Welcome to Back In Shape Chiropractic

Please write as clearly as possible. If you need help, please let us know.

Patient Information Date__________

Legal Name______________________________

Address ____________________ ______________ ______ __________
Street City State Zip

Sex ☐ Male ☐ Female Birthdate____________ Age________

Patient Social Security #_______________ Driver's License#____________ ☐ Verified

☐Single ☐Married ☐Widowed ☐Divor /Sep. Spouse/Partner Name________________

Occupation________________ ☐ Full Time ☐ Part time Employer_______________

Hobbies/Interests(optional)____

How did you here about our office:
☐ Phonebook ☐ Insurance Company List ☐Sign ☐ Internet(how)________________
☐ Advertisement____________ ☐ Patient Referral_____________ ☐Other_____________

Contact Information

Home Phone__________________ Mobile Phone_______________

Work Phone__________________ E-mail_______________________
For Newsletter and Special Offers

Please let us know if we should not leave messages at any of the above numbers.
Emergency/Other Contact
Name_________________ Relationship____________ Phone_______________

Insurance Information(You do not need to fill out if we have copied your card.)

Primary Insurance Company______________________________ ☐ Health ☐ Auto ☐ Work

Subscriber Name(if other than patient)__________________DOB_________SS#__________

Phone #____________________

ID #/Claim#__________________ Adjuster/Caseworker Name & Phone__________________

Other Insurance______________________ Phone#___________ID#_________________

Kevin M. Segal, D.C. 6501 SE King Road, Milwaukie, OR 97222 (503)788-3800

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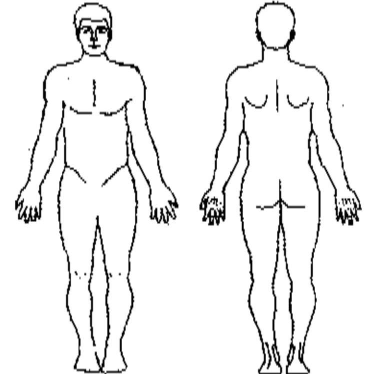
MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

____

____

____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: ______________________________

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe) ______________________________

____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** ____________

WHAT AREAS WERE TAKEN? ______________________________

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births ____________
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date) ____________	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications: ____________
☐	☐	Cancer/Tumor			____________
☐	☐	Osteoporosis			____________
☐	☐	Recent Trauma			

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ______________________________ **Date:** ______________________________

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score ________

Name ______________________________

PRINTED

______________________________ ________________

Signature **Date**

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www.chiroevidence.com

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CONSENT TO TREATMENT FORM

To our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy, traction, prescribed home care, massage, 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 chance of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that, regardless of payment for services, as with most medical treatments there is no guarantee or warranty for a specific cure or result.

________________________ (Signature)

________________________ (Today's Date)

Patient's Statement of Privacy Rights

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.

2. You are entitled to see your medical records.

3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPAA, there is a fee for this service.

4. You are entitled to make an amendment to your patient health information within those records.

5. While the doctor has a right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.

6. You have the right to specify how access to your health information is restricted and from whom.

7. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.

8. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.

9. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.

10. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing that standard.

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

______________________ ______________________________ __________

Patient Name Signature Date

BACK IN SHAPE CHIROPRACTIC CLINIC FINANCIAL POLICY

All services/supplies received at this office are your financial responsibility.
We accept cash, check, debit and credit card payments.
All supplements/vitamins, supports and other supplies must be paid for when received.
Generally, maintenance/preventative care is not covered by insurance.
All payments are due at the time of service, unless other arrangements have been agreed upon. ***We do offer a payment at time-of-service discount of $15 off your total fees and an additional discount for massage services.***

Health Insurance/Medicare & Supplemental or Secondary coverage

It is always your responsibility to know the specifics of your coverage; What your benefits are, deductibles, co-payments, which modalities are covered, etc. We will call to verify your coverage, but this does not guarantee any specific payments. We will take any contracted discounts that we are required to. You understand and agree that any fees for procedures/tests not included in your plan are your responsibility. This may include massage, electric stimulation, etc. All co-pays and amounts subject to deductible will be due at the time of service, but please keep in mind that these are sometimes estimated, and you may have additional financial responsibility once we hear back from your insurance(this can sometimes take months). As a courtesy to our patients, we will bill(and re-bill) your insurance company for you. Please keep in mind that if there is a discrepancy, we will let you know as soon as possible, but you may have to call your insurance company to help obtain payment. **Medicare** covers the adjustment only for a specific problem or injury, nothing else. Exams and additional tests & modalities are your responsibility. If you have supplemental or secondary coverage, we will attempt to bill your insurance(this sometimes takes awhile as we may have to wait for a denial from your primary insurance), but if payment to us is not made, you will be responsible for your balance.

Workers Compensation Claims

All workers compensation cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out and a claim Is filed. If the claim is filed improperly or denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, you are then responsible for prompt payment of your account balance. It can take 30 days or more from filing to accept/deny your case, so we me not immediately know if your insurance will pay.

Personal Injury/Motor Vehicle Accidents

Personal injury and auto accident treatment charges will be billed to your auto insurance company through your PIP coverage, providing that a claim has been filed and the appropriate paper work has been done. You may have to return additional paperwork to your insurance company for your claims to be paid. Keep in mind we do not do third party billings to other insurance companies. If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service. Generally supplements/vitamins, lab work, supports and other supplies may not be covered by insurance companies and may be your responsibility. You are immediately responsible for any and all charges not paid by your auto insurance company.

Assignment Of Benefits and Release Of Information

As the patient whose name appears below, I hereby authorize Dr. Kevin Segal, D.C. to file on my behalf for payment of any medical benefits arising out of any insurance covering me and hereby assign the benefits to Dr. Kevin Segal, D.C. for application on the patient's bill. I further authorize the release of necessary information, including medical information, for this or any related claim of medical benefits. I permit a photocopy of this authorization to be used in place of the original.

You are responsible for timely payment of your account. Patient balances are due 30 days after any insurance EOBs are received at our office. Balances over 60 days are subject to a $10 statement re-billing fee for each monthly statement sent to you. Unpaid balances over 90 days old may be sent to collections and all collection agency costs and interest(12% APR) on your balance will be added to your account charges.

There will be a $30 fee charged to your account for missed appointments not cancelled or rescheduled at least 4 hours in advance. Insurance will not pay this fee.

I have thoroughly read in its entirety, understand and agree with the above financial policy and its terms for all case types.

____
Patient Name Printed

______________________________ ________________
Patient Signature Date