CENTRAL OREGON CHIROPRACTIC
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Redmond, OR 97756
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Info@CentralOregonChiropractic.com

Date ____-____-_____

Full Name:_____ Gender: □M □F Birth Date:_____

Address:_____ City:_____ State: ____ Zip:_____

Home Phone: _____ Cell: _____ Cell Provider (for txt reminders):_____

E-mail: _____SSN#_____

Employer: _____ Occupation: _____

In case of emergency, contact: _____Relationship: _____

Primary phone number:_____ Secondary number: _____

Who may we thank for referring you?_____

Patient Health Information (PHI) Privacy Agreement

The patient understands and agrees to allow Central Oregon Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. Central Oregon Chiropractic staff has been trained in the area of protecting PHI. Precautions have been taken to assure patient records are not available to those who do not need them. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. Patients have the right to file a formal complaint with Central Oregon Chiropractic about any possible violations of these policies and procedures.

I understand that receiving PHI via email may not be secure, however, I would prefer email correspondence on all PHI between myself and Central Oregon Chiropractic: **□Yes** **□ No**

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient/Guardian Signature:_____ Date: _____

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including massage therapy and various modes of physical therapy by Dr. Kent Rookstool, DC, and his Chiropractic Assistant(s). I have had the opportunity to discuss with the doctor and/or with clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments offered at Central Oregon Chiropractic. Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment, which include but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient/ Guardian Signature:_____ Date: _____

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X-Ray Consent Form

Patient Name: _____ Date: _____

In the event that X-Rays are recommended by Dr. Rookstool, I hereby authorize the performance of diagnostic x-rays. At this time, I know of no other condition which the taking of x-rays would further complicate and I consent to having diagnostic x-rays performed.

With full understand of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed in the Present and/or future if requested by the doctor.

Female Patients Only:

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor or certified staff of Central Oregon Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant □ Yes □ No

I could be pregnant □ Yes □ No

I am late with my menstrual period □ Yes □ No

With full understand of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed today if requested by the doctor.

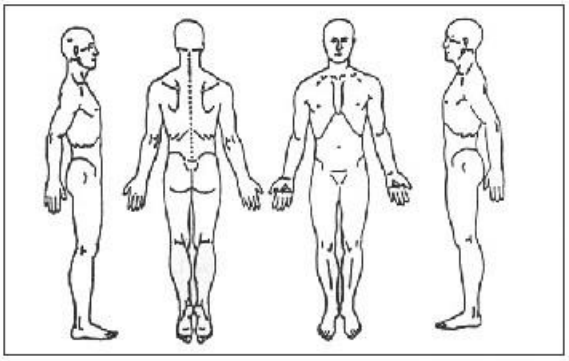
Patient/Guardian Signature: _____ Date: _____

What brings you in today?_____

_____

Please mark the diagram with the abbreviations listed below to indicate your symptoms.

S = Spasms
H = Shooting Pain
P = Sharp Pain
D = Dull Pain
F = Stiffness
T = Tingling
N = Numbness



Does anything help to relieve your symptom(s)? □ Ice □ Heat □ Stretching □ Pressure/Massage □ Rest □ Exercise □ Sitting □ Standing □ Lying down □ Medication □ Other _____

What makes your symptoms worse? □ Sitting □ Standing □ Walking □ Lying □ Bending □ Stretching □ Lifting □ Twisting □ Reaching out □ Other _____

What activities, if any, is your pain interfering with? □ Work/School □ Sleep □ Recreation □ Daily Routines □ Other _____

Current **medications, vitamins**, etc.	Taking for:

List and describe any **surgeries and hospital stays** (please give approximate dates) _____

_____

_____

_____

Please list all **broken bones and sprains**: _____

_____

_____

Do you have a primary care physician? □ No □ Yes (Who? _____)

Do you give consent for us to share your treatment progress with the above providers? □ No □ Yes

Functional Rating Index

For use with Neck and/or Back Problems only.

