Balance Health & Injury Clinic, PC

1217 NE Burnside Rd, STE 301 ◆ Gresham, OR 97030 ◆ PH 503.492.2625

Office use (DT of apt):

Patient Information

Name: _____

DOB: ____/____/____ (MM/DD/YYYY) Sex: M F ❑ Married ❑ Single ❑ Other

Address: _____

_____
City State Zip

Primary Phone: _____ ❑ Mobile

Secondary: _____ ❑ Mobile

eMail: _____

Detailed Information

Employer: _____

Occupation: _____

Work Phone: _____ Ext _____

Emergency Contact:

Name: _____

Relationship: _____ Phone: _____

Referred by: _____

Appointment Reminders, Thank a Friend, Refer a Friend

Appointment Reminders: Avoid late cancellation or no-call/no-show fees by signing up for a single reminder (text or email). Messages go out the night before your appointment at 6 PM. Please see the front desk or our Medical Concierge to enroll.

Thank a Friend: We love when people refer their friends and family to us. Tell us who referred you and we will send them a gift certificate as a thank you for their kind words. Gift certificates are good for services only at ***Balance*** and are <u>always</u> anonymous. Did one of our current patients send you here? If so, who? _____

Refer a Friend: Do you know someone who could benefit from our services? Ask the front desk for a referral card with your name on it. When your friend or family member shows up, not only will they save $5 for dropping your name, but you will get a thank you gift certificate in the mail as well!

Insurance Billing, Financial Policy, Time of Service, Assignment and Release

Financial Policy: The responsible party is obligated for payment in full of this account. <u>You are responsible for timely payment of your account. Patient balances are due 30 days after receipt of your statement. Any unpaid balances over 90 days after billing are subject to interest charges as established by ORS 82.010, currently at 9% APR. Balances 90 days past due will be assigned to Cascade Collections, Inc. for processing.</u>
All supplements, lab work, supports, or supplies must be paid for at the time of receipt. We accept cash, check, and credit/debit card payments.

There will be an additional charge of $30 for all returned checks due to insufficient funds.

Time of Service: is defined as payments made immediately after services are received. Any services not paid for in this manner do not qualify as *Time of Service* and will be charged to the responsible party at our current listed billed rate for services.

Insurance Billing: We will gladly submit medical bills on your behalf. All estimated co-pays, co-insurance, deductibles, and supply charges are due on the day services are rendered unless special arrangements have been made <u>prior</u> to visit. Remaining charges after insurance processing will be billed monthly to responsible party. ***Possession of an insurance ID card is NOT a guarantee of coverage. We will make every attempt to verify benefits, however, due to privacy limitations imposed by insurance carriers, it is the responsibility of the patient to ensure coverage.***
I acknowledge that any quote of benefits relayed by the clinic staff is only a quote and does not guarantee payment by my insurance carrier. In the event that my insurance fails to pay partially or in full, I agree to be held financially responsible for any and all allowed charges. Any worker compensation or auto claim denied by carrier will be come due in full immediately upon receipt of denial unless there is an attorney lien in place. If you suspend or terminate care, all fees due will be charged directly to you. In the event of non-payment, the responsible party shall bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Assignment and Release: ***If billing insurance,*** I authorize my insurance company to pay the above named office any professional and medical expense benefits allowable and otherwise payable to me (or my dependent) under my current policy agreement as payment toward the services rendered. I authorize the release of any medical information necessary to process this claim. A photocopy of this assignment shall be considered as effective and valid as the original.

There may be a $30 fee charged for missed appointments not cancelled or rescheduled at least 24 hours in advance.

