Lanning Family Chiropractic, P.C.

2300 SW 2nd Street, Suite C · McMinnville, OR 97128
T: 503-474-0664 F: 503-474-3856 lanningfamilychiropractic.com

NEW PATIENT REGISTRATION

Name _____ _____ Male _____ Female
Last First Middle

Mailing Address _____ City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ Date of Birth _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email Address _____

Emergency Contact _____ Phone # _____

Please list your chief complaints in order of severity (pain, symptoms, etc.)
1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____

Have you ever experienced these complaints while working? _____ Yes _____ No If yes, date experienced _____

Employer _____ Title/Occupation _____

Have you been in an auto accident in the last 12 months? _____ Yes _____ No Date of accident ____/____/____

How many other passengers were in the car with you? _____

Please indicate medications (over the counter)/prescriptions you are currently taking. _____

_____

How were you referred to us? ____ Phone Book ____ Friend ____ Sign ____ Ad _____ Other

RESPONSIBLE PARTY INFORMATION

Primary Insurance _____ Policyholder _____

ID # _____ Group # _____

Secondary Insurance _____ Policyholder _____

ID # _____ Group # _____

If primary or secondary policyholder is spouse:

Spouse's Social Security # _____ Spouse's Date of Birth _____

Please complete both sides

ACKNOWLEDGEMENT AND UNDERSTANDING

Patient or Guardian, please initial each item below:

1. _____ I hereby authorize Lanning Family Chiropractic, P.C. to provide chiropractic services for me.

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services..

3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys fees and cost of collections.

4. _____ For services I receive at Lanning Family Chiropractic, P.C. I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans to: Lanning Family Chiropractic, P.C.

5. _____ I authorize release of patient's records to third parties (i.e. insurance) requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true, complete information.

Dated this day : _____
Date

Patient or Guardian Signature:_____

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian I hereby authorize treatment for the following patient to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

Minor's Name_____Birthdate_____

This authorization will be effective as of_____/_____/_____Expires_____/_____/_____.

Signature of parent or Guardian:_____

Today's Date_____/_____/_____.

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INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the above named doctor of chiropractic.

I have had the opportunity to discuss with the doctor the purpose and benefits of the recommended chiropractic care, and alternatives to chiropractic treatment have been reviewed.

Though chiropractic treatments are usually beneficial and rarely cause any problem, I understand that, like many other forms of health care, there are some risks. These can include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I further understand that health care providers cannot guarantee the results of treatment. I acknowledge that no guarantee of the outcome of the chiropractic care I have requested has been made. I have had ample opportunity to ask questions, and my questions have been answered to my satisfaction.

I have read and understand the content of the above consent to chiropractic care form.

