ASPEN CHIROPRACTIC CENTER

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*	

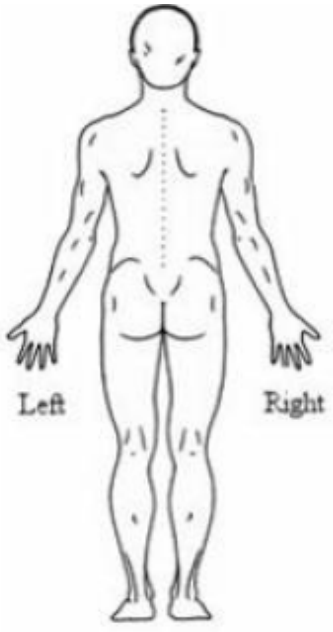
Are you pregnant? **Y N** Due Date:

Injuries/Surgeries

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Symptom / Location 1 _____

Please mark the location of pain



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

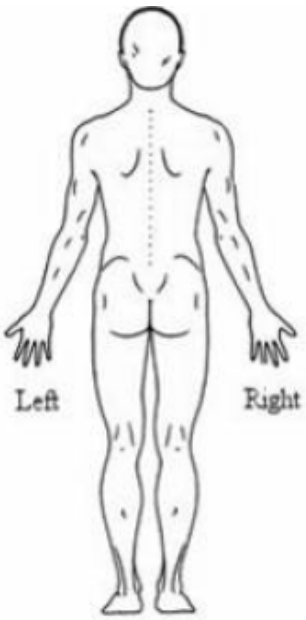
If yes, where does the symptom radiate? _____

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

Symptom / Location 2 _____

Please mark the location of pain



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Morning Afternoon Evening Night Unaffected by time of day

Functional Rating Index Neck/Back Problems Only

Instructions

In order to properly assess your condition, we must understand how much your neck and/ or back problems have affected your ability to manage everyday activities. Please select a response which most closely describes your condition right now.

Today, do you or would you have any difficulty at all with:

	Activities	0	1	2	3	4
1	Pain Intensity	No Pain	Mild pain	Moderate pain	Severe pain	Worse possible pain
2	Sleeping	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
3	Personal Care (washing, dressing, etc.)	No Pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate paoin; need some assistance	Severe pain; need 100% assistance
4	Travel (driving, etc.)	No Pain; on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain; need 100% assistance
5	Work	Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot Work
6	Recreation	Can do all activities	Can do most activities	Can do some activities	Can do a few activiites	Cannot do any activities
7	Frequency of pain	No Pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant paoin; 100% of the day
8	Lifting	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9	Walking	No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
10	Standing	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Date _____

Score: _____

Percent: _____

Aspen Chiropractic Center

Consent, Financial Responsibility & Office Policies

Payment / Insurance
Payment (including co-pays) is due at the time services are rendered unless other arrangements are made in advance with the office manager. We will complete necessary forms to submit claims to insurance carriers. You are responsible for any balance not paid by insurance.

Cash Patient Discount (TOS)
Cash patients may receive a Time of Service (TOS) reduction when payment is made at the time of visit. If payment is not made at time of service, charges will reflect the usual and customary/fee schedule rates.

Cancellation / No-Call No-Show Policy
Appointments canceled with less than 24-hour notice may be charged a $25 fee (not covered by insurance). Missed appointments without calling may be charged based on appointment type. After three (3) late cancellations and/or no-call no-shows, the patient may be placed on walk-in status only (wait times vary; massage not guaranteed). If running late, please call the office.

Communication Consent
I give permission for Aspen Chiropractic to contact me with appointment reminders by text message and/or voice message at the number provided.

Privacy Practices (HIPAA)
Aspen Chiropractic maintains the privacy of individually identifiable health information (IIHI) as required by law. I acknowledge receiving the Notice of Privacy Practices and understand my information will be kept confidential in accordance with HIPAA.

Informed Consent to Care
Chiropractic care may include examination/testing and chiropractic adjustments and supportive therapies. Potential benefits include improved joint motion, reduced inflammation/swelling, reduced pain, and improved function/well-being. Results are not guaranteed and no promise to cure is made.

Risks
As with all health care, risks may include (but are not limited to) muscle spasm, temporary symptom increase, lack of improvement, burns/scarring from therapies (hot/cold/e-stim), fractures, disc injuries, dislocation, strains/sprains, and rare vascular events including cervical arterial dissection and stroke. Estimated association is extremely rare (reported from 1 in 1,000,000 to 1 in 2,000,000 cervical adjustments).

Alternatives
Alternatives may include self-care, OTC medications, rest/physical measures, medical care/prescriptions, physical therapy, bracing, injections, surgery, and obtaining a second opinion.

Authorization / Assignment of Benefits

I authorize Aspen Chiropractic Center to release information necessary to insurance carriers, process insurance claims, and use a photocopy of my signature to process claims for the period of lifetime. I assign all medical benefits to which I am entitled and authorize my insurance carrier(s) to pay Aspen Chiropractic Center directly. I understand I am financially responsible for any amount not covered by insurance and that fees are due at the time of service unless prior arrangements are made.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

Office Witness: _____ Date: _____

By signing above, I acknowledge and agree to the policies and informed consent described on this page.

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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

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