PDX CHIROPRACTOR

2850 SE 82nd Ave Suite 8
Portland, OR 97266
P: (503) 777- 3000
F: (503) 777- 0002
pdxchiro@outlook.com

6149 SW Murray Blvd.
Beaverton, OR 97008
P: (503) 747- 2475
F: (503) 908- 2298
bepdxchiro@outlook.com

PATIENT INFORMATION

Name: _____ **Today's Date:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Cell #: _____ - _____ - _____ **E-mail:** _____

Date of Birth: _____ **Sex:** M F Prefer Not to Answer

Marital Status: _____ **Occupation & Employer:** _____

Work #: ____ - ____ - _____

Name of Family Doctor: _____ **Preferred Language:** _____

What are you most concerned about? _____

Who can we thank for referring you? _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____ **Phone #:** _____ - _____ - _____

Name: _____ **Relationship:** _____ **Phone #:** _____ - _____ - _____

INSURANCE CLAIM INFORMATION

Date of Accident: ____ / ____ / _____ **Driver's Name:** _____

Insured Name: _____ **Relationship to Insured:** _____

Insurance Company:_____ **Insured Policy #:** _____

Claim #: _____ **Adjuster:** _____

Other Driver's Name: _____

Other Vehicle's Insurance: _____ **Claim #:** _____

ATTORNEY INFORMATION

Is there an attorney involved? □ Yes □ No **Law Firm:** _____

Attorney's Name: _____ **Phone #:** _____ - _____ - _____

If you were a pedestrian or on a bicycle:

- Do you or anyone in your household own a car? □ Yes □ No **Auto Insurance:** _____

PLEASE PROVIDE YOUR PHOTO ID AND CAR INSURANCE

The above information is accurate to the best of my knowledge.

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

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Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and, if necessary, diagnostic x-rays, on me by one of the clinic's physicians.

I have had the opportunity to discuss with the Chiropractic Physician the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am aware that, as in all healthcare, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, fractures and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor/associates/personnel to exercise judgment during the course of the procedure which they feel is at the time, based upon the known facts, is in my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the chiropractic procedures mentioned above. I intend for this consent form to cover the entire course of all treatments.

_____ _____

Patient/ Guardian Signature **Date**

_____ _____

Print Name **Signature of Chiropractic Physician**

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HIPAA Patient Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing the consent.

The terms of the notice may change. You can contact our office for an updated copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree with these restrictions.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

Patient/ Guardian Signature: _____Date: _____ / _____ / _____

Print Name (Patient/ Guardian):_____

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FORM

I authorize: _____,
(Name of Person / Entity disclosing information)

To disclose a copy of all medical and health records regarding;
_____DOB:_____ /_____ /_____,
(Patient Name) MM DD YYYY

TO PDX Chiropractor (Recipient),

At the request of the individual, for the purpose of providing healthcare.

If the information to be disclosed contains any type of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____HIV/AIDS Information
_____Mental health information
_____Genetic testing information
_____Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclose pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You may revoke this authorization in writing at any time. If you revoke your authorization described above, it may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, send a written statement declaring you are revoking authorization to:
PDX Chiropractor
2850 SE 82nd Ave. #8
Portland, OR 97266

SIGNATURE
I have read this authorization and I understand it. Unless revoked, this authorization expires in seven years

By: _____ **Date:** ____ / ____ / _____
(Individual or Representative)

Description of representative's authority: _____

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IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the clinic and doctors on whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of certain accident or injury-producing event which occurred on or about the date of injury(DOI) indicated below, to the full extent of the cost and treatment provided me by the Clinic.

I hereby authorized and direct my attorney(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for the treatment and other professional services. Rendered me both by reason of this accident and by any other bills that are due the Clinic and to withhold such sums from the settlements, judgments, or verdicts which may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by the clinic.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the clinic's additional protection and in consideration for the Clinic's waiting for payment. I further understand that payment for services rendered by the Clinic is not contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand that if my attorney(s) does/do not protect the Clinic's interest, the

Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against attorney(s) for failing to honor this binding and irrevocable agreement between me and the Clinic.

I further understand and agree that the Clinic is not responsible for paying any of my attorney's fees and the Clinic does not agree to pay my attorney fees for honoring this agreement between me and the Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM SIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT ANY PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, AND LIEN."

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

Patient/Guardian Printed Name: _____