_____
Print Patient Name

_____ _____
Patient / Guardian Signature Date

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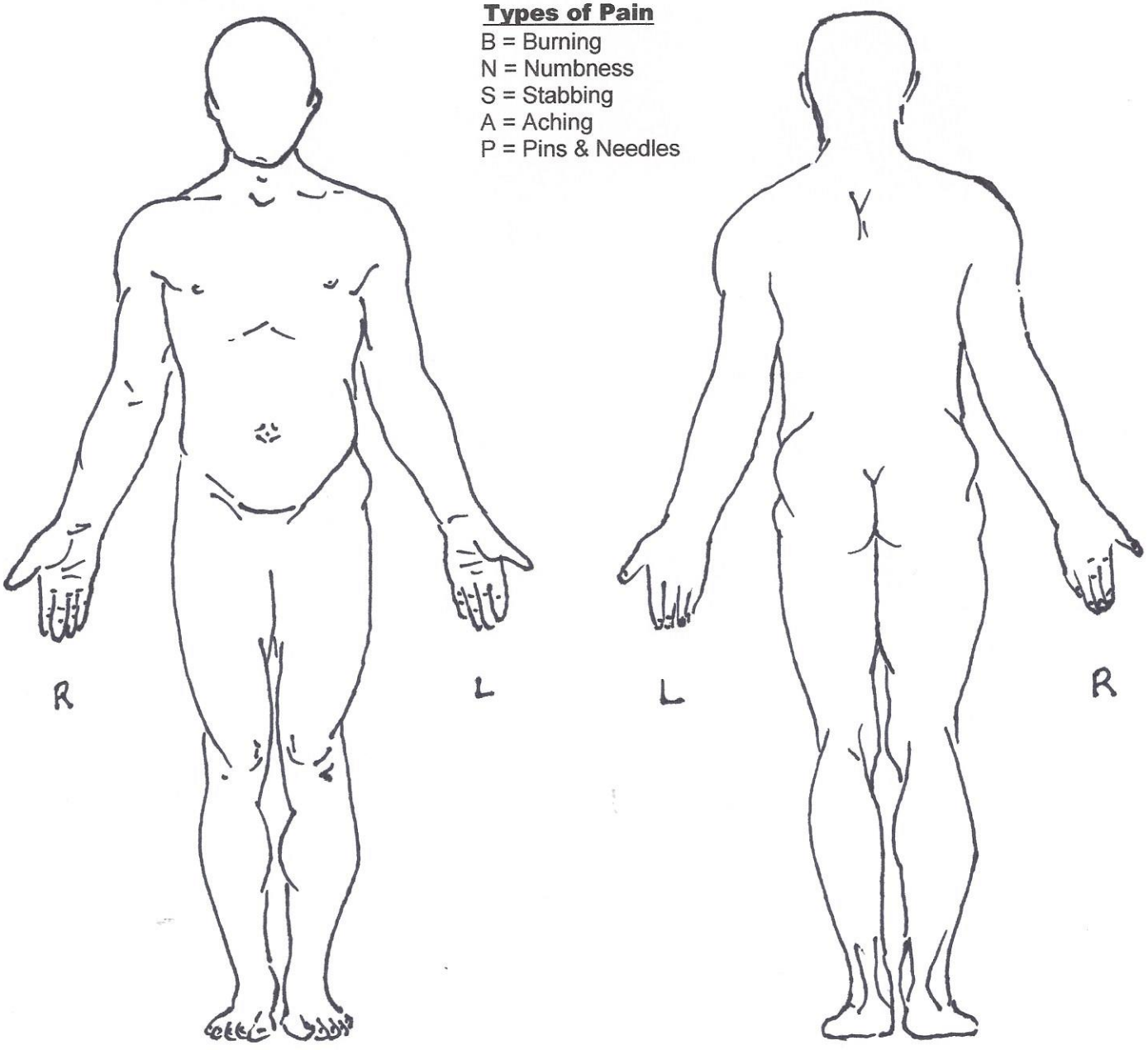
PAIN DIAGRAM

If you have any of the symptoms shown on the diagram, indicate where they are by writing in the appropriate letter on the affected body part.

Types of Pain
B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles



Patient Name _____ Date _____

Height _____ Weight _____ Date of Birth _____

If you are in pain NOW, how bad is it? Put a circle around the appropriate number on the following scale:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

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CLINIC FINANCIAL POLICY

1. All payments are due at the time of service, unless special arrangements have been agreed upon prior to visit.
2. Co-pays, co-insurance and charges applied to your deductible are your patient responsibility and will be due at the time of service.
3. As a courtesy to our patients, we will 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, however, we will not get involved with any dispute between you and your insurance carrier.
4. If you have a credit balance, upon request, we will reimburse you after payment has been received.
5. All products, supports and other equipment/supplies **MUST** be paid for at the time they are received.
6. In the event of an NSF check an additional bank fee will be charged and checks will no longer be accepted. ***We do not accept post-dated checks.***
7. Time of service discount for non-insurance accounts will be forfeited if full payment is not received at the time of service.

Workers' Compensation Claims

1. All workers' compensation cases will be billed directly to the insurance company, providing the appropriate paperwork has been completed and a claim is filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. ***Please keep in mind that if your claim is denied, you are responsible for prompt payment of your account.***

Personal Injury/Motor Vehicle Accidents

1. Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paperwork has been completed.
2. Keep in mind we do not do third party billings to other insurance companies.
3. 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.
4. Generally, supports and other equipment/supplies may not be covered by insurance companies, and must be paid for at the time they are received. Should the insurance company pay, we will reimburse you for the amount paid.

I have read and understand the above financial policy.

_____
Print Patient Name

_____ _____
Patient / Guardian Signature Date

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Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Lanning Family Chiropractic, P.C. 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.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

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.

Notice of treatment/ discussion of treatment in Common Areas

Every attempt will be made to keep all personal health Information Private. Sometimes in rare cases, treatment and/ or discussion of care could take place near other patients in our office. You may request a private room at any time to discuss your treatment further.

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	Time
Witness Signature	Date