Peak Health CHIROPRACTIC

Dr. Cortney L. Short, DC
4055 SW 185th Ave. Suite 200
Aloha, OR 97078
Phone: 503-642-1449
Fax: 503-642-1577
peakhealthchiro.com

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Preferred Pronouns: _____

Address: _____ City _____ State_____

Zip _____ Cell Phone _____ Other Phone _____ E-mail_____

Occupation: _____ Employer: _____

Marital Status: *M S D W* Spouse: _____ # of Children: _____

You may leave messages for me on my phone, answering device, and/or with a family member. Yes / No

Did you consult other doctors for this condition? **Yes / No** Have you ever had chiropractic care before? **Yes / No**

Please list all car accidents, injuries, surgeries, or other traumas: _____

_____

Whom may we thank for referring you to our office**?** _____

For Women: Date last menstrual cycle began _____ Are you pregnant? Y / N

Due to changes in health insurance fees, patient self-billing has become a much more cost-effective way for you to get reimbursement for your care. Self-billing allows us to keep our fees low, so you can get the care you need without any added cost. Therefore, our policy is that full payment is due at the time of service and bills will no longer be sent to your insurance provider. Statements will be provided for individuals to submit to their own insurance ensuring that as your insurance provider pays for your care, they will send reimbursement directly to you.

Relief or Correct the Cause? More often than not, people are looking to solve **the cause** of their problems and will benefit from corrective care. Your doctor will take your needs into account when recommending a course of care.

Relief care is focused on decreasing symptoms or pain, but not the cause of it, like drying a floor wet from a leak, but not repairing the leak.

Corrective care goes beyond relief to solve the cause of the problem. This care may require more time and attention, but the results are far better.

I understand I am financially responsible for all expense incurred in the course of my treatment at Peak Health Chiropractic. **I authorize Peak Health Chiropractic to render all necessary examination and/or diagnostic x-rays which may be necessary for treatment.** I understand and agree that Peak Health Chiropractic has the right to refuse to accept me as a patient at any time.

Signature: _____ **Date:**_____

THANK YOU FOR ALLOWING US TO SERVE YOU!

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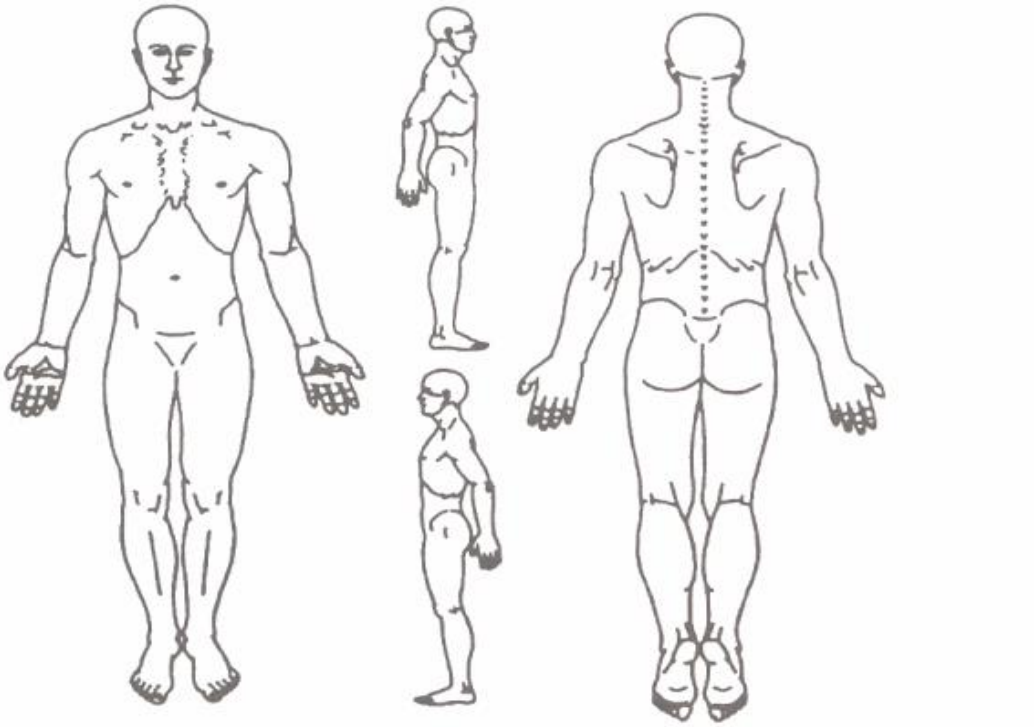
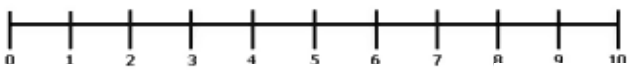
WRITE THE APPROPRIATE LETTER(S) AT THE LOCATION(S) WHERE YOU ARE EXPERIENCING PAIN OR DISCOMFORT ON THE IMAGES BELOW.

B=Burning **C**=Cramping **D**=Dull **N**=Numb **S**=Stabbing/Cutting **T**=Tingling



ON THE SCALES BELOW, PLEASE DRAW AN "X" ON THE SPOT THAT BEST REPRESENTS YOUR PAIN OR DISCOMFORT.

*Rate the pain you have right <u>NOW</u>:



No Pain — Moderate Pain — Worst Pain Possible

*Rate your <u>AVERAGE</u> pain in the last week:

No Pain — Moderate Pain — Worst Pain Possible

*Rate your pain at its <u>BEST</u> in the past week:

No Pain — Moderate Pain — Worst Pain Possible

*Rate your pain at its <u>WORST</u> in the past week:

No Pain — Moderate Pain — Worst Pain Possible

Patient Name _____ **Date of Birth** _____

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Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name: _____Phone _____

Address: _____

_____

SECTION B: TO THE PATIENT—this notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: **By signing this form, you are consenting to treatment** and, our use and disclosure of your (PHI) and (EHR) protected health information and along with electronic health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent, along with being posted in office. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Peak Health Chiropractic, Office. 4055 SW 185th Avenue, Suite 200 Aloha, OR 97078 503-642-1449
office@peakhealthchiro.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature _____ ***Date***: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____ _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

Authorization is given for _____ to have access to my Medical records.

Sign_____ Date_____