BODY SAGE

Orthopedic Massage & Chiropractic Wellness
9430 SW Coral Street, Suite 203 Tigard, OR 97223
Tel: (503) 644-1418 Fax: 503 644-1422

WELCOME

The doctors and staff of **BODY SAGE** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

PATIENT INDENTIFICATION

Patient's Last Name: **First:** **MI:** Mr. □ Mrs. □ Miss □ Ms. □

_____ is this your legal name? Yes □ No □

If *not*, what is your legal name? _____

Marital Status: Single □ Married □ Divorced □ Widowed □ Separated □

Date of Birth: ____/____/_____ Age: _____ Sex: Male □ Female □

Mailing Address: _____

City: _____ State: _____Zip Code: _____

Telephone: _____ Email: _____

Occupation: _____ Employer: _____

Name of Parent of Minor Patient (If applicable) _____

How did you hear about Body Sage: Dr. □ Insurance □ Family □ Friend □ Web □ Yellow Pages□
Social Media □ Mailer □ Other □ _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance: Kaiser □ Aetna □ Cigna □ Ash □ CHP □ Providence □ Other □ _____

Subscribers Name: _____ Subscribers Birthdate: ____/____/_____

Group No. _____ Policy Number: _____

Deductible: Yes □ No □ Deductible Amount: $ _____ has this amount been met? Yes □ No □

Amount remaining until deductible is satisfied: $_____Co-pay: Yes □ No □ Amount $ or % _____

Physician Referral Required? Yes □ No □ Treating Physician: _____

Patient's relationship to subscriber: Self □ Spouse □ Child □ Other □

Secondary Insurance (*if applicable*): Kaiser □ Aetna □ Cigna □ Ash □ CHP □ Providence □ Other □ _____

Subscribers Name: _____ Subscribers Birthdate: ____/____/_____

Group No. _____ Policy Number: _____

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IN CASE OF EMERGENCY

Name of relative or local friend: _____

Relationship to patient: _____ Phone Number: _____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of **BODY SAGE** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment but are part of the process of information gathering so that the doctor can determine whether or not to accept me as a patient.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the treating physician or therapist. I understand that I am financially responsible for any balance. I also authorize Body Sage Orthopedic Massage & Chiropractic Wellness and my insurance company to release any information required to process my claims.

Patient Signature _____ **Date** ____/____/20_____

Signature of Parent of Minor Patient: _____ **Date** ____/____/20_____

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Patient History

In our office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Your Early Years: (birth to 17yrs) *Current research has shown that many of the health challenges that occur in our adult life have their beginnings during our childhood years, some starting as early as birth.*

(Y) Yes (N) No

Did you have any serious falls as a child? _____ Were you vaccinated? _____
Were you involved in any car accidents as a child? _____ As a child, did you receive regular chiropractic care?___
Were you active in youth sports? _____ Did you have any surgery as a child? _____
Did you wear braces/head gear/retainer or other?_____ Date of most recent auto accident/injury:_____
Did you use any medications (antibiotics, inhalers, aspirin, etc.) on an on-going basis? Y N

Adult Years: (18+yrs)
Did/ do you smoke? Y / N How much_____ how long _____ did/ do you play any adult sports? _____
Did/ do you drink alcohol? Y / N How often _____ how Much? _____
Did/ do you participate in any extreme sports? _____
Have you been in any accidents? ____ what year? _____
On a scale from 1-10 describe your stress level. (1=none/ 10 Extreme) *Occupational* 1 2 3 4 5 6 7 8 9 10
Personal 1 2 3 4 5 6 7 8 9 10

Do you?
Belong to health club: _____ *Take vitamins:* _____ *Drink bottled water:* _____

Please Circle: Describe your			
Diet	*Excellent*	*Good*	*Poor*
Exercise	*Excellent*	*Good*	*Poor*
Sleep	*Excellent*	*Good*	*Poor*
General	*Excellent*	*Good*	*Poor*
Health	*Excellent*	*Good*	*Poor*

Reasons for consulting office: Please briefly describe the *chief area of complaint* ***If you have no symptoms or complaints and are interested in Wellness services, please let us know.***
Intensity Scale-1=low 10=unbearable
1._____ Date of Onset_____ ***1 2 3 4 5 6 7 8 9 10***
2._____ Date of Onset _____ _____ ***1 2 3 4 5 6 7 8 9 10***
3._____ Date of Onset _____ ***1 2 3 4 5 6 7 8 9 10***
How often is the pain present? Δ Intermittent (25% or less) Δ Occasional (26-50%) Δ Frequent (51-80%)
Δ Constant (81-100%)
Since your problem began, is your pain? Δ Getting better Δ Staying the same Δ Getting worse
How did your problem begin? Δ Auto accident Δ Work related Δ Other type of accident Δ Gradual Onset Δ Sudden Onset
Δ No Specific reason please explain: _____
What makes it worse? Δ Walking Δ Standing Δ Sitting Δ Stairs Δ Driving Δ Working Δ Moving/Exercise
Δ Sneezing/Coughing Δ Other:_____ What makes it better:_____

