FORTIER CHIROPRACTIC HEALTHCARE

Auto Accident ▪ Work Injury ▪ Back Pain ▪ Headache▪ Sports Injury

220 Fifth Avenue SW Albany, OR 97321 Ph.(541) 926-0510 Fax(541) 926-5540
www.fortierchiropractic.com

Date _____

CONFIDENTIAL NEW PATIENT REGISTRATION

Thank you for choosing our practice for your health care needs. Please complete this form in ink.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help!

Is this visit: ❑Routine ❑Auto Accident ❑Work Injury ❑Other If Accident, DOI ____/___/_____

DOB _____/_____/_____ **Age** _____ **Sex: ❑M ❑F**

Name _____
Last First Middle Initial

Address_____
Street Apt# City State Zip

Phone: ❑ H (_____) _____–_____ **❑ W** (_____) _____–_____ **❑ C** (_____) _____-_____

Marital Status: **❑M ❑W ❑S ❑D ❑Sep** **E-mail Address**: _____

Appointment Reminders Via ❑Email ❑Phone Call ❑Text (*Phone Carrier* _____)

Employer/Occupation _____

Address_____ **Phone #** _____
Street City State Zip

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY INFORMATION

❑ SELF or ☐ Name (Guarantor)_____
Last First Middle Initial

Address _____
Street City State Zip

Relationship to Patient _____ **Phone #** _____

Emergency Contact _____

Relationship _____ **Phone #** _____

*****Please notify our front office staff if there is an alternate address/phone number or form of communication that you wish us to contact you by other than your listed information above.***

6/1/2018 Rev

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PATIENT INFORMED CONSENT FORM

I, the undersigned, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapies, massage, therapeutic exercise, and physiological therapeutics (e.g. vitamin/mineral supplements, botanicals, homeopathic preparations, etc.), on me (or the patient named above, for whom I am legally responsible) by the Chiropractic Physicians of Fortier Chiropractic Healthcare, P.C. who now or in the future treats me in the office.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some rare risks to treatment, including but not limited to sprain and strains, fractures, strokes, general aggravations of inflammatory conditions, nutrient-drug and nutrient-nutrient interactions. I understand that I will have the opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that the doctor will perform an exam in order to minimize any risk of care; however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise professional judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, is in my best interest. Finally, I understand that the doctor, as with any therapeutic procedure, can give no guarantee or assurance as to the results of the procedure.

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 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 read the following carefully and initial each statement.

____ I understand that Fortier Chiropractic Healthcare is an integrated healthcare clinic. As coordinated care is an important mission of this clinic, there may be times when I am asked to have other physicians observe my care. I understand that I do have the right to refuse observation on any given day.

____I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.)I should discuss this with the doctor because it may affect my care.

____I understand that I play an important role in my own healthcare. Just as a patient can choose to discontinue care at any time, Fortier Chiropractic physicians reserve the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

_____ Date:_____
Patient's/Guardian's Signature

_____ Date:_____
Doctor's Signature

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Your Protected Health Information will be used by Fortier Chiropractic Health Care, S-Corp or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Print Patient's Full Name

Text Messaging & Emailing

_____ I hereby consent and state my preference to have Fortier Chiropractic Healthcare communicate with me by

(initial) email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

Notice of Patient Privacy Policy

HIPAA

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

I have been given a copy of the Notice of Patient Privacy Policy.

_____ _____

Patient or Legally Authorized Individual Signature Date

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PATIENT FINANCIAL POLICY

The goal of Fortier Chiropractic Healthcare is to render care within our realm of expertise to stimulate your innate ability to heal. We will always give 100% of our energy to accomplish this and will do our best to prevent financial constraints from interfering with your ability to receive this care. To prevent misunderstandings about the financial aspects of care, the following discloses our financial policy.

PATIENTS WITH HEALTH INSURANCE COVERAGE

During your visit with us, we will verify your insurance coverage to see if chiropractic (and if necessary, out-of-network) care is covered and any limitations that exist. We will explain this to you, and then bill the insurance for the services provided. You are expected to pay your "co-pay" &/or "co-insurance (the portion that your insurance doesn't cover) **on the date of service.** Please note: The "co-insurance" is a said percentage of your insurance company's allowable fee schedule and differs between insurance policies. Because of this, the amount FCHC collects at time of service is only an **estimate.** You will be notified by FCHC if further payment or refund is in order.

If, for some reason, your insurance does not pay for a particular visit, those charges are then your responsibility. It is therefore prudent for you to understand your insurance policy and contact your insurance promptly with any questions or problems. However, we do reserve the right to no longer bill your insurance company, if that company is unreasonably hard to work with.