Patient or Guardian's Signature: _____ Today's Date: _____

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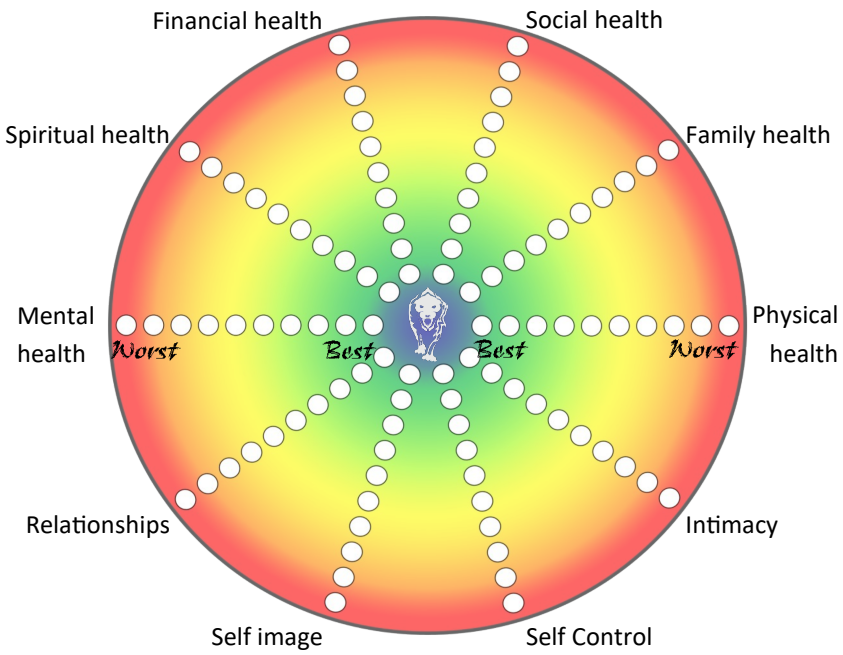
We want to make sure we're on the same page when it comes to achieving your health goals and there are many factors which influence our healing. If you have an extra moment, please consider completing the Wellness Target below. Your provider can use this information to develop a more thorough understanding of your health picture and how to help achieve your goals.

Wellness Target

How "on Target" is your health?

Maintaining *Balance* in all areas of your life helps to reduce stress, increase joy and beneficial sleep, and will keep you healthy longer.

This exercise will help us get a better overall impression of how you are doing in ***life*** which we use to create a well-rounded treatment plan for your ***health***. The outside edge of the target is lowest, or "***not great***", while the closer to the panther is best, meaning "***things are perfect***." Please mark your level of satisfaction in each category.



DID YOU KNOW?

All it takes is a moment to change a lifetime.

A chance, a decision, a step, a change...

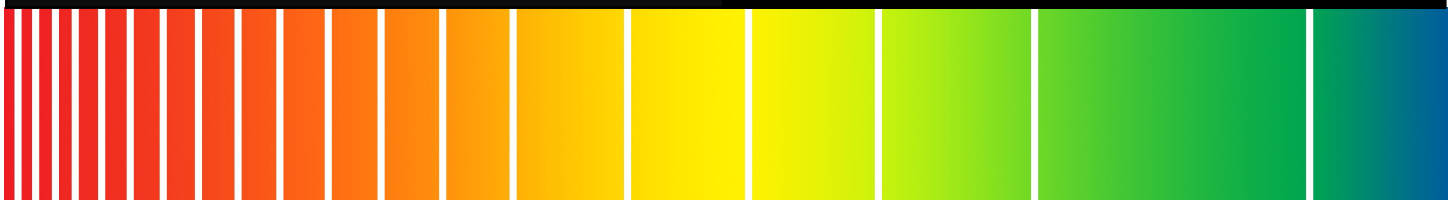
Balance

Quite possibly one of the most asked questions is how often we will need to treat a person before they get better. To be honest, everyone is different: your age, length and severity of illness, and desire to get better all factor into your results. Your practitioner will use the information provided in this packet combined with details from your interview and examination to come up with a treatment plan designed *specifically* for you!

While the level of care will always be the same, how far you want to take it will determine how much your life will improve. There are some, oddly enough, who just want to stop the pain temporarily and walk away from treatment the moment their symptoms ease only to return to start the process all over again a few months later. At Balance we will craft a plan to not just relieve your symptoms, but also to correct the underlying conditions which created the situation in the first place, resulting in a more robust, happy, and pain-free life. How far you go is up to you!

HOW OFTEN WILL I NEED TREATMENT?

FREQUENCY OF CARE



Acute Care: frequent treatments targeted at resolving the key symptoms and provide relief.

Continuing care: reduced frequency with the intention of correcting imbalance and maintaining reduced symptoms.

Wellness care: infrequent treatments designed to maintain Balance, prevent relapse, and protect future health.

