Heresco Chiropractic

Patient History Update

Today's Date: ____/____/____

Legal Name: _____Birthdate: ____/____/____ Age: ___ Gender: _____

Address: _____ City, State, Zip: _____

E-Mail Address (*Please print clearly*): _____

Cell Phone #: _____ Work Phone #: _____ Home Phone # _____

We offer Text Appointment Confirmations. Please initial here if you'd like to receive those. ☐

Employer:_____Occupation:_____

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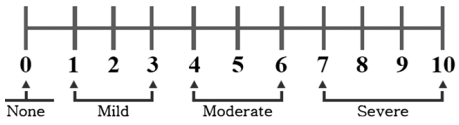
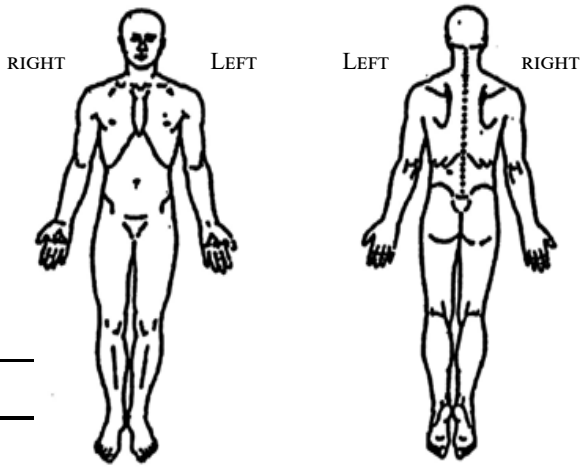
1. What is your Height? _____ What is your Weight? _____

2. Please mark area(s) of injury, pain, or discomfort using:
A) Letters to describe your pain.
B) Numbers for the degree of pain using a scale from 1-10.

- N = Numbing
- P = Pins & Needles
- B = Burning





3. What has been bothering you and how can we help? _____

_____

4. Are you having any new symptoms? _____

_____

Use opposite side to answer any questions you would like to elaborate on :-)

5. How long have you had this problem?_____

6. How do you think your condition began?_____

7. What aggravates your condition? _____

8. What has helped your condition? _____

9. Have you been diagnosed with any new conditions?_____

10. Any significant traumas in the past we should know about? _____

_____

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Pt file #: _____

BP: _____

Pulse: _____

Name of Person who took vitals:

_____

Heresco Chiropractic 408 NW 7th Street - Corvallis OR 97330 **Ph: 541.757.9933 Fax: 541-757-7713**
Provider: Joseph Shepro, DC, Don Peterson, DC, Jason Kennedy, DC

Heresco Chiropractic

Patient's Legal Name: _____ **File#:** _____

11. Please list all surgical procedures with dates: _____

_____

_____

12. Date of your last physical & name of doctor: _____

13. Since we last saw you, you have been seen by Dr. ? _____

14. Who is/are your current treating health care providers? _____

15. Do you have any questions about your health or treatment? _____

_____

Please complete this area with your current medications. If you have a form already completed, we can copy it to save you time.

Medication	Dose	Frequency	For What Condition	Prescribing Doctor	Side Effects/None

16. If this is a minor, who is the guardian or patient representative with medical decision-making authority?

Name and relationship _____

Additional Space if Needed: _____

_____

_____

_____

_____

_____

17. **It is your responsibility to inform your doctor of any health changes prior to treatment..**

Patient/ Guardian Printed Name: _____

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

Heresco Chiropractic

Informed Consent to Chiropractic Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent when starting treatment.

I _____(Legal Name), of _____(Town of Residence) hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/ adjustments involving the movement of the joints and soft tissues. These manipulations/adjustments may be **performed by any of the chiropractors on staff** at this office. Physiotherapy and exercises may also be used. Although chiropractic care, including spinal manipulation/adjustment is considered to be a low risk and highly effective form of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

_____ **Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Initials

_____ **Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Initials

_____ **Fractures/Joint Injury**:I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones
Initials from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. If a tendon is weak or partially torn, manipulation may cause it to tear the rest of the way.

