Patient Profile

True Balance Chiropractic, LLC
51669 Columbia River Hwy Suite 130
Scappoose, OR 97056
Phone: (503) 987-1696
Fax: (503) 987-1152

Today's Date: ____-____-____ Date of Injury: ____-____-____

Full Name: _____
(First) (MI) (Last)

Address: _____
(Street Address)

_____
(City) (State) (Zip)

Date of Birth: ____-____-____ Gender: ( ) M ( ) F Marital Status: ( ) M ( ) S ( ) D ( ) W

Occupation:_____ Employer:_____

Email address: _____

Home Phone: _____Cell Phone: _____

Emergency Contact:

Name: _____Relationship: _____Phone: _____

Insurance information: Health Insurance ( ) Auto Insurance ( ) Worker's Compensation ( )

Name of Primary Insurance: _____

Health Insurance	Auto Insurance/Worker's Compensation
Policy or ID#: _____	Claim #: _____
Group #: _____	Adjuster's Name: _____
Name of Policy Holder: _____	Adjusters Phone #: _____
Policy Holder's Date of Birth: _____-_____-_____	Employer: _____
Policy Holder's Employer: _____	Date of Injury: _____-_____-_____

Name of Secondary Insurance:_____

Are you interested in joining our discount program through ChiroHealthUSA? Yes/No
The discount program is for uninsured or underinsured patients only.

PATIENT HISTORY

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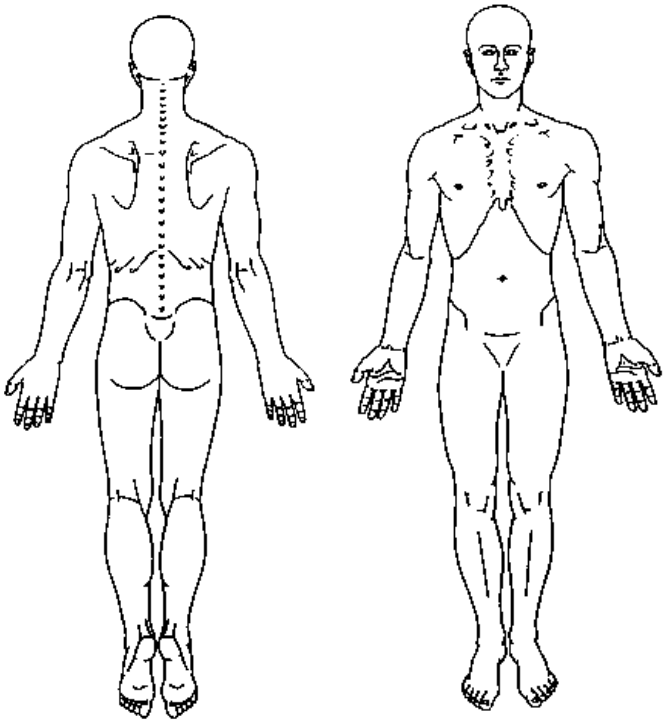
Patient Name _____**Today's Date** _____

Please indicate the reason for your visit: Wellness Care ____ Auto accident ____ Work Accident ____ Other ____

Chief Complaint – list the areas of your complaint(s) beginning with the most severe and ending with the least severe.

Area of Complaint	Indicate the severity today 0=no symptoms 10=Worse imaginable	Circle the type of complaint	Date complaint started
Example Low Back	4	**Dull Pain Sharp Pain Soreness Stiffness Numbness Burning Weakness Tingling**	2/4/2015
1.		**Dull Pain Sharp Pain Soreness Stiffness Numbness Burning Weakness Tingling**	
2.		**Dull Pain Sharp Pain Soreness Stiffness Numbness Burning Weakness Tingling**	
3.		**Dull Pain Sharp Pain Soreness Stiffness Numbness Burning Weakness Tingling**	

Use the diagram below to illustrate the location of your complaint(s):



Please Circle all activities that aggravate your symptoms:

Bending	Bowel Movements	Coughing/sneezing
Getting up	Lifting	Lying down
Reading	Sitting	Sleeping
Urination	Turning my Head	Walking
Daily Routine	Driving	Standing
Pulling	Pushing	Typing
Working	Writing	Other:

Please Circle activities/therapies that alleviate your symptoms:

Ice	Heat	Massage
Stretching	Medication	Lying down
Standing	Sitting	Other:

Have you had treatment for this complaint in the past? **YES/NO,** If yes, what type? _____

Are you currently under the care of another healthcare provider or therapist? **YES/NO** If yes, what type? _____

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Please check the box to indicate which of the following you are currently experiencing or have experienced in the past.