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Date

Basic Health Information/New Injury

Name: _____ DOB: _____ Sex: M F

Reason for visit: _____

When did your symptoms begin? _____

What caused them? _____

Since onset, have your symptoms been getting ❑ Better ❑ Worse ❑ No change

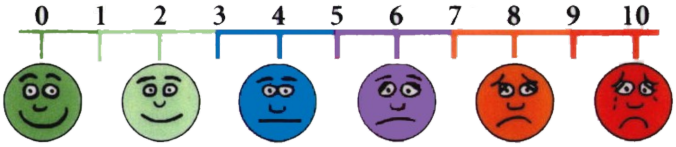
Other providers seen for this: _____

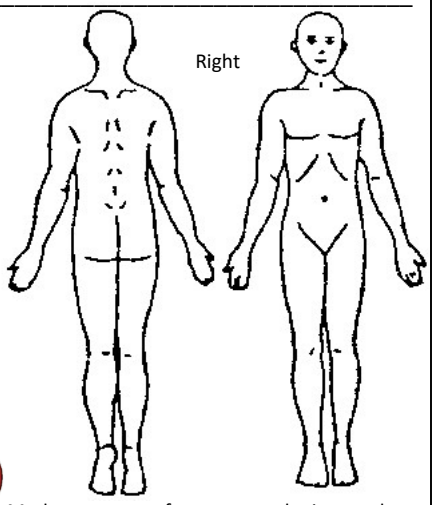
Does it interfere with your ❑ Sleep ❑ Work ❑ Daily Routine ❑ Recreation

What makes your symptoms better? _____

What makes your symptoms worse? _____

Please circle the number that corresponds to the severity of your symptoms.





Mark your areas of concern on the image above.

Surgical History

List with year:

Allergies or Reactions to Medication

Current Medication/Supplements

Please list all medications or supplements with dose:

Please check ☑ for you and ⊘ for family history.

Medical History - Personal and Family

❑❍ AIDs/HIV	❑❍ Emphysema	❑❍ Hepatitis	❑❍ Obesity
❑❍ Alcoholism	❑❍ Epilepsy	❑❍ Hyper/Hypo Thyroid	❑❍ Osteoporosis/penia
❑❍ Anemia	❑❍ Goiter	❑❍ Measles	❑❍ Parasites
❑❍ Arthritis	❑❍ Gout	❑❍ Mental Illness	❑❍ Pneumonia
❑❍ Cancer _____	❑❍ Heart Attack _____	❑❍ Multiple Sclerosis	❑❍ Stroke _____
❑❍ Diabetes _____	❑❍ Heart Disease _____	❑❍ Mumps	❑❍ Tuberculosis

Personal Health Information

Health Habits

Alcohol: _____glasses / day week month

Caffeine: _____glasses / day week month

Tobacco: _____packs / day week month

Stress: None Moderate Daily Heavy

Exercise: None Moderate Daily Heavy

Work Activity

❑ Sitting
❑ Standing
❑ Computer
❑ Light Labor
❑ Heavy Labor
❑ Hazards
❑ Repetitive

Female Health

Date of last menses: _____ ❑ Menopause
Age of first period: _____ ❑ PMS
Menses: ❑ Spotting ❑ Light ❑ Heavy
❑ Irregular ❑ Painful ❑ Clots ❑ Absent
Are you currently pregnant? ❑ Y ❑ N
Are you currently breast feeding? ❑ Y ❑ N
# of pregnancies: _____ # of live births: _____

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Personal Signs and Symptoms

Please check ☑ for all that apply.

Provider Reviewed: ____ on ____

General

I do not experience any of the *general* items below ❑

❑ Bleed easily	❑ Fatigue	❑ Night sweats	❑ Poor sleep	❑ Swollen glands
❑ Bruise easily	❑ Fever	❑ Peculiar tastes	❑ Short temper	❑ Vivid dreams
❑ Chills	❑ Lack of strength	❑ Poor appetite	❑ Sweat easily	❑ Weight gain
❑ Cold hands/feet	❑ Muscle cramps	❑ Poor circulation	❑ Sudden energy drop	❑ Weight loss

Head, Ears, Eyes, Nose, and Throat (HEENT)

I do not experience any of the *HEENT* items below ❑

❑ Blurry vision	❑ Ear aches	❑ Excess saliva	❑ Nasal congestion	❑ Sinus pain
❑ Concussion	❑ Headache/migraine	❑ Grinding teeth	❑ Nose bleeds	❑ Spots in eyes
❑ Dizziness/vertigo	❑ Thyroid issues	❑ Itchy eyes	❑ Red eyes	❑ Sore throat
❑ Dry throat/mouth	❑ Eye pain/strain	❑ Mouth sores	❑ Ringing ears	❑ Teeth/gum problems