_____ **Stroke/ Cervical Artery Dissection** Although dissections and strokes happen with some frequency in our world, dissections and strokes associated
Initials with chiropractic adjustments are rare. I am aware that significant injuries can result from a cervical (neck) artery dissection, including nerve or brain damage from subsequent stroke, but that dissections associated with chiropractic adjustments are reported in approximately once in one million treatments to once in ten million treatments. To put it in perspective, there is a higher chance of morbidity from taking an aspirin or Tylenol. If you have any unusual symptoms before, during or following treatment, you should immediately advise your doctor(s) and seek appropriate care

_____ **Physiotherapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is ob-
Initials tained, there will be a temporary increase in pain and possible blistering and infection. This should be reported to the doctor.

_____ Tests have been performed on me to minimize the risk of complications from treatment and I freely assume these risks. There are no reliable tests,
Initials however, to determine if you are at risk of a stroke or Cervical Artery Dissection. Also, you must provide a complete history on your initial visit and subsequent visits so that appropriate tests can be performed. Your participation is paramount in the success of treatment and reduced risk.

_____ Treatment Results I also understand that there are beneficial effects associated with these treatment procedures including decreased pain,
Initials improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree with the performance of these procedures by my doctor and such other persons of the doctor's choosing including other chiropractors that work for this office and certified assistants.

_____ Alternative Treatments Available
Initials Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, and possible surgery, medicine injections, and acupuncture. All of these alternatives carry a certain form of risk as well and should be discussed with your health care provider.

_____ **Medications:** Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for
Initials concern. Drugs may mask pathology, produce inadequate or short-term relief, undesired side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

_____ **Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and
Initials pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

_____ **Surgery:** Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain
Initials or reaction to anesthesia, and prolonged recovery.

_____ **Non-treatment:** I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted
Initials motion possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

_____ **Health care should be shared** by the doctor & the patient. You have a responsibility to tell the doctor if your health changes, such as but not
Initials limited to, new medications, a new condition such as diabetes, any surgeries, etc. Please do your part so we can help keep you healthy and safe.

_____ **COVID –19:** While Heresco Chiropractic and Associates are taking many steps to wear face masks, disinfect, clean, and practice social distancing
Initials the best we are able, there is always a risk of infection. By signing this, you acknowledge that and wish to proceed with care.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered by one of the doctors to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ _____ _____/_____/_____
Signature of Patient *Patient #* *Date*

_____ _____
Signature of Guardian *Signature of Witness*

Heresco Chiropractic

HIPAA - Notice to Patient

Acknowledgement of Receipt of *Notice of Privacy Practices* - *This form will be retained in your medical record.*

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Legal Name:_____ **Patient #**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Heresco Chiropractic and Associates. I understand that the Notice describes the uses and disclosures of my protected health information by Heresco Chiropractic and Associates and informs me of my rights with respect to my protected health information. I also understand that I can find this entire form on **www.Heresco.com** website.

_____ _____ _____/_____/_____

Signature of Patient or the Legal Representative *Printed Name of Patient or the Legal Representative* *Today's Date*

_____

If legal Representative, indicate relationship

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We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____/____/_____

Employee's Name **Today's Date**

This form is based on current federal law, is subject to change based on changes in federal law, and the content may need to be modified to adhere to state law or subsequent guidance or advisories. Doctors are advised to consult with their state licensing Board or local counsel.

Condition of Patient at Time of Consent Process

Based on my personal observation and direct conversation with the patient, I conclude that throughout the consent process he/she was:

- ☐ Of legal age
- ☐ Under the age of 18. The legal guardian of the patient has given consent to the treatment of this youth. Guardian Name: _____
- ☐ On prescription/OTC medication but unimpaired.
- ☐ Resolute in denying the use of alcohol and/or recreational drugs prior to consent.
- ☐ Oriented as to time and place.
- ☐ Coherent and lucid.
- ☐ Able to understand the language used.
- ☐ Assisted in understanding by use of an interpreter. Interpreter's name: _____
- ☐ Assisted in consent process by family members: Name: _____ Relationship: _____
- ☐ Assisted in consent process by staff member. Name: _____
- ☐ I encouraged and answered questions regarding this form with the patient.
- ☐ PARQ films:_____

Patient had the following questions and was supplied with the following answers:

Comments: _____

I certify that I held a PARQ conference with the patient and that the above accurately describes to the best of my knowledge the patient's state during the consent process in this case.

