WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

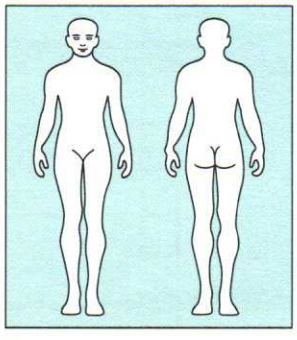
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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Sherwood Family Chiropractic

Dr. Jennifer Nienaber DC; Dr. Erica DePuydt DC; Dr. Nisreen Malik DC
Amanda Chaney LMT lic.# 15564; Michelle Johnson LMT lic.#: 21386 ; Ani Pugmire LMT lic.#: 23698
20508 SW Roy Rogers Rd, C-115 Sherwood, OR 97140 Ph: 503-906-3585 Fax: 503-906-3586

Office Policy

Patient(s) with no insurance:
Payments: "Time of Service" patients are receiving this rate when payment is paid on the date treatment was rendered. This rate cannot be honored if payment is not received the day of treatment. Any checks returned as **NSF are subject to a $25.00 fee per item**

Patient(s) with insurance:
All co-payments are to be paid at the time of service. This is Oregon Law, required by all Insurance Carriers. The insurance carrier may pay less than the actual bill for services. **I am aware and agree that all billings NOT covered or paid by insurance will be my responsibility.**

Missed appointments:
It is our office policy that there is a $25.00 fee for appointments canceled within 24 hours. There is a $50.00 missed appointment fee for chiropractic appointments, a $80.00 fee for a missed 60 minute massage, a $50 fee for a missed 30 minute massage, and a $100.00 fee for a missed 90 minute massage. These fees cannot be billed to your insurance carrier. This is patient responsibility, payable at the time of your next scheduled visit.

Supplement/Supports:
Payments for supplements, orthopedic supports, etc. are required at the time they are dispensed.

X-rays:
Should your provider determine x-rays are needed, you will be referred out to a radiology center to get them done.

Patient Phone Calls:
Please notify our office if you prefer we not confirm your appointments with an answering machine if unable to reach you directly. This is provided to you on our HIPAA Communication form.

Appointment times:
Appointment times are made to allow the daily schedule to move efficiently. If you are up to 15 minutes late for your scheduled appointment time your treatment time may need to be reduced, or for chiropractic visits you will most likely need to reschedule your appointment. We expect our staff members to treat each patient with courtesy and respect and we expect the same from our patients. We are here to assist you in your needs however we do not tolerate inappropriate behavior and engaging in such is cause for termination of care.

Massage Appointments:
Optional massage techniques that may be used during your appointment upon your verbal consent include Gua sha and cupping. Gua sha is a technique using plastic or ceramic tools. The tools are scraped along the skin in an effort to 'move blood' to treat pain, cold or flu. Gua sha can leave some marks or bruises (resembling 'road rash') in the area where the scraping is performed. It could possibly leave the area feeling sore. Cupping uses glass or plastic round 'cups' that act as suction devices. They are placed on the skin to bring blood to the surface and improve circulation to the area. This technique will leave round bruise marks in the area that are usually not painful. Gua sha and cupping are optional treatments and you are free to stop at any time.

I have read and understand all of the above.

_____

Patient or Responsible Parties Signature Date

Sherwood Family Chiropractic and Massage
Dr. Jennifer Nienaber DC; Dr. Erica DePuydt DC;
Amanda Chaney LMT lic.# 15564; Debbie Davis LMT lic#21663 Ani Pugmire LMT lic#23698
20508 SW Roy Rogers Rd C115 Sherwood, OR 97140 **503-906-3585**

INFORMED CONSENT FOR CHIROPRACTIC EXAMINATION AND TREATMENT

Patient Name: _____ DOB: _____ Date: _____

Chiropractic Examination

In order to provide an appropriate evaluation and treatment recommendations, a doctor will need to obtain a medical history from you and perform an examination. This examination will include palpation, where the doctor uses his hands on your spine, and/or other joints, and the surrounding soft tissue. Palpation allows the doctor to assess joint function and areas of subluxation. Your examination may also include other evaluations techniques such as: assessing your range of motion, orthopedic and neurological testing, imaging studies (like x-rays), obtaining your blood pressure and other relevant vital signs. Some portions of the examination may elicit or aggravate your pain or symptoms. It is important that you communicate all symptoms to the doctor and advise him/her if any portion of the examination causes you pain. All our patients are encouraged to ask questions before, during and after all aspects of the examination and subsequent care.

I _____ (print name), give my consent for examination.

_____ _____

Signature of Patient or Guardian Date

Chiropractic Treatment

Procedure: Chiropractic adjustment or manipulation is a manual procedure where the doctor uses his/her hands – or an instrument – to manipulate the joints of the body to restore or enhance joint function and mobility. You may hear an audible "pop" or "click" or feel or sense movement. Chiropractic care may include any of the following depending on your condition: chiropractic adjustments of the spine or other joints, manual muscle work such as massage, traction, ultrasound therapy, electric muscle stimulation (EMS), heat or cold therapy, the use of therapeutic exercise, cold laser light therapy and the use of nutritional counseling and supplementation. Your doctor will discuss with you a proposed treatment plan, which may at times be carried out by other doctors in the clinic or trained staff.