Respiratory

I do not experience any of the *respiratory* items below ❑

❑ Allergies	❑ Cough	❑ Frequent cold/flu	❑ Pneumonia	❑ Tight chest
❑ Asthma	❑ Coughing blood	❑ Phlegm	❑ Shortness of breath	❑ Wheezing

Cardiovascular

I do not experience any of the *cardiovascular* items below ❑

❑ Blood clots	❑ Edema/swelling	❑ Heart palpitations	❑ Irregular heartbeat	❑ Phlebitis
❑ Chest pain	❑ Fainting	❑ High blood pressure	❑ Low blood pressure	❑ Tachycardia

Gastrointestinal

I do not experience any of the *gastrointestinal* items below ❑

❑ Abdominal pain/ bloating	❑ Blood in stool	❑ Floating stools	❑ Indigestion	❑ Nausea
	❑ Constipation	❑ Gas/belching	❑ Intestinal pain/ cramps	❑ Odorous stools
❑ Acid reflux	❑ Dark stools	❑ Hemorrhoids		❑ Rectal pain
❑ Bad breath	❑ Diarrhea	❑ Hiccups	❑ Mucous in stools	❑ Vomiting

Musculoskeletal

I do not experience any of the *musculoskeletal* items below ❑

❑ Low back pain	❑ Redness/heat	❑ Limited range	❑ Rib pain	❑ Moving pain
❑ Neck/shoulder pain	❑ Swelling	❑ Limited use	❑ Dull/achy pain	❑ Stabbing pain
❑ Upper back pain	❑ Joint pain	❑ Muscle pain	❑ Fixed pain	❑ Throbbing/burning

Skin and Hair

I do not experience any of the *skin and hair* items below ❑

❑ Acne	❑ Dry/brittle nails	❑ Eczema	❑ Loss of hair	❑ Rash/hives
❑ Dandruff	❑ Dry skin	❑ Fungal infection	❑ Psoriasis	❑ Ulcerations

Neuropsychological

I do not experience any of the *neuropsychological* items below ❑

❑ Abuse survivor	❑ Considered or attempted suicide	❑ Easily stressed	❑ Poor memory	❑ Sudden weakness
❑ Anxiety		❑ Irritable	❑ Seeing a therapist	❑ Tics
❑ Confusion	❑ Depression	❑ Numbness	❑ Seizures	❑ Tingling

Genitourinary

I do not experience any of the *genitourinary* items below ❑

❑ Bedwetting	❑ Dribbling urine	❑ Incomplete urine	❑ Nocturnal emission	❑ Premature ejaculate
❑ Blood in urine	❑ Frequent urination	❑ Increased libido	❑ Pain with urination	❑ Urgent urination
❑ Decreased libido	❑ Impotence	❑ Kidney stones	❑ Painful erection	❑ Wake to urinate

Patient Signature

I have completed this document to the best of my ability and understand that any omissions may impact the ability of my providers to make an appropriate diagnosis and/or treatment plan.

Printed name of patient (or guardian)	Signature of same	Date

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INFORMED CONSENT

I hereby request and consent to the performance of one or more services 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.

If I elect to treat with acupuncture, 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.

If I elect to treat with chiropractic, 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.

If I elect to treat with massage, 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.

If I am prescribed or recommended to take herbs or supplements, I understand that 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.

CLOSURES

Closure due to inclement weather: in the case of inclement weather please call the clinic prior to your appointment. Our status will be noted on our voicemail and on Facebook at Balance/HIC.

PATIENT SIGNATURE

I have read the above consent, policies and procedures and have completed this form with the understanding that omissions or inaccuracies may adversely impact the ability of my practitioners to make an educated and thorough diagnosis, and therefore my treatment.

Printed name of patient (or guardian)	Signature of same	Date

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Your Privacy Is Our Priority

HIPAA Privacy Notification

I consent to the use or disclosure of my identifiable health information by practitioners operating at *Balance Health and Injury Clinic, PC* (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.

Patient Signature

I have read the above notification and understand my rights to privacy as a patient.

Printed name of patient (or guardian)	Signature of same	Date