# Live Well Chiropractic and Massage
## Confidential Patient Information and Health Intake

### PATIENT INFORMATION

Name:_____Today's Date:_____
(First, Middle, Last) (Nick Name)

Date of Birth: _____ Age: _____

Address: _____ Apt.#_____

City: _____ State: _____ Zip Code: _____

Cell Ph:_____ Email: _____

Gender at birth: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How did you find our clinic? ☐ Referral Who? _____ ☐ Internet ☐ Location ☐ Other _____

### EMPLOYMENT INFORMATION

Check all that apply: ☐ Employed Full Time ☐ Employed Part Time ☐ Stay at home parent
☐ Full time student ☐ Part time student ☐ Unemployed

Employer:_____

Job Title:_____

### EMERGENCY CONTACT

Name: _____Relationship:_____Telephone #: _____

### PAYMENT INFORMATION

(Check all that apply): ☐ Health Insurance ☐ Health Saving Account ☐ Flexible Savings account

☐ Cost Sharing Membership ☐ Self Pay

### PLEASE CHECK ALL REASONS FOR PURSUING CHIROPRACTIC CARE

☐ I have never been to a chiropractor before
☐ I'm continuing ongoing care from another chiropractor
☐ I have a specific condition that concerns me.
☐ I'm interested in wellness and natural health care.
☐ I'm concerned about my health and I'm looking for answers.
☐ I have no idea why I'm here. Please take the time to explain to me what you do.

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### CURRENT COMPLAINTS

List up to 3 problem areas below in order of severity and circle the frequency and severity of each problem:

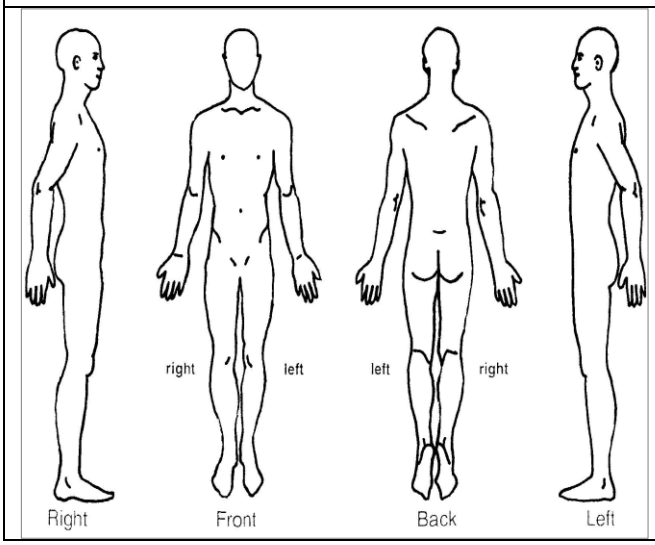
1) _____ Severity: Mild - Moderate - Severe
Frequency : Rare - Intermittent - Frequent - Constant

2) _____ Severity: Mild - Moderate - Severe
Frequency : Rare - Intermittent - Frequent - Constant

3) _____ Severity: Mild - Moderate - Severe
Frequency : Rare - Intermittent - Frequent - Constant

Please indicate the location of your pain/symptoms on the diagram below. Use the symbols to best describe the type(s) of pain/symptoms you have:

D= Dull Ache
T= Tingling (Pins & Needles)
S = Sharp
N= Numbness
B= Burning
Z= Stiffness / Tight




Tell us more about your complaint(s) if needed.
When did each begin? What happened?

_____
_____
_____
_____
_____

Have you had this or similar conditions in the past?

☐ No ☐ Yes When?: _____

Have you seen any other healthcare providers for this condition?

☐ No ☐ Yes Who?_____

Have you had X-Rays, MRI, Etc. for this condition?

