1240 E. Main Street, Cottage Grove, OR 97424
Phone (541) 767-3788 Fax (541)946-1057

Patient Information

Date ______________________

Name ______________________
Last Name | First Name | Middle Initial

Address ______________________ **Sex** **M** **F**

City ______________________ **Age** __________

State __________ **Zip** __________ **Birthdate** __________

E-Mail ______________________

Phone Number ______________________
Cell | Home

Employer / School ______________________ **Phone** __________

Occupation ______________________

Employer / School Address ______________________
____

Emergency Contact

Name ______________________ __________
Relationship

Phone ______________________
Cell | Home

Primary Insurance		**Secondary Insurance**	
Member ID		Member ID	
Group		Group	
Subscriber		Subscriber	
Subscriber Birthdate		Subscriber Birthdate	

Medications	Allergies	Vitamins/Herbs/Minerals

Health History

What Treatment have you already received for your condition?

Medication	**Y**	**N**	Surgery	**Y**	**N**	Physical Therapy	**Y**	**N**
Chiropractic	**Y**	**N**	None	**Y**	**N**	Other	______	

Is this condition due to an accident? **Y** **N** Date: ______

Type of accident **Auto** **Work** **Home** **Other** Has this accident been reported? **Y** **N**

Name of other doctors who have treated your current condition: ______

Date of Last:

Physical Exam	______	Dental X-Ray	______
Spinal Exam	______	Spinal X-Ray	______
Blood Test	______	Chest X-Ray	______
Urine Test	______	MRI, CT-Scan, Bone Scan	______

Circle Yes or No to indicate if you have had any of the following

AIDS/HIVE	Y	N	Diabetes	Y	N	Liver Disease	Y	N	Rheumatoid Arthritis	Y	N
Alcoholism	Y	N	Emphysema	Y	N	Measles	Y	N	Rheumatic Fever	Y	N
Allergy Shots	Y	N	Epilepsy	Y	N	Migraine Headaches	Y	N	Scarlet Fever	Y	N
Anemia	Y	N	Fractures	Y	N	Miscarriage	Y	N	STD	Y	N
Anorexia	Y	N	Glaucoma	Y	N	Mononucleosis	Y	N	Stroke	Y	N
Appendicitis	Y	N	Goiter	Y	N	Multiple Sclerosis	Y	N	Suicide Attempt	Y	N
Arthritis	Y	N	Gonorrhea	Y	N	Mumps	Y	N	Thyroid Problems	Y	N
Asthma	Y	N	Gout	Y	N	Osteoporosis	Y	N	Tonsilitis	Y	N
Bleeding disorders	Y	N	Heart Disease	Y	N	Pacemaker	Y	N	Tuberculosis	Y	N
Breast Lump	Y	N	Hepatitis	Y	N	Parkinson's Disease	Y	N	Tumors, Growths	Y	N
Bronchitis	Y	N	Hernia	Y	N	Pinched Nerve	Y	N	Typhoid Fever	Y	N
Bulimia	Y	N	Herniated Disk	Y	N	Pneumonia	Y	N	Ulcers	Y	N
Cancer	Y	N	Herpes	Y	N	Polio	Y	N	Vaginal Infections	Y	N
Cataracts	Y	N	High blood Pressure	Y	N	Prostate Problem	Y	N	Whooping Cough	Y	N
Chemical Dependency	Y	N	High Cholesterol	Y	N	Prosthesis	Y	N	Other	Y	N
Chicken Pox	Y	N	Kidney Disease	Y	N	Psychiatric Care	Y	N			

Circle your response

Exercise	**Work Activity**	**Habits**		
None	Siting	Smoking	*Packs/day*	______
Moderate	Standing	Alcohol	*Drinks/week*	______
Daily	Light Labor	Coffee/Caffeine	*Cups/Day*	______
Heavy	Heavy Labor	High Stress Level	*Reason*	______

Are you pregnant? **Y** **N** Due Date:

Injuries/Surgeries

	Description	Date
Falls	______	______
Head Injuries	______	______
Broken Bones	______	______
Dislocations	______	______
Surgeries	______	______

Symptom / Location 1 ______________________________

On a scale from 0-10, with 10 being the worst, circle the number that best describes the pain

1 2 3 4 5 6 7 8 9 10

What percentage of day do you experience the pain at the stated intensity

5 10 15 20 25 30 35 40 45 50 60 65 70 75 80 85 90 95 100

When did the symptom begin?

______________________________ Suddenly or Gradually (circle one)

Did the symptom start

How did the symptoms begin?

____

What makes the symptom worse? (circle all that apply)

Any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, driving, walking, running, nothing.

