

Balance Health and Injury Clinic

ES Acupuncture & My Family Chiropractor & Sunfire Massage



PATIENT INFORMATION AND POLICIES

Date: _____ Patient Gender: M F
Name (First, MI, Last): _____ Birth Date: _____ Age: _____
Marital Status: S M Other

Address: _____
City: _____ State: _____ Zip: _____ SSN: _____

Contact Information: _____
Home: () Employer Name: _____
Cell: () Occupation: _____
Email: _____ Work Phone: ()

How would you prefer us to contact you? Home Cell Work
May we send you cards and newsletters? Yes No

Emergency Contact: _____ Phone: ()

How did you hear about our clinic?

Please read and sign acknowledgement below.

Payment of Services: Payment is to be made at the time services are rendered and can be made in the form of cash, credit card, or personal check. Please complete the insurance information section below if you would like us to bill your insurance. **Insurance coverage must be verified prior to treatment.**

Insurance Billing: If you have insurance that covers acupuncture, chiropractic, or massage, we will gladly submit your claims for you. You are responsible for your deductible, your co-pay and co-insurance amounts. If your insurance denies payment of a claim, you are responsible for the **billed charges.**

Herbs/Supplements: Herbs and supplements range from \$6-\$60 and are not included in any discount program. Herbs and supplements are not covered by insurance and are to be paid for at the time of delivery. Herbs and supplements are non-refundable.

Appointment Changes: Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 hours notice, you will be charged a \$25 fee *per practitioner*. Insurance will not pay for a missed appointment. Please call the clinic and leave a message to change or cancel an appointment.

Closure due to Inclement Weather: We follow the Gresham/Barlow school district for school closures. In the event of inclement weather conditions, please call the clinic before your appointment. We will indicate our status on voicemail.

X

Patient Signature (or Patient Representative)

Date

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CURRENT INJURY OR HEALTH CONCERN

Name: _____ Gender: M F Today's Date: _____

Reason for your visit today (list symptoms in order of severity): _____ Height: _____
Weight: _____

Date of Injury/Initial Complaint: _____ Have you experienced this before? Y N
What seemed to be the initial cause? _____ Is it getting better or worse? _____

Have you seen other practitioners for this condition? _____ Who? _____
Type of treatment: _____ Results: _____

Is this complaint related to: Job Auto Accident Home Injury Fall Other _____
Does complaint bother you: Sleep Work Hobbies Other _____

Please circle the number that corresponds to the severity of your symptoms (pain or effect on daily living)
(Less Severe/Nuisance) ◀ 1 2 3 4 5 6 7 8 9 10 ▶ (Most Severe/Excruciating)

What seems to make it better? (heat/cold/rest/activity/pressure, etc.) _____

What seems to make it worse? (heat/cold/rest/activity/pressure, etc.) _____

List any prescriptions, OTC medication, or supplements you are taking (include dosage if known): _____

List any drug/food allergies or sensitivities: _____

Do you drink alcohol? N Y # _____ Daily Weekly Monthly Frequently Rarely
Do you drink caffeine? N Y # _____ Daily Weekly Monthly Frequently Rarely
Do you use tobacco? N Y # _____ Daily Weekly Monthly Frequently Rarely

List any current contagious diseases: _____

Females only Age of menarche: _____ Date of last menses: _____ Are you pregnant: Y N

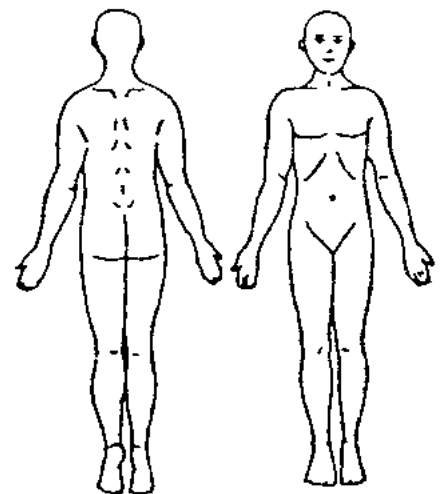
Medical History

(Circle) any of the following that you have or have had; star (*) those that your immediate family has or has had)

AIDs/HIV	Herpes	Thyroid Disorders
Alcoholism	High Blood Pressure	Major Trauma (list/year)
Allergies	Measles	_____
Anemia	Multiple Sclerosis	_____
Appendicitis	Mumps	_____
Arteriosclerosis	Pacemaker	_____
Asthma	Pleurisy	Tuberculosis
Cancer (type/area)	Pneumonia	Typhoid Fever
_____	Polio	Ulcers
Diabetes	Rheumatic Fever	Venereal Disease
Emphysema	Seizure Disorder	Whooping Cough
Epilepsy	Stroke	Other (list)
Goiter	Surgery (list/year)	_____
Gout	_____	_____
Heart Disease	_____	_____
Hepatitis	_____	_____

Symptom Chart

(Outline on the diagram the area(s) of your complaint)



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HIPAA PRIVACY NOTIFICATION

I consent to the use or disclosure of my identifiable health information by practitioners operating at *Balance Health and Injury Clinic* (hereon noted as *Balance*) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Balance* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Practitioners operating at *Balance* are not required to agree to the restrictions that I may request. However, if practitioners operating at *Balance* agree to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that practitioners operating at *Balance* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review *Balance's* Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is also provided at the front desk and on the organizations' web sites at www.balhic.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

The practitioners operating at *Balance* reserve the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

X

Patient Signature (Or Patient Representative)

Date



INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture, chiropractic and /or massage treatments and other procedures within the scope of practice of my provider on me (or on the person named below, for whom I am legally responsible) by the practitioner I see now or other practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for my practitioner, including those working at the clinic or office listed above, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, chiropractic, moxibustion, cupping, electrical stimulation, ultrasound, Tui-na (oriental manual therapy), massage, herbal medicine, exercise and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that chiropractic therapy is a generally safe method of treatment, but that it may have some side effects including non-painful cavitations or “popping” and soreness in the area following treatment. The cavitation or “popping” commonly occurs during an adjustment and is caused by the joint fluid converting from a liquid to a gas and is a normal side effect of the treatment. Unusual risks of chiropractic treatments include soft tissue injury, physical therapy burns, rib fracture and very rare disc herniation and stroke. I understand that while this document describes the major risks of chiropractic treatment, other side effects and risks may occur.

I have been informed that massage therapy is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, and the possible aggravation of symptoms after treatment.

The herbs and nutritional supplements that have been recommended are traditionally considered safe when prescribed by competently trained practitioners. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of treatment, and have had the opportunity to ask questions. 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.

X

Patient Signature (Or Patient Representative)

Date