Current	Past	Muscles/Joints	Current	Past	Gastrointestinal	Current	Past	Ear/Nose/Throat
		Low Back Problems			Belching/Gas			Ear Ache
		Pain between shoulders			Constipation/Diarrhea			Ear Noises
		Neck Problems			Excessive Hunger/thirst			Enlarged Thyroid
		Arm Problems			Call Bladder issues			Frequent Colds
		Leg Problems			Nausea			Hay Fever
		Swollen Joints			Abdominal Pain			Nasal Blockage
		Painful Joints			Ulcer			Nose Bleeds
		Stiff Joints			Poor Appetite			Poor Vision
		Sore Muscles			Poor Digestion			Sinusitis
		Weak Muscles			Vomiting			Sore Throats
		Sprains/Strains			Black/bloody Stool			Difficulty Speaking
		Broken Bones			Weight loss/gain			Difficulty Swallowing
		Osteoporosis						
		Osteoarthritis	**Current**	**Past**	**Health**	**Current**	**Past**	**Genitourinary**
		Rheumatoid Arthritis			Diabetes			Blood in Urine
		Numbness			Benign Cancer			Frequent Urination
		Herniated/bulging disc			Malignant Cancer			Kidney Infection
		Sciatica			Autoimmune disease			Painful Urination
		Fibromyalgia			Nervousness			Prostate Problems
Current	**Past**	**Cardiovascular**			Seizures			Loss of Bladder Control
		High Blood Pressure			Frequent Fever			Difficulty urinating
		Heart attack	**Current**	**Past**	**Skin/Allergies**	**Current**	**Past**	**Women Only**
		Chest Pain			Sensitive Skin			Birth Control
		Poor Circulation			Bruising Easily			Hormone Replacement
		Irregular Heart Beat			Dryness			Cramps
		Stroke			Rash/itching/Hives			Excessive Flow
		Ankle Swelling			Eczema/Psoriasis			Hot Flashes
		Varicose Veins	**Current**	**Past**	**Respiratory**			Irregular Cycle
		Loss of Consciousness			Asthma			Miscarriage
		Dizziness			Chronic Cough			Painful Periods
		Fainting			Difficulty Breathing			Vaginal Discharge
		Headache			Spitting Blood			Breast Pain
		Heart Disease			Wheezing			Pregnancy, how many?

List additional current and past health conditions: _____

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List Current Medications, vitamins, herbal supplements, and over-the-counter medications.

1._____ 3. _____

2. _____ 4. _____

List Allergies to medications, foods, lotions, etc. _____

Do health conditions run in your family? (arthritis, epilepsy, cancer, diabetes, high blood pressure, high cholesterol, heart disease, kidney disease, skin conditions, etc.):

Mother: _____

Father: _____

Siblings: _____

Grand Parents: _____

List Past Injuries –please list the year and indicate whether or not you are still affected by the injury.

Broken Bones:_____

Work Injuries:_____

Auto Injuries:_____

Sports/Other Injuries:_____

Personal Habits –Please check the appropriate box. 0=Never, 3=Sometimes, 6=Frequently

Exercise	0	3	6	Smoke	0	3	6	Drink Alcohol	0	3	6	Use Drugs	0	3	6	Experience Stress	0	3	6

Hospitalizations	Description	Year	Hospital
Illness (Type)	_____	_____	_____
	_____	_____	_____
Surgery (Type)	_____	_____	_____
	_____	_____	_____

Do you have any implants, screws, plates, or other foreign objects in your body? **NO/YES**

Have you ever had x-rays, CT, MRI, or other medical imaging? **YES/NO** If yes, what areas of the body and when _____

_____

We support integrated health and co-management of our patients. Please list your primary healthcare provider and any other provider in which you give permission for us to coordinate your care. We will provide them a copy of your chiropractic treatment plan.

_____ _____

Provider Name Location of Practice

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my health.

_____ _____

Patient Signature (or guardian) **Date**

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HEALTH INSURANCE COVERAGE: Our office does not verify insurance benefits. Payment decisions are made by your insurance company and are beyond our control. We will bill them appropriately, however it is the policy holder's responsibility for any remaining balance on your account.
SELF-PAYS AND CO-PAYS: Self-pay or insurance co-pays must be collected at the time of service. Discounts are available through ChiroHealthUSA.
VISITS RELATING TO AUTO ACCIDENTS OR WORK INJURIES: Pre-existing conditions are not covered, only conditions related to the injury. Secondary insurance information will be collected in the event services are not fully covered by auto or worker's compensation. Out-of-pocket costs may apply.
ACCOUNTS: All charges to your account will remain your financial responsibility. A 10% finance charge will be imposed on account balances which have not been paid within sixty (60) days of the time of service. Unpaid account balances ninety (90) days after the time of service will be sent to collections. Payments plans are available if set up within 90 days of the date of service. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, as well as all court costs.
APPOINTMENT SCHEDULING/MISSED APPOINTMENTS: If an appointment must be changed, a 24 hours notice is appreciated. **A $30 missed appointment fee per service will be assigned to your account when a scheduled appointment is missed without notice.** This fee will not be billed to your insurance.
ESTABLISHED PATIENT EXAMINATIONS: Periodic examinations are required to continue care and must be billed in addition to regular treatment fees.