Risks: Chiropractic care, as in the practice of medicine and all healthcare, carries some risk during examination and treatment. Patients may experience temporary muscle soreness, inflammation, dizziness, worsening of symptoms with treatment, therapies or physical examination. Soreness following treatment, like that following exercise, should resolve within 24-48 hours. While the chances of experiencing serious complications are rare, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, burns or skin irritation from heat or other therapies, sprains/strains, disc injuries, dislocations or rib fractures following any manual technique. More serious complications are extremely rare. Vertebral artery dissection is associated with many neck movements, including chiropractic adjustments of the cervical spine. Current research indicates vertebral artery dissection is not caused by, but is associated with, cervical adjustment. According to some authorities, the association between cervical adjustments and vertebral artery dissection is one in a million (1 in 1 million). Vertebral artery dissections can lead to medical complications, including stroke. Additional information on side-effects, risks and complications is available upon request. If you have any unusual symptoms following treatment, you should immediately advise your doctor and seek care.

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INFORMED CONSENT FOR CHIROPRACTIC EXAMINATION AND TREATMENT

Patient Name: _____DOB: _____ Date: _____

Patient Participation: In order to provide you with the best recommendations and evaluate contraindications to care, it is critical you provide us with complete and accurate information about your medical history, symptoms, medications and changes in condition or symptoms. In some instances, it is important we coordinate your care with your other providers, and/or refer you to other specialists.

Alternatives: In addition to the alternative therapies offered by this clinic, other treatment options for musculoskeletal conditions may include rest, over-the-counter analgesics, prescription medications, injection therapies, acupuncture, physical therapy and surgery. Each of these actions carry their own sets of risks, some significant, and should be discussed in detail with your other healthcare providers. Remaining untreated may result in the formation of adhesions and reduced mobility, which can complicate future treatment and rehabilitation.

DO NOT SIGN BELOW UNTIL YOU HAVE MET WITH THE DOCTOR

I hereby acknowledge that I have provided complete and accurate information regarding my health history, medication and symptoms and will notify my doctor if there are any changes to same. I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I understand there is no guarantee or warranty for a specific cure or result. I hereby give my full consent to treatment.

Patient Name: _____Guardian Name: _____

_____ _____ _____
Signature of Patient or Guardian Date

PARQ and discussion completed with patient:

Doctor Name: _____ Interpreter if applicable: _____

_____ _____ _____
Signature of Doctor Date

Sherwood Family Chiropractic

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HIPAA Communications

Patient Name: _____ Date of Birth:_____

The communication can be delivered by the following (Please ✓ if permissible):

Appointment Message
___ Home Phone
___ Cell Phone
___ Text Message
___ Work Phone
___ With Someone Listed Below

Medical Information
___ Home Phone
___ Cell Phone
___ Text Message
___ Work Phone
___ With Someone Listed Below

Contact Information:
Home Phone #: _____
Cell Phone#: _____
Work Phone #: _____

I give permission to Sherwood Family Chiropractic staff to discuss with the following listed individual(s), information reasonably deemed to be directly related to such individual's involvement on the above referenced patients' health care.

Name:_____
Relationship to Patient:_____
Phone #:_____

Name:_____
Relationship to Patient:_____
Phone #:_____

Name:_____
Relationship to Patient:_____
Phone #:_____

Name::_____
Relationship to Patient:_____
Phone #: _____

Email Confidentiality Notice: Email transmission is not secure and should not be used for confidential or privileged communications. Because email can be altered electronically, the integrity of the communication cannot be guaranteed.

I understand that I may change the above information at any time. Any change requested does not affect any communication previously made in reasonable reliance on this form. I have had the opportunity to receive and read the Sherwood Family Chiropractic Notice of Privacy Practices.

_____ _____ _____

Patient Name **(Printed)** Patient Name **(Signature)** Date

SHERWOOD FAMILY CHIROPRACTIC CLINIC

Dr. Jennifer Nienaber DC, Dr. Erica DePuydt DC, Dr. Amanda Cochran DC
20508 SW Roy Rogers Rd C115
Sherwood, OR 97140
503-906-3585

AUTHORIZATION FORM AND HIPAA REGULATIONS

This certifies that I have read and understand the information offered to me to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I UNDERSTAND THAT MY CHIROPRACTIC INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

I ALSO CERTIFY THAT I HAVE BEEN OFFERED OR READ AND UNDERSTAND THE OREGON HIPAA REGULATIONS.

I am also aware that I can seek treatment from another health care provider for my current complaint if I opt to do so.

_____ _____

Signature of Patient (or legal guardian of a minor) Date