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*Medications currently taking (*OTC/Prescription)*:*_____
Were you treated for this condition previously? _Yes _No If yes, by whom? Δ Chiropractor Δ MD Δ Physical Therapist Δ Other_____List dates, types of treatments and results:

_____
_____
_____

Does your problem affect your ability to work or affect your routine daily activities? Δ No effect Δ Limited restrictions but can function Δ Needs some assistance with daily activities Δ Cannot work Δ Cannot function without assistance Δ Totally disabled --- List all Surgeries:

_____
_____

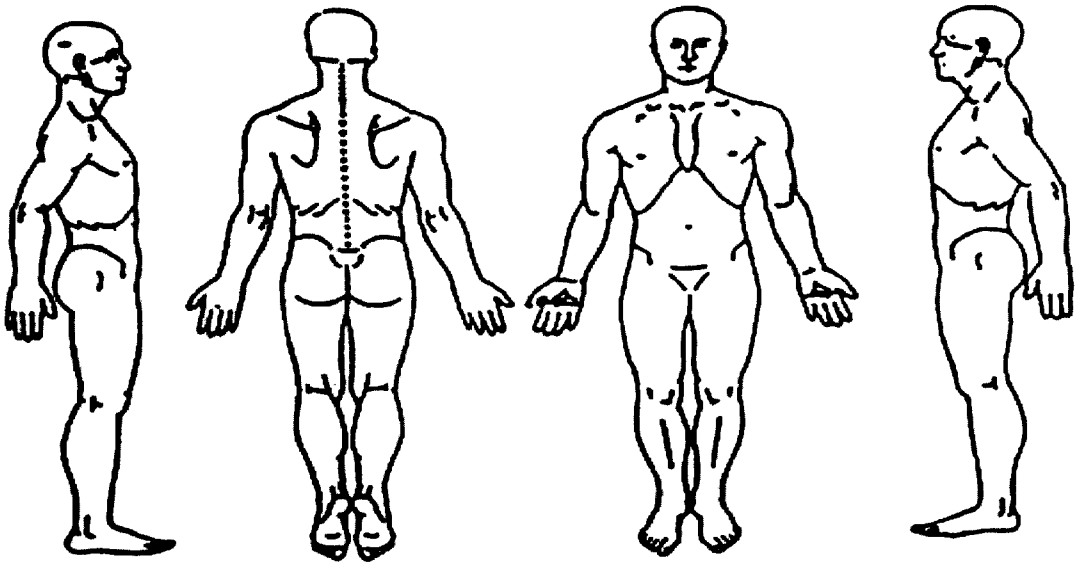
Previous Chiropractor: Δ Yes Δ No Dr._____
Time under care_____ Last Visit_____
Reason for interrupting care: _____
Other Doctors seen for this problem: Δ MD/specialist_____ Δ Physical Therapist Δ Other: _____

List dates, types of treatments and results:

_____

Family Health Profile: *At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:*
Mother _____Sister _____
Brother_____ Father _____
Spouse _____ Child _____

Using the letters below please mark on these figures the area and type of altered sensation you are experiencing.
P = Pain **T** = Tingling **S** = Stiffness
B = Burning **N** = Numbness **M** = Muscle Spasm



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Please indicate beside the below activity whether you engage in it:
OFTEN = "O" SOMETIMES = "S"

SOCIAL HISTORY

_____ Horseback riding _____ Tennis
_____ Bowling _____ Gymnastics
_____ Golf _____ Skiing
_____ Volleyball _____ Water skiing
_____ Baseball/softball _____ Hunting
_____ Handball _____ Fishing
_____ Racquetball _____ Lawn mowing
_____ Basketball _____ Weed eater use
_____ Walking (mile or less) _____ Snow shoveling
_____ Walking (more than mile) _____ Gardening
_____ Jogging (mile or less) (mile or more) _____ Child care
_____ Dancing _____ Girl/Boy Scouts
_____ Scuba diving _____ Cycling
_____ Back packing _____ Climbing stairs
_____ Swimming _____ Alcohol _____ per day_____ per week
_____ Aerobics _____ Yoga
_____ Resistance training _____ Medication
_____ Free weights _____ Tobacco
_____ Exercise machines _____ Football
Other_____

FAMILY HISTORY

Please indicate if any of the following is currently or has contributed to some stress or personal lifestyle changes within the past three years.

_____ Marriage _____ Dependence problems
_____ Birth of a child _____ Alcohol
_____ Divorce _____ Drugs
_____ Death of spouse _____ Change in jobs
_____ Marital separation _____ Loss of job
_____ Death of a family member or friend _____ Retirement
_____ Handicapped household member _____ Change in living conditions
_____ Caregiver to family member _____ Change in residence
_____ Spousal abuse _____ Change in financial status

Doctors Notes:

_____

_____

_____

Name (Printed):_____ **DOB:** _____/_____/_____

Signature: _____ **Date:** _____/_____/_____

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INFORMED CONSENT

The primary treatment used by doctors of chiropractic is the spinal adjustment.

The doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click." You may feel or sense movement.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations.

Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. These complications are extremely rare occurrences.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the initial examination.

- I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment.
- I have discussed it with the Doctors of Body Sage Orthopedic Massage & Chiropractic Wellness and have had my questions answered to my satisfaction.
- By signing below, I state that I have weighed the risks involved in undergoing treatment recommended. Having been informed of the risks, I hereby give the doctors of Body Sage Orthopedic Massage & Chiropractic Wellness consent to treatment.

_____
Patient name (print)

_____ _____/_____/20_____
Patient Signature **Date**

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CONSENT TO AUTHORIZE DISCLOSURE OF INFORMATION (HIPAA)

Patient's Name: _____

Patient's DOB: _____/_____/_____ **Patient's Phone Number** _____

I hereby authorize the use and disclosure of individually-identifiable health information related to me as described below:

Specific description of information to be used or disclosed:

A. **Schedule re-schedule, confirm or cancel appointments**
B. **All account financial information, to include all third party information (MVA, WC)**
C. **Making payments, insurance inquiry, account balances or collection inquiry**
D. **Requesting medical records and billing invoices**
E. **Retrieving prescriptions, imaging orders, medication samples or specific written**
F. **doctors' orders**

I authorize the following person to receive my information:
(Please write the name of the person)

NAME: _____ **RELATIONSHIP TO PATIENT:** _____

I understand I may revoke this authorization at any time by notifying Body Sage Orthopedic Massage & Chiropractic Wellness in writing. If I choose to do so, my revocation will not affect any action taken by Body Sage Orthopedic Massage & Chiropractic Wellness before receiving my revocation.

This authorization will expire on: 12/31/2017 (unless revoked sooner by patient/parent representative)

Patient's Signature: _____ **DATE:** ____/____/20____

PATIENT REPRESENTATIVE: (If applicable)

NAME: _____ **RELATIONSHIP TO PATIENT:** _____

DRIVER'S LICENSE # _____ **ISSUING STATE:** _____

Patient's Signature: _____ **DATE:** ____/____/20____

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FINANCIAL POLICY

Thank you for choosing **Body Sage Orthopedic Massage & Chiropractic Wellness** as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered we have been advised to develop this payment policy. Please read it, ask any questions you have, and sign in the space provided. A copy will be furnished upon your request.

1. **Insurance:** We participate in most insurance plans. We can verify and check on your insurance benefits for you prior to receiving care, but it is your responsibility to know your insurance benefits. However, insurance companies will never allow that a quote of coverage is a guarantee of benefits. If you have a copay, coinsurance or unmet deductible, you will be responsible for payment at time of service. We will require a deposit of $80.00 until your insurance is verified. We will bill your insurance for services rendered in the office. After the receipt of Explanation of Benefits (EOB) from your insurance carrier, we can apply the deposit to your co-pays or refund the balance. **Patient Initials** _____
2. **Time of Service Discount (TOS):** We offer a time of service discount to our patients that have high deductibles. No health insurance or just prefer to pay cash. Payment is due in full at the time services are rendered. Please note that we will not bill your insurance or go back and bill at a later date once a TOS discount is given.
3. **Non-Covered Services:** Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit.
4. **Proof of Insurance:** All patients must complete our patient information forms before seeing a therapist or the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of a claim.
5. **Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly, but it is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, and we are not a party to that contract.
6. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 90 days, the balance will automatically be billed to you.
7. **Personal Injury/Workers' Compensation:** Most Personal Injury and Workers' Compensation claims are covered 100%. However, it is your responsibility to provide our office with the documentation necessary to prove a valid claim, as well as the name(s) of any claims adjuster/attorney, etc. handling the case, claim numbers, and mailing address to send bills. Failure to provide the documentation needed will result in the immediate conversion of your case to cash, and all payment will be due on receipt. **Patient Initials** _____

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8. **Non-payment:** If your account is over 90 days past due you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted, unless otherwise negotiated with Body Sage Massage. Please be aware that if a balance remains unpaid we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
9. **Missed Appointments:** Our policy is to charge $50.00 for missed appointments not canceled within a 24 hour period to your appointment time. This also includes same day re-scheduled appointments. These charges will be your responsibility and billed directly to you.

Please help us to serve you better by keeping your regularly scheduled appointment. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy for Body Sage Massage Orthopedic Massage & Chiropractic Wellness and agree to abide by its guidelines. I also understand that I am ultimately financially responsible for all services not paid by insurance or other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice and pay it promptly, or contact the office to make payment arrangements.

Patient/Guardian Signature: _____ **Date**: _____