_____**(Initial)** I understand and agree to the policies above.

INFORMED CONSENT: We do not treat any disease or condition other than biomechanical neuro-musculo-skeletal findings. If during the course of your treatment we encounter a condition that is not within the chiropractic scope of practice we will refer you to the appropriate physician immediately. We may use chiropractic manipulation, manual therapy techniques, physiotherapy, exercises therapies, nutritional advisement, and other modalities of treatment. As with any form of health care, there are complications to chiropractic treatment that have been reported (mostly due to manipulations performed by non-licensed chiropractors) and include sprain/strain injuries, irritation of disc conditions, and rarely rib fractures. Symptoms including dizziness, nausea, and flushing are rare. A risk of stroke occurring with chiropractic care is extremely rare. According to research, there is no evidence of excess risk of stroke associated with chiropractic care, when compared to other health care services. It is important to inform your chiropractor if you experience any unusual symptoms during or after your chiropractic treatment. Patients with weakened bones (osteoporosis, other conditions) may be susceptible to bone fracture. It is important to inform your chiropractor if you have been diagnosed with a bone weakening condition. I understand that chiropractic, like that of any alternative care, has not been scientifically proven effective for everyone. I am aware and acknowledge there is no guarantee to the results or outcome of care. It is important to answer all health questions thoroughly and honestly to create a safe effective treatment plan for you. It is your responsibility to update the doctor of any changes to your health or new injuries during the course of care.

_____**(Initial)** I understand the possible risks and consent to treatment.

Protected Health Information (PHI)
We are committed to HIPAA regulations and the protection of your PHI. By signing this consent form you are permitting your physician to use or disclose your PHI to our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. You have the right to inspect and copy your PHI, request restriction of your PHI, request to receive confidential communications from us by alternative means or at an alternative location, to have your physician amend your PHI, to make a formal complaint if PHI violations are suspected.

_____**(Initial)** I have received a copy of the Notice of Privacy Practices. I understand and consent to the disclosure of my PHI as described above and in the Notice of Privacy Practices.

I hereby instruct and direct my current insurance carrier(s) to pay by check made out and mailed to: Teah Brown, DC, LMT: True Balance Chiropractic, LLC 51669 Columbia River Hwy Suite 130, Scappoose, Oregon 97056. I authorize Teah Brown, DC, LMT True Balance Chiropractic, LLC to deposit checks received on my account when made out to me or both myself and Teah Brown, DC, LMT True Balance Chiropractic, LLC for the professional or medical expenses and benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNEMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.
I also authorize the release of any information pertinent to my care to any insurance company, adjuster, or attorney involved in this case.

_____**(Initial)** I authorize this office to bill my insurance company for services rendered, to accept payment for services, and to release my PHI/chart notes to my insurance company if required for payment.

_____ _____
Patient Signature (or guardian) **Today's Date**

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It explains how we may use and disclose your protected health information (PHI) to carryout treatment, payment, or health care operations and for purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present, or future physical or mental health conditions and related health care services.

We are required to abide by the terms of this notice of privacy practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised notice of privacy practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

By signing this consent form you are permitting your physician to use or disclose your PHI as described in section 1. Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your PHI that the physician's office is permitted to make once you have signed our consent form. Theses examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose PHI to other physicians who may be treating you when we have the necessary permission from you to disclose your PHI. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or teat to you. In addition, we may disclose your PHI to another physician or health care provider (example a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, you PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointments.

We will share your PHI with third party "business associates" that perform various activities (example: billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We may disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use and disclose your demographics for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or contact you for fundraising activities supported by the office. We may also send you information about products or services that we believe may be beneficial to you.

Other permitted and required uses and disclosures that may be made with your consent, authorization, or opportunity to object: We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

2. YOUR RIGHTS

The following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to laws that prohibits access to PHI. Depending on the circumstances a decision to deny access may be reviewed. Please contact Dr. Teah Brown, DC. LMT (OR 10565) if you have questions about access to your medical record.

You have the right to request restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interested to permit use and disclosure of you PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction in writing to Dr. Teah Brown, DC, LMT.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to Dr. Teah Brown, DC, LMT.

You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. The right applies to disclosures for purposes other than treatment, payment or healthcare operations as descried in the notice of privacy practices. It excludes disclosures we have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to review specific information regarding these disclosures that occurred after September 6, 2011. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying Dr. Teah Brown, DC, LMT of your complaint. We will not retaliate against you for filing a complaint. Please contact Dr. Teah Brown, DC, LMT at (503) 987-1696 for further information about the complaint process and all questions regarding this document and the release of your PHI.

In the unlikely event that your PHI is disclosed by mistake or inappropriately disclosed you will be informed by mail immediately.