☐ No ☐ Yes,
How long ago? (estimate)_____

Is this condition interfering with your: ☐ daily routine ☐ work ☐ sleep? Explain _____

What actions/movements aggravate your symptoms?_____

What makes your symptoms feel better? _____

Have you tried medication? ☐ Yes ☐ No Does medication help?_____

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### PERSONAL HEALTH HISTORY

List any serious accidents or injuries you have had:

_____

Medications including over the counter you are currently taking:

_____

Have you been hospitalized for any reason? ☐ Yes ☐ No If yes, for what? _____

List any serious illness/conditions (including cancer) you currently have or have had:

_____

Have you had any surgeries? ☐ Yes ☐ No If yes, for what?_____

PREVIOUS HEALTH PROBLEMS: Please circle any of the following you have had or presently have:

| | | | |
|---|---|---|---|
| ☐ Fractured Bones | ☐ Joint Replacement | ☐ Cervical Whiplash | ☐ Knocked Unconscious |
| ☐ Slipped Spinal Disc | ☐ Spinal Surgery | ☐ Spinal Taps | ☐ Osteoporosis |
| ☐ Pacemaker | ☐ Stroke | ☐ Heart Disease | ☐ Convulsions/Seizures |
| ☐ Diabetes | ☐ Fainting | ☐ Alcoholism | ☐ Cyst |
| ☐ Dislocations | ☐ Metal Screws/Implants | ☐ Concussion | ☐ Ruptured Spinal Disc |
| ☐ Pinched Nerve | ☐ Spinal Injections | ☐ Scoliosis | ☐ Electronic Implant |
| ☐ High Blood Pressure | ☐ Aneurysm | ☐ Lung Disease | ☐ Dizziness |
| ☐ Memory Lapse | ☐ Birth Defects | ☐ Tumor | ☐ NONE OF THESE |

Family health history: (describe any conditions/diseases suffered by family members) :

_____

### HEALTH HABITS

Do you exercise? ☐ NO ☐ YES How often?_____ ☐ Walking ☐ Running ☐ Weights ☐ Pool
☐ Home Exercise ☐ Membership to Fitness Facility

Work environment? ☐ Sitting all day ☐ Standing all day ☐ Combo of sit/stand ☐ Heavy Lifting ☐ Repetitive Motions

Do you smoke? ☐ NO ☐ YES Packs/day_____
Do you drink alcohol? ☐ NO ☐ YES Drinks/day_____
Do you use recreational drugs (*your answer is confidential) ? ☐ NO ☐ YES Which?_____

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### LIFESTYLE STRESS PATTERNS

List or circle the **physical** stresses you are under (excessive sitting, standing, repetitious movements, contact sports)

_____

List or circle the **chemical** stresses you take in (meds, cleaning solutions, pesticides, preservatives, recreational drugs)

_____

List or circle the **emotional** stresses in your life (depression/anxiety, relationship conflicts/abuse, work stress, spiritual stress, family stress)

_____

### GOALS FOR MY CARE

Please check all reasons that apply:

☐ **Relief Care**: Symptomatic relief of pain or discomfort.

☐ **Corrective Care**: Correcting and relieving the cause of the problem as well as the symptoms.

☐ **Wellness Care**: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, have any changes in health.

Patient Signature: _____ Date: _____

Parent Signature (if applicable): _____ Date: _____

# Live Well Chiropractic and Massage

## Privacy Policy and Informed Disclosure and Consent

### Informed Consent for Care

All health care treatments carry the possibility of complications. Dr. Nathan Edmonds has informed me of the possible risks of chiropractic manipulation and related treatment, and I understand these risks. I have discussed treatment options and their associated risks and benefits with the doctor and all of my questions have been answered. The doctor has recommended chiropractic manipulation and related treatment. I understand the risks and choose to follow his recommendations. Further, I request and give my consent for chiropractic manipulation, massage therapy and related treatment. I intend for this consent to cover all treatments now and in the future by the doctor or any other provider he appoints to administer treatment. I do not expect the doctor to be able to explain all risks and complications. I choose to rely on the doctor to exercise judgment that is in my best interest during treatment.

### Notice of Privacy Practices and Disclosure of Protected Health Information

In the course of your care as a patient at our office we may use or disclose personal and health related information about you in the following ways: 1) Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment of treatment. 2) Your health records as well as your billing records may be disclosed to another party, such as insurance carrier (HMO, PPO, etc.) or your employer (if they are responsible for payment). 3) Your name, address, phone number, and your health records may be used to contact you regarding appointment reminder, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

* If we are providing health care services to you based on the orders of another health care provider.
* If we provide health care services to you in an emergency.
* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to.
* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. By signing below, I acknowledge that I have read the above information and give full disclosure of my information.