Other (please describe) ______________________________

What makes the symptom better? (circle all that apply)

Rest, Ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing

Other (please describe) ______________________________

Describe the quality of the symptom (circle all that apply)

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep nagging, shooting, stinging

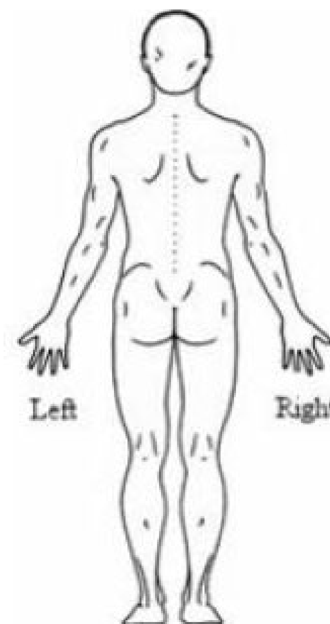
Does the symptom radiate to another part of your body? **Yes** **No**

If yes, where does the symptom radiate? ______________________________

Is the symptom worse at certain times of the day or night? (circle all that apply)

Morning Afternoon Evening Night Unaffected by time of day

Please mark the location of pain



Symptom / Location 2 ______________________________

On a scale from 0-10, with 10 being the worst, circle the number that best describes the pain

1 2 3 4 5 6 7 8 9 10

What percentage of day do you experience the pain at the stated intensity

5 10 15 20 25 30 35 40 45 50 60 65 70 75 80 85 90 95 100

When did the symptom begin?

____

Did the symptom start Suddenly or Gradually (circle one)

How did the symptoms begin?

____

What makes the symptom worse? (circle all that apply)

Any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, driving, walking, running, nothing.

Other (please describe) ______________________________

What makes the symptom better? (circle all that apply)

Rest, Ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing

Other (please describe) ______________________________

Describe the quality of the symptom (circle all that apply)

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep nagging, shooting, stinging

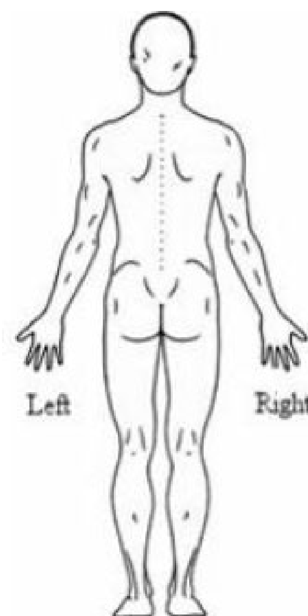
Does the symptom radiate to another part of your body? **Yes** **No**

If yes, where does the symptom radiate? ______________________________

Is the symptom worse at certain times of the day or night? (circle all that apply)

Morning Afternoon Evening Night Unaffected by time of day

Please mark the location of pain



Payment Information:

Payment and co-pays are expected at the time services are rendered unless payment arrangements have been made with the office manager in advance. If you have any questions regarding payments and fees in our office, please ask our billing manager.

Cash Patients

We are able to offer a discount to our cash patients if they pay at the time of service. This is called a TOS (Time of Service) reduction. The only way we can legally offer this discount is if the treatment is paid for at the time services are rendered. If payment is unable to be made at the time of service, our statements will reflect the required insurance fee schedule usual and customary charges.

Privacy Policy

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and service we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices we have in effect at the time. I have received a copy of the Aspen Chiropractic, PC Privacy Policies and understand that my IIHI will be kept confidential according to the HIPPA mandates.

Benefits, Risks, and Alternatives

I understand that, as with all forms of manual therapy, there are certain benefits, risks, and alternatives to receiving chiropractic care. I accept these benefits, risks and alternatives and understand that if I have concerns or questions regarding the benefits, risks, and alternatives of Chiropractic Manipulative Therapy, I have the right to discuss them with my doctor and refuse care.

Cancellation / No Call - No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Cancelled Chiropractic Appointments w/o 24 Hr Notice

If you have a scheduled chiropractic appointment that is not canceled at least 24 hours in advance you will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance company.

No Call-No Show Policy

If you have a scheduled appointment and are running late, please contact our office and we will work with you so that you can still be seen that day. However, failure to call and missing a scheduled appointment will result in a No Call-No Show, and you will be charged according to your appointment type as stated above. Three (3) Cancellations without 24-hour notice, or three (3) No Call-No Shows (or any combination thereof) will result in the patient being placed on a walk-in basis only. When you require an appointment, you will still be able to be seen, however wait times will vary based on provider availability and the number of patients with scheduled appointments, as preference will be given to those with scheduled appointments. If you are placed on a walk-in basis, we cannot guarantee that we will have a massage appointment available, however, we can place you on a cancellation list and contact you if an opening becomes available.

Communication

I hereby give Aspen Chiropractic permission to send me text message appointment reminders and/ or voice messages at the number I have provided.

Signature ________________________ Date ____________

Office Witness ________________________ Date ____________

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

____
Printed Name

____
Signature — Date

____
Office Witness — Date

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

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