PATIENTS PAYING OUT OF POCKET/ "CASH" PATIENTS

Cash, checks, and credit cards are accepted and payment is expected at the time of service. In this case, we offer a "date of service discount" due to the reduced administrative cost and handling. However, this does not include supplies or supplements. Legally, we can only grant this discount if the patient pays prior to or on the day of service.

If you are unable to pay at the time of service, we will be unable to give you the discount and you will be charged the full price due to the administrative costs and handling of your account.

PATIENTS WITH AUTO/WORKER'S COMPENSATION CLAIMS

For patients under care relative to an automobile accident or injured on the job, insurance will cover the cost of care in nearly all cases. We are required to bill *your* auto insurance (or the insurance of the driver of the vehicle in which you were riding) or your WC insurance. Nutritional supplements and some orthopedic equipment, if recommended, are typically not paid for by insurance and are the patient's financial responsibility.

If and when your insurance discontinues paying for your treatment, you are then responsible for payment of your care. If necessary, a monthly payment plan may be arranged. If you decide to get legal aid, we will hold payment until settlement of your claim as long as you are using one of the attorneys we strongly recommend.

OUTSTANDING BALANCE POLICY

Patients will receive a monthly fee of **$50** if their account has a balance that is 90+ days overdue and no payments are being made on it. Overdue accounts will not receive this fee if regular payments are being made to the account. If no payment is made after 180+ days, we unfortunately will need to send the account to collections. All "*bounced checks*" receive an administrative correction fee of **$25** per occurrence. Please speak to the office manager, if you have any concerns regarding this policy.

** I have been informed of and understand this financial policy and agree to its terms. I understand that unless specific arrangements are made with Fortier Chiropractic Healthcare, I am responsible for any balance acquired on this account. I understand that if I discontinue care, all charges are due and payable immediately.*

Patient's Signature	Patient's Printed Name	Date

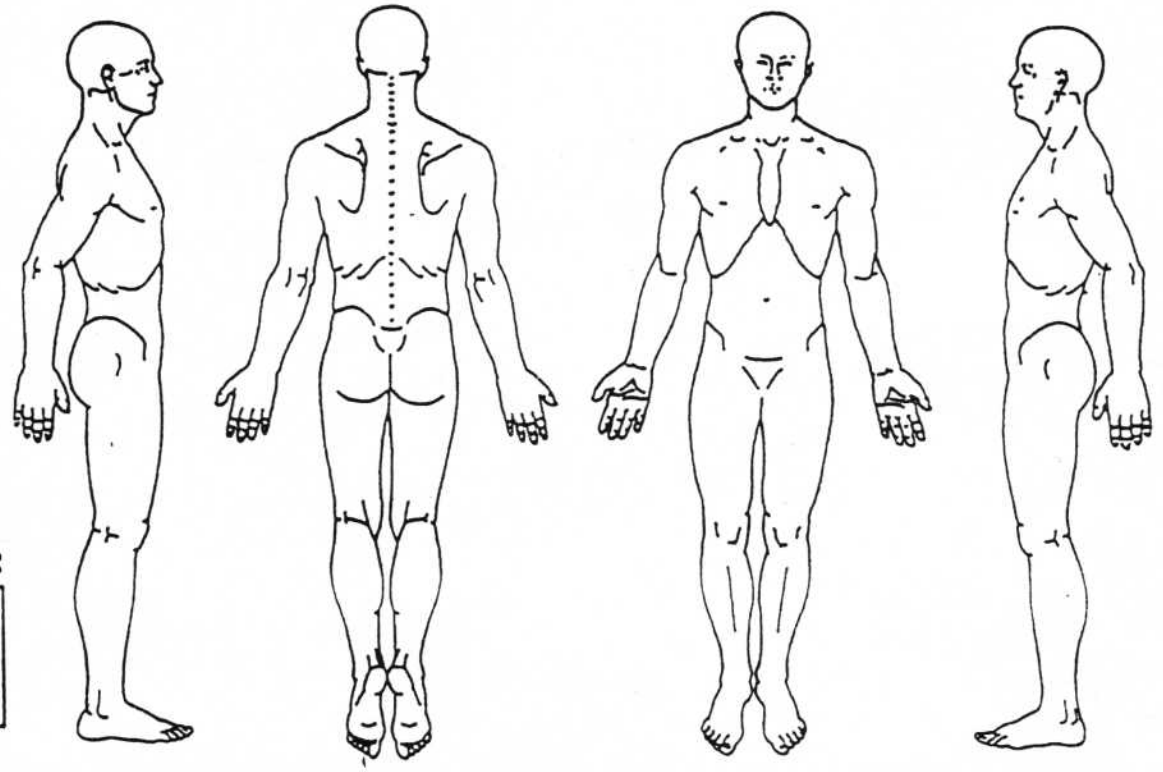
PATIENT RECORD

Name _____ **Date** ___/___/___ **Time** _____

Please use the following key to accurately mark the figures below in which you feel the described sensations. Use the appropriate symbols and mark all affected areas.

