulcers □ Hives/Rash □ Numbness

Nervous System

□ Seizures □ Limb Weakness □ Stroke □ Loss of Consciousness
□ Facial Weakness □ Stress □ Loss of Balance □ Unsteady Gait
□ Memory Loss □Slurred Speech □ Difficulty Concentrating □ ADD/ADHD

Psychological

□ Bipolar Disorder □ Anxiety □ Depression □ Behavioral Changes
□ Insomnia □ Convulsions □ Mood Swings □ Change of Appetite

Hematologic

□ Anemia □ Blood Transfusion □ Frequent Bleeding □ Blood Clotting
□ Bruising Easily

□ **Other symptom(s) not listed**

□**No symptoms**

Health Status:

On a scale of 1 – 10, how would you rate your overall **stress levels**?
No Stress ☺ □1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 **Most Stress** ☹

On a scale of 1 – 10, how would you rate your overall **nutrition and diet**?
Worst ☹ □1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 **Best** ☺

Are you on any dietary restrictions? □ Yes □ No Please describe: _____

On a scale of 1 – 10, how would you rate your overall health **today**?
Worst ☹ □1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 **Best** ☺

On a scale of 1 – 10, where would you **like** your overall health to be?
Worst ☹ □1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 **Best** ☺
How can we help you reach your health goals? _____

_____

Patient Initials: _____ Date: ____/____/_____

Assignment of Benefits

A. I, the undersigned (or my dependent), hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party that accepts assignment.
B. I authorize the payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to **Natural Life Chiropractic**. I authorize the direct payment to this office of any sum I now, or hereafter, owe this office by my attorney, out of proceeds of any settlement of my case, and by any insurance company contractually obligated to make payment to me or this office based upon the charges submitted for products and services rendered by Natural Life Chiropractic.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for products or professional services rendered will be immediately due and payable.
D. I understand and agree that payment will be due upon receipt of services rendered and any outstanding bills with no payments made will be sent to collections after 60 days.
E. This assignment will remain in effect until revoked by me in writing. Any photocopy of this assignment is to be considered as valid and original. I have read and fully understand this agreement.

Patient Signature: _____ Date: _____/_____/_____

Guardian Signature: _____ Date: _____/_____/_____

Advanced Beneficiary Notice of Non-Covered Services

PHYSICIAN NOTICE

I am being advised by this letter that my insurance company will only pay for services that it deems to be "medically necessary" and that are covered benefits. If my insurance company determines that a particular service, although it would be otherwise covered, is not medically necessary or a covered benefit, the insurance company will deny payment for this service. If these treatments are not covered, I understand Natural Life Chiropractic will bill me for payment of these services. If the insurance company does deny payment I agree to be personally and fully responsible for payment.

Patient Signature: _____ Date: _____/_____/_____

Patient Initials: _____ Date: ____/____/_____

Informed Consent to Examination and Treatment

Nicole-Marie Westbrook, DC, Maria Dorski, DC

I hereby request and consent to the performance of chiropractic treatments also known as chiropractic adjustments or chiropractic manipulative treatments, and any other associated procedures: physical examination tests, diagnostic radiographs, physical therapy procedures, electrotherapy etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

In our experience, the most effective treatment for spinal joint dysfunction involves manipulation of the spinal joints. Specifically, manipulation can reduce pain, tenderness, and muscle spasm and can improve the mobility of your spine, as well as many other beneficial effects. As with all other forms of treatment, manipulation of the spinal joints may have unwanted side effects of which you should be made aware. A very small percentage of patients (less than 1%) may experience discomfort after a manipulation, ranging from aching feeling of stiffness to actual soreness. This may, depending on the type of condition you have and for how long you have been experiencing it, be an expected consequence of the form of treatment. In the very rare instance (from 1 in 1 million to 10 in 1 million) serious neurological damage may occur as a result of this type of treatment and is not limited to fractures, disc injuries, stroke, dislocation, sprains, strains or unknown physical aberrations reasonably undetectable by the doctor.

We at Natural Life Chiropractic take every precaution in our diagnosis and treatment to minimize these unfortunate occurrences. Although we offer spinal manipulation with the utmost confidence in its proven benefits, you have the choice to decide not to have this type of treatment. There are other forms of treatment available to you here including soft tissue therapy, electrical therapy, and mobilization, among others. I do not expect the doctor to be able to anticipate or explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. Again, it is my responsibility to make it known any condition(s) I am suffering from which would otherwise not come to the attention of the doctor. I understand and accept that an undesirable result does not necessarily indicate an error in judgment.

I am authorizing Natural Life Chiropractic to proceed with any treatment deemed necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request. I intend for this consent to cover the entire course of treatment for my present condition(s) for which I seek treatment.

I have read the above statements and have had the opportunity to discuss this with my treating doctor and have any questions answered. I am of legal age of consent, of sound mind, and understand the risks to care. My signature below acknowledges my consent to examination, evaluation and proposed course of treatment by Natural Life Chiropractic.

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian or Representative Witness

Patient Initials: _____ Date: ____/____/_____

HIPPA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. **Your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment, and health care operations.**

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as radiologists that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Dr. Maria Dorski, DC.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

I have read the HIPAA Patient Consent Form. All questions I have regarding this policy have been answered.

Patient Signature _____Date _____/_____/_____

Guardian Signature_____Date_____/_____/_____

Patient Initials: _____ Date: ____/____/_____

Financial Policy

This is an agreement between **Natural Life Chiropractic** and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", "their", and "our" refer to Natural Life Chiropractic.

Assignment of Insurance Benefits: You authorize your insurance company(s), if any, to pay benefits directly to Natural Life Chiropractic.

Authorization: You authorize Natural Life Chiropractic, and their respective agents and contractors to contact you regarding your balance at the current or any future phone number that you provide for your cellular phone and other contact phone using automated telephone dialing equipment or artificial or pre-recorded voice or text messages.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in effect. You may receive a copy of this agreement upon request.

Insurance: Insurance is a contract between you and your insurance company. As a courtesy to you, we will verify your chiropractic benefits and file claims to your insurance company. Verification of your insurance is not a guarantee of benefits or payment. Your insurance company will make the final determination of your eligibility and subsequent payments. If you disagree with any verification or payment on your behalf, it will be your responsibility to pay your account balance in full. Any discrepancies will be handled between you and your insurance company. Any unpaid insurance balance over 30 days will be transferred to you and it will become your responsibility.

Payments: A payment is due to your account on the date of service unless other written arrangements have been approved. If there is a balance on your monthly statement, payment is due within 30 days unless other written arrangements have been approved. If no payment is made after 60 days or more, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay your balance in full in addition of up to 66.67% in collection fees.

Other: There will be a $30.00 fee assessed for all returned checks and a $25.00 cancellation fee at will of NLC for any no call/no show appointment or cancellation within 24 hours of scheduled appointment time.

I have read and understand the financial policy and agree to all terms and conditions stated herein. I agree to make payments on my account on each date of service. I also understand that if no payment is made on my account after 60 days, my account will be subject to be sent to a collection agency/attorney and agree to pay all costs/court costs incurred if such an event should happen.

Patient's Name: _____Guardian Name: _____

Patient/Guardian Signature: _____ Date: ____/_____/_____