### Consent of Professional Services and Release of Information

*I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care, massage therapy or any clinic services that he/she deems necessary in my case; and further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies, workers compensation carriers, welfare funds or the patients' employer.*

Patient Name: _____

Patient Signature: _____ Date: _____

Parent's Signature (if applicable): _____ Date: _____

Live Well Chiropractic and Massage - Dr. Nathan Edmonds DC
20229 Highway 213 Oregon City OR 97045 Office | 503.342.2719 Fax | 503.305.3263

# Live Well Chiropractic and Massage

## Payment Policy and Patient Agreement

Thank you for choosing Live Well Chiropractic. We will do our best to provide you the highest quality chiropractic service. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following financial policy prior to your treatment. Should you have any questions, feel free to ask.

Your insurance is an agreement between you and your insurance company. Insurance coverage varies greatly and we cannot be certain that your policy will cover the services we provided in our office. ***While our office can call and verify your insurance over the phone, it is not a guarantee of payment and most insurance companies do not cover 100% of services rendered.*** The chiropractor may utilize any of the above procedures, separately or combined, at any time during the course of treatment, which may incur additional charges. It is to be understood and agreed that all services rendered to you and your family are your personal responsibility and you are personally responsible for payment of any non- covered services, deductibles, co-pays and co-insurance.

The following prices are estimates and can change without notice. Prices ranges start with "Time of Service" rates, and represent prices when paid at the time of the appointment. Your insurance (if applicable) may or may not cover a portion or even all charges depending on your policy.

Professional Fee Statement

| | |
|---|---|
| Comprehensive Orthopedic/Neurological Examination | $75 - 210 |
| Adjustments | $55 - 78 |
| Massage Therapy (per unit) | $40 - 52 |
| X-Rays (per region) | $75 - 145 |
| Modalities | $15 - 25 |
| Exercise/Rehab Procedures | $38 - 58 |

**Personal Injury (Auto Accident)**

I understand that I am financially responsible for securing any necessary medical payment plan policy in the event that my care is due to a motor vehicle accident, or any other third party responsibility. I intend to pay 100% of usual and customary fees, and I understand that any monies obtained in settlement will go toward any outstanding balances for care provided at this office.

**Insurance Policy Coverage**

I understand that I am financially responsible for any applicable deductible, co-insurance, or co-pays associated with my policy. Should services be denied, the usual & customary fee schedule listed above should apply. I understand that having insurance does not ensure that my carrier will pay for my chiropractic care. I acknowledge that my plan may have certain restrictions with regard to yearly visit limits, capitated amounts of coverage, etc. I understand that my carrier and I have a contractual agreement and that my provider may or may not be in network with any given insurance plan.

**Medicare**

I agree to pay for any necessary co-pays, and/or deductibles associated with my care. I understand that these insurance plans may deny payment for chiropractic services based on their opinion of 'medical necessity'. I agree to pay any outstanding balances that may result should my policy or supplemental carrier elect to not provide payment for services. Further, I understand that these plans only cover the manipulation, and any other exams/X-rays/therapies/modalities that I receive will be my financial responsibility.

**Assignment of Benefits:**

Authorization to Pay Benefits to Physician/Office (Statement): *I hereby assign payment directly to Live Well Chiropractic for any and all procedures and treatments provided, if any, otherwise payable to me for services provided, but not to exceed the indebtedness to Live Well Chiropractic for those services. I understand that I am financially responsible for charges not covered by my insurance.*

**Massage Cancellation/No-Show Policy**

Cancellations without charge are accepted any time before the close of business on the business day preceding your appointment. This allows the opportunity for someone else to schedule an appointment. If an appointment is not cancelled within this time, a charge of the full appointment price will be applied. A charge of the full appointment price will be applied to scheduled appointments that are either forgotten or unable to be met. This amount must be paid prior to the next scheduled appointment.

My signature below signifies my agreement and understanding with Live Well's Payment Policy and Patient Agreement.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent's Signature (if applicable): _____ Date: _____

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