Dull Ache NNN **Stabbing/Cutting** /// /// ///, **Burning** XXX

Numb = = = **Tingling (Pins & Needles)** :::: **Cramping** SSS



OFFICE USE

☐ 1
☐ 2-5
☐ >5

Please place one mark on the line below to indicate your present pain level.

No Pain ├──────────────────────────────────────┤ Worst Pain Ever

Using the scale of 0 to 100, with 0 = no pain and 100 = worst possible pain, please write the number indicating your present pain level in the box at the right: ☐

Patient's Signature _____

OFFICE USE

☐ OSWESTRY ☐ NDI ☐ DPQ

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Patient Health History

Name: _____ **Date of Birth**: _____**Date:**_____
Height: _____ **Weight:** _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1._____

2._____

Please list ALL prescription medication you are taking and WHY:

Symptoms developed from: □ Work □ Auto Accident □ Other _____
When did it occur? **Is it getting worse?** Y / N
Have you ever had these symptoms before: Y / N **If yes, when?**
Symptoms: □ come and go □ Constant □ nearly constant
Symptoms are worse: □ morning □ afternoon □ evening □ unchanged
(Women) Are you pregnant? Y / N **Taking birth control?** Y / N
Occupation:
What activities make symptoms worse? □ Bending □ Lifting □ Laying Down □ Reaching □ Sitting □ Standing □ Straining at Stool □ Walking □ Other_____
What activities make symptoms better? □ Bending □ Heat □ Ice □ Lifting □ Laying Down □ Reaching □ Turning Head □ Walking □ Other
Symptoms feel like: □ Deep/dull □ Sharp □ Stiffness □ Shooting □ Numbness □ Tingling □ Burning □ Cramps □ Swelling □ Catching/locking □ Popping/clicking □ Electrical
Have you seen a Chiropractor before? Y / N **If yes, when?**
Doctor Previously See for THIS condition:
Name of primary care physician: **Clinic/City:**

Please check any <u>ADDITIONAL</u> symptoms you may be experiencing

❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

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Past Health/Family Health History

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No
Describe Condition_____ Date of Last Physical Exam_____
Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

SURGICAL HISTORY: 1._____Date:_____
2._____ Date:_____
3._____ Date:_____

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____ Date:_____ Resolved: Y / N
❑Job ❑Auto ❑Other 2._____Date:_____ Resolved: Y / N

Habits	None	Light	Mod.	Heavy
- Alcohol				
- Drugs				
- Tobacco				
- Exercise				

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father
(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS/HIV	❑	❑	❑	fibromyalgia	❑	❑	❑	Parkinson's Disease
❑	❑	❑	anemia	❑	❑	❑	headaches	❑	❑	❑	poor circulation
❑	❑	❑	arthritis	❑	❑	❑	heart trouble	❑	❑	❑	rheumatic fever
❑	❑	❑	asthma	❑	❑	❑	hepatitis	❑	❑	❑	rheumatism
❑	❑	❑	back pain	❑	❑	❑	herniated disc	❑	❑	❑	rheumatic arthritis
❑	❑	❑	bladder trouble	❑	❑	❑	high blood pressure	❑	❑	❑	scarlet fever
❑	❑	❑	bone fracture	❑	❑	❑	high cholesterol	❑	❑	❑	scoliosis
❑	❑	❑	cancer _____	❑	❑	❑	kidney disorder	❑	❑	❑	serious injury _____
❑	❑	❑	chest pain	❑	❑	❑	bowel control loss	❑	❑	❑	stroke
❑	❑	❑	concussion	❑	❑	❑	lung disease	❑	❑	❑	_____
❑	❑	❑	convulsions	❑	❑	❑	multiple sclerosis	❑	❑	❑	_____
❑	❑	❑	deceased	❑	❑	❑	neck pain	❑	❑	❑	_____
❑	❑	❑	diabetes	❑	❑	❑	osteoporosis	❑	❑	❑	_____

This Space Is for Clinic Use Only:

Radiating Pain: Y / N Change in B & B Sx: Y / N Past Medical Hx Contributory: Y / N