_____ _____/_____/_____ ☐ Dr. Shepro ☐ Dr. Peterson ☐ Dr. Kennedy ☐ Dr. _____

Signature of Doctor Date

Heresco Chiropractic

Financial Policy

Legal Name (please print):_____

_____ ***Initials*** **ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE -**Payment is required at the time services are rendered, unless other arrangements have been made in advance. Our Payment Account Representative can establish a payment plan if needed. We offer 3 different payment options: cash, check, and all major credit cards.

_____ ***Initials*** **APPOINTMENTS -**If you need to reschedule an appointment, please give us a 24 hour notice. Our phones are available 24 hours a day, 7 days a week at (541)757-9933.

_____ ***Initials*** **MASSAGE APPOINTMENTS -*If you need to reschedule or cancel a massage you must give at least 24 hours notice.*** If you fail to give a 24 hour notice, your account will be charged the full price of the missed massage.

_____ ***Initials*** **INSURANCE BILLING -**Please provide us a copy of your insurance card so that we can complete a complementary insurance verification to check for stipulations your policy places on your care. We will bill your health, automotive, or workers compensation insurance companies dependent on your source of injury. **It is your responsibility to inform us of any changes to your policy. Failure to notify us of changes to your insurance may result in denials and charges will become your responsibility.**

_____ ***Initials*** **INSURANCE MAXIMUMS -**Most insurances have a set maximum number of visits and/or a max dollar amount that they will pay towards your chiropractic treatment each year. Our primary focus is to take care of you and your health condition. We do our best to help you spend your healthcare dollars wisely and effectively. We treat our patients, not your insurance company. If recommended treatment of your condition goes beyond your insurance company's maximum for the year, we will try to notify you of it as soon as we know. Be aware that when we bill your insurance company, it can take up to 45-60 days to get a response from your insurance. **Please be advised that any treatment accrued during this lag time will be your responsibility. You are responsible for tracking your maximums.** If you have concerns about the maximums allowed by your insurance company, we encourage you to call the Insurance Department. They are available Monday through Friday from 8 AM - 4:30 PM

Your insurance maximum is: _____.

_____ ***Initials*** **SELF PAY -**If you do not have insurance or if you have insurance that does not cover chiropractic, you will be considered self pay. You will be required to pay each visit in full at the time of treatment. There are several discounts for payment received at the time of treatment and even bigger discount for payments in advance. Please ask our front desk receptionists for details or if you have any questions.

_____ ***Initials*** **PERSONAL INJURY -**When a Personal Injury occurs, your insurance will send you a Personal Injury Protection (PIP) application. **The PIP form must be completed before your insurance will pay on your claim.** Our billing department will contact your insurance company to verify coverage. If you have any questions regarding your personal injury please contact our billing department at 541-757-9933.

In Oregon, when an automotive collision occurs, regardless of who's at fault we are required to bill **your** auto insurance. Your auto insurance will recoup payment from the opposing insurance company.

_____ ***Initials*** **WORKERS' COMPENSATION -**Workers' Compensation requires specific information when handling claims like your address, employers name and full address, claim number, and claim manager's name. You will be asked to provide the name and address of your private insurance company on your initial visit. **In the event your claim is denied, we will have an alternate source to bill for services rendered.**

_____ ***Initials*** **MEDICARE -Medicare ONLY covers the cost of the chiropractic adjustments designed to help correct a vertebral subluxation.** An examination is necessary to identify a vertebral subluxation. Medicare requires this and doesn't pay for the cost of the exam or any needed x-rays. Procedures like massage, traction, electric muscle stimulation or other therapies are **NOT COVERED** by Medicare. Medicare does not pay for chiropractic care to maintain your progress or help prevent problems. Most patients see the value of some type of wellness care, Medicare does not pay for the coverage of it.

_____ ***Initials*** **BILLING AND CREDIT -**Statements will be mailed monthly and are due for payment within 10 days. Monthly statements will follow until the account is paid in full. If you have not paid your bill, or have not set up a payment plan, we will ask for the assistance of a collection agency.

_____ ***Initials*** ***CONSENT:*** *I have read, initialed and understand the Heresco Chiropractic and Associates Financial Policy. I fully understand that I am ultimately responsible for all services provided by Heresco Chiropractic and Associates.*

_____ _____ _____ _____/_____/_____

Signature of Patient *Patient#* *Date*

_____ _____

Signature of Guardian *Signature of Witness*

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