*Chiropractic Associates*
*Rodney J. Cross, DC, Michael P. Thille, DC*
*117 N. Larch Ave., Redmond, OR 97756*
*541-548-4014 fax 541-548-0544*

# REGISTRATION FORM

First Name _____ MI ___ Last Name _____ Date _____

Date of Birth _____ Age _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Other

Race/Ethnicity _____ ☐ Declined to Specify Language ☐ English ☐ Other

Mailing address _____

City/State/Zip _____

Contact phone # _____ Email _____@_____

Is it okay to leave a detailed message? Yes: ☐ No: ☐

Employer _____ Work # _____

How did you hear about us? _____

Emergency contact _____ Relationship to patient _____ Phone # _____

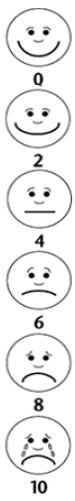
☐ **Injury at work** (only mark if filing w/employer)
**Date of accident _____**

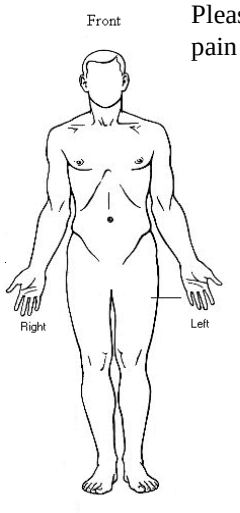
☐ **Auto Accident**
**Date of accident _____**

Reason for seeing the doctor? ☐ Back pain ☐ Leg pain ☐ Neck pain ☐ Arm/Shoulder pain ☐ other

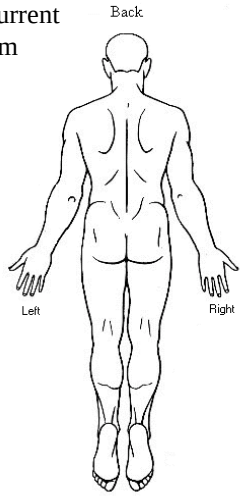
Duration of condition ☐ Less than 1 week ☐ 2-4 weeks ☐ 1-2 months ☐ 2-6 months ☐ > 6 months

Cause of condition _____ Primary Care Physician _____




Please mark where your current pain is on the body diagram




Weight _____

Height _____

Blood Pressure_____

Pulse Rate:_____

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Indicate by marking any of the following conditions that apply to you now or in the past. *This is a confidential record of your medical history.*

- ☐ History of Osteoarthritis
- ☐ History of High Blood Pressure
- ☐ History of Diabetes
- ☐ Cancer
- ☐ Asthma
- ☐ Arthritis
- ☐ Heart trouble
- ☐ Kidney trouble
- ☐ Depression
- ☐ Nervousness
- ☐ Bloody urine
- ☐ Frequent urination
- ☐ Cough or wheezing
- ☐ Shortness of breath
- ☐ Night Sweats
- ☐ Palpitation of heart
- ☐ Headaches
- ☐ Fainting or dizziness
- ☐ Swollen ankle
- ☐ Numbness or tingling
- ☐ Leg cramps
- ☐ Drink Coffee
- ☐ Taken cortisone
- ☐ Possible pregnancy

**Tobacco** *(select all that apply)*

- ☐ Never Smoker
- ☐ Former Smoker
  End year:_____
- ☐ Every Day Smoker
  Start Year:_____
- ☐ Smokeless Tobacco
- ☐ Vaping
- ☐ Declined to specify

**Alcohol Use:**

- ☐ Never
- ☐ Rare
- ☐ Occasional
- ☐ Every Day
- ☐ Declined to Specify

*Please describe as fully and completely as possible.*

| | |
|---|---|
| *Past Health Problems* | |
| *Surgery/Operations (last 7 years)* | |
| *Current Medications* | |
| *Medication Allergies* | |

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## FINANCIAL AGREEMENT—HIPAA COMPLIANT

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments.

I hereby authorize the doctor to furnish my insurance company all information, which the insurance company requests to process claims. I hereby assign to the doctor all money to which I am entitled for medical expense relative to the services, but not to exceed my indebtedness to the physician. It is understood that any money received from my insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to the doctor(s) for charges not covered by this assignment. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event legal action should be come necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon, and all proceeds of insurance.

I request that payment of authorized Medicare benefits are made either to me or on my behalf to (provider/supplier listed) for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible for the deductible, coinsurance, and non-covered services.

This authorizes request of medical information, when necessary, to obtain pertinent information on my behalf from other doctors as required for professional communication purposes.

*The charge for returned checks is $35. The interest rate on unpaid balances is 1.5% per month.*

***Payments and copays are due at time of service.***

**As a convenience to you, we will attempt to contact your insurance company to obtain your chiropractic benefits. However, we may not always receive correct information. The contract is between you and your insurance company therefore, you are ultimately responsible for all your incurred charges/fees.**

Patient Signature _____ Date _____
*(Signature on file)*

***(Must be signed regardless of insurance or cash patient)***

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# CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTH CARE OPERATIONS.

I understand that Chiropractic Associates, P. C. will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results diagnoses, treatments, procedures, prescriptions and similar types of health related information.

I understand and agree that Chiropractic Associates, P.C. may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage and submit bill, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my chiropractors efforts to provide me with, arrange and be reimbursed for quality cost effective health care.

I also understand that I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the practices followed by employees, staff and other office personnel of this practice and my right regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and I have a right to updated copies of those.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices. I also understand that by law this office is not required to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received/reviewed a copy of the Notice of Privacy Practices.

Patient _____ Date_____

Representative_____ Date_____

Relationship to patient: Self Spouse Parent Other:_____

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**Beneficiary Agreement:**
I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not make payment for services, I will be responsible for any co-payment, co-insurance, or deductible that applies.

**Insurance Disclaimer:**
A quote of benefits and/or authorization DOES NOT GUARANTEE PAYMENT or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations and exclusions of the member's contract with their insurance company at time of service. We do urge our patients to call their insurance company to verify their benefits before scheduling an appointment. We check our patient's benefits as a courtesy and we give the information available to us at that time; however your insurance company will ultimately determine how they will pay for benefits once they receive a claim.

**Insurance Liability for Payment:**
Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service and you will be responsible for payment of that service.

- Please note that your insurance company has a contract with you, the insured, and not with this office. Any disputes with your insurance company are your responsibility to resolve.
- Verification of coverage is **NOT** a guarantee of payment, and benefits are subject to plan limitations and coverage at the time the claim is received.
- *Please understand that financial responsibility for your account is yours, not your insurance company.*

Patient's printed name

Patient's signature

Date