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 one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worse possible pain

2. Sleeping

Perfect Sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

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.)

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

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

No pain	Mild pain	Moderate pain	Severe pain	Worse possible pain

7. Frequency of Pain

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

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

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

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

Name: _____ **Total Score:** _____

Signature:_____ **Date:**_____

Family Health History

Patient Name _____ Date _____

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	Self Age___	**Father** Age___	**Mother** Age___	**Spouse** Age___	**Brother**(s) Age____	Age____	**Sister**(s) Age____	Age____	**Children** Age____	Age____
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										

CENTRAL OREGON CHIROPRACTIC

Financial Policy

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to your health and well-being. Payment is due at the time of treatment. We accept several methods of payment including cash, check, major credit/debit cards (Visa, MasterCard, Discover)

All account balances are to be paid promptly. If a balance has exceeded $200.00 or existed over 90 days, your privilege to schedule appointments will be suspended until the account is current. In the event of unforeseen circumstances, please communicate with our office to arrange and sign a payment plan.

Missed Appointment Policy: Your appointment time is reserved for you; please arrive on time to maximize your time with the doctor. Please give 24 hour notice if you are unable to keep your appointment, or a $25 fee may be applied to your account.

If you have questions on your suggested treatment plan or the available payment options, please do not hesitate to ask. We are here to help you!

Please sign your initials in the box next to the category that applies to you. This indicates that you have read and clearly understand your situation and obligations.

□ **General (Non-insurance):** Fees are to be paid at the time of service, unless special arrangements have been made in advance. After your initial new patient office visit, your typical charges will be based on the treatment plan you accept from the doctor's recommendations. This may include an adjustment, therapies, exam fees, and/or other supportive care.

□ **Treatment Packages:** Purchase a bundle of treatments and save! Some packages may be used as a family plan also. You must have a signed Treatment Package Agreement on file to use this option.

□ **Group/Private Insurance:** Central Oregon Chiropractic will verify your insurance coverage as a courtesy, but as your insurance company cannot guarantee payments based on quoting your benefits, neither can we. You are responsible for ALL deductibles, co-payments, coinsurances, and non-covered therapies at the time of service. When necessary the fee will be estimated and you will be billed/refunded the difference when your insurance issues payment. All payments must be made in accordance with your agreement with your insurance provider and our agreement with your insurance provider (if any exists); this includes you being personally responsible for payment should you reach your benefit maximum or should any lapse in coverage occur.

□ **Medicare:** This office has contracted with Medicare to accept assignment. This means we bill Medicare for your adjustment fee. Medicare pays for adjustment fees only, not therapies and exams. You are responsible for deductibles and co-payments according to Medicare guidelines, and any other service you accept as part of your necessary treatment. If you have a secondary insurance, Medicare will forward your claim under the Medigap policy.

□ **Worker's Compensation:** Under the Oregon Worker's Compensation Law, Chiropractic services are covered initially for 18 visits or 60 days of care. Beyond these limits, you will need a referral and treatment plan from a medical doctor (MD) to return to our office for additional treatment. The insurance company has 45 days to accept or deny a claim. If your claim is denied, you will become personally responsible for the payment of your care

□ **Auto Accident/Personal Injuries:** It is our policy to bill your auto/personal insurance directly regardless of who was at fault in the accident/injury. If there is a third party involved, they will reimburse your insurance company when the claim is settled. Through your insurance policy, you are entitled to coverage for up to one year, after which you may need an attorney to arbitrate. If we have not received payment within 90 days, your claim is denied, or you are being treated past your one year PIP benefit date, you will be expected to pay for your fees in full.

I have read and understand the office policies and fees of this office. I understand that I am ultimately responsible for payment of my care and any fees incurred.

Patient (or Guardian) Signature_____ Today's Date_____

Print Patient Name _____ Date of Birth _____