ELK RIDGE
Chiropractic & Wellness Center

NEW PATIENT INFORMATION
Medicare Packet

Please answer every question to the best of your ability.

_____
Patient Full Name

Street Address: _____ City: _____ State: ____ Zip:_____

Mailing Address: _____ City: _____ State: ____ Zip:_____

Birthdate: _____ E-mail: _____

Social # _____ Home #: _____ Cell #: _____

Marital Status: ☐ Married ☐ Partnership ☐ Single Are you a student? Yes / No ☐ Part-Time ☐ Full-Time

Who referred you: _____ (We want to thank them for referring you)

Emergency Contact: _____ #: _____

Your Occupation: _____ ☐ Part-Time ☐ Full-Time

Your Employer/ Business Name: _____

Most Recent Chiropractor: _____ City: _____ State: _____

Date of the Last visit to your previous Chiropractor (approximate): _____

Reason for leaving last Chiropractor: _____

Primary Care Physician or Naturopath: _____

Are you currently under Doctor Supervision? YES NO Who: _____

Insurance Company: _____ Customer Service #:_____

Primary Policy Holder: _____ Primary's Birthday: _____

Consent to Treatment:

I _____ hereby give my permission to the examining physician to order x-rays, routine tests, and Chiropractic treatment for my condition. I understand that I will be presented in this packet a "Terms of Acceptance" which explains Chiropractic, "Our Fee Structure" that shows the cost, and "HIPPA" that explains my records privacy.

PATIENT/ GUARDIAN SIGNATURE: _____ **TODAY'S DATE**: _____

FINANCIAL AGREEEMENT

This agreement deals solely with financial obligations. There is no guarantee that any illness, injury, or disease can be prevented or cured by participation in this program. Any balance due for services and products already received are due, regardless of results.

Please read and sign below.

Insurance: A portion of my care provided may be covered by my insurance. I understand that payments made are applied to my deductible, co-pay, and/ or co-insurance, as well as non-covered products/ services that may receive. The benefits quoted above are an estimate based on the information received from my insurance. I am financially responsible for all services/ products I received that my insurance doesn't cover.

SERVICES & PRODUCTS	MEDICARE COST
Adjustment (each visit)	$36.00
Extremity Adjustment (each visit)	$31.00
Manual Therapy (each visit)	$28.00
Therapeutic Rehab (each visit)	$30.00
Examination	$41.00
Laser Light Therapy	$10.00
E-stim (15 minutes)	$18.00

SSN#: In order for my insurance to be billed, I understand that Elk Ridge Chiropractic & Wellness Center must have a copy of my ID and insurance card. Until my insurance pays their portion, I understand that Elk Ridge Chiropractic & Wellness Center is extending credit to me. For this reason, I must have my Social # on file.

Financial Responsibility: Payment is always due at the time of service or paid in advance. These policies in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the debt balance for services/ products already received, that balance is due in full.

Collections & Other Fees: Should my account go to collections, for any amount owed on services and products already received; I agree to pay ALL costs, late fees, collection fees, and any expenses, including attorney fees. Fees: Bounced Check $25 Credit Card Charge Back $25 per incident. Account late fee is 5% of my account balance per 30 day increment past the due date, per month.

Fee Structure: Please note that if you become involved in a motor vehicle accident or work injury, our fee structure may differ due to the complexity of your needs in such cases. All fees are subject to change.

Billing Insurance: Should I have Chiropractic coverage through my insurance carrier; I authorize Elk Ridge Chiropractic & Wellness Center to bill my insurance and send the documents required for reimbursement. I understand that I am financially responsible for all service, products, deductibles, co-pays, and co-insurances not paid by my insurance to Elk Ridge Chiropractic & Wellness Center. Should my insurance reimburse me rather than the clinic, I understand that I must notify the clinic immediately, and that I am financially responsible to reimburse the clinic for the amount that the insurance was to pay the clinic.

Time Of Service Payment: I understand that any deductible, co-pay, and/ or co-insurance are due at the time of service. I also understand that any natural supplements and any supports that I receive will not be covered by insurance and therefore I will pay in full at the time of receipt. Payment for services and products received is due in full at the time of service.

Agreement: I understand and agree to the terms of the agreement outlined above.

PATIENT/ GUARDIAN SIGNATURE: _____ TODAY'S DATE: _____

HIPAA

Certificate of Privacy Assurance to Patients

In the course of your care as a patient at Elk Ridge Chiropractic & Wellness Center, we may use or disclose personal information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, a HMO, or a PPO, if they are or may be responsible for payment of services.
- Your name, address, phone number, and your health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine.
- Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted/required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at another address other than your home or if you would like the information in a different form please advise us in writing as to your preferences.

This office utilizes an "*Open Adjusting*" environment for our ongoing patient care. "*Open Adjusting*" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private and confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your experience with our office and to enhance your access to quality health care and health information. If you choose not to be adjusted in an "*Open Adjusting*" environment, other arrangements will be made for you.

You have the right to inspect and/or copy your health information with a signed records release for seven (7) years from the date that the record was created or as long as the information remains in our files. In addition you have the right to an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of our patient file and protect your health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy policy will apply to all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

I have read and agree to the above.

PATIENT/ GUARDIAN SIGNATURE: _____ TODAY'S DATE: _____

A. Notifier: Natasha Ruegsegger, DC at 424 NE Franklin Ave in Bend OR, 97701

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
__Extremity Adjustments	Not a covered service.	$ 31.00
__Examinations and Progress Evaluations	May not be considered necessary.	$ 41.00
__Natural Supplements	Not a covered service.	$ ___.00 Each
__Durable Medical Equipment	Not a covered service.	$ ___.00 Each
__Spinal Adjustment	May not be considered necessary.	$ 36.00
__Therapeutic Rehabilitation	Not a covered service.	$ 30.00
__IFC/High Volt	Not a covered service.	$ 18.00
__Manual Therapy	Not a covered service.	$ 28.00
__Rock Tape	Not a covered service.	$ 5.00 – 25.00
__Laser Light Therapy	Not a covered service.	$ 10.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CONSULTATION & HEALTH HISTORY

HOW ARE YOU FEELING TODAY?

Primary Complaint/ Symptom: _____

When did this originally happen (date)? _____ Is this a flare-up? When did the flare-up start: _____

What were you doing when you first noticed this pain? _____

Was this an: ☐ Auto Accident or ☐ Work Related Injury Date of Incident: _____

How often do you experience this pain/discomfort? ☐ Constantly ☐ Intermittently (comes & goes) ☐ Occasionally (infrequent)

This pain occurs _____ times per ☐ Day ☐ Week ☐ Month ☐ Year

When does this pain occur or feel worse? ☐ In the Morning ☐ At Work ☐ After Work ☐ Sitting ☐ Standing ☐ Bending

☐ Exercising ☐ Sneezing ☐ Other:_____

Please CIRCLE all that apply describing how you feel:

Aching Burning Cramping Dull Numb Pain Pins & Needles Sharp Shooting Sore Stabbing Throbbing Tight Tingling

At its worst - Pain Scale (1=no pain/discomfort, 10=worst pain ever) Pick ONE: **1 2 3 4 5 6 7 8 9 10**

Does your Primary Complaint: ☐ **MOVE** ☐ **RADIATE** ☐ **STAY** | Where does it move/radiate to?_____

Other Complaints/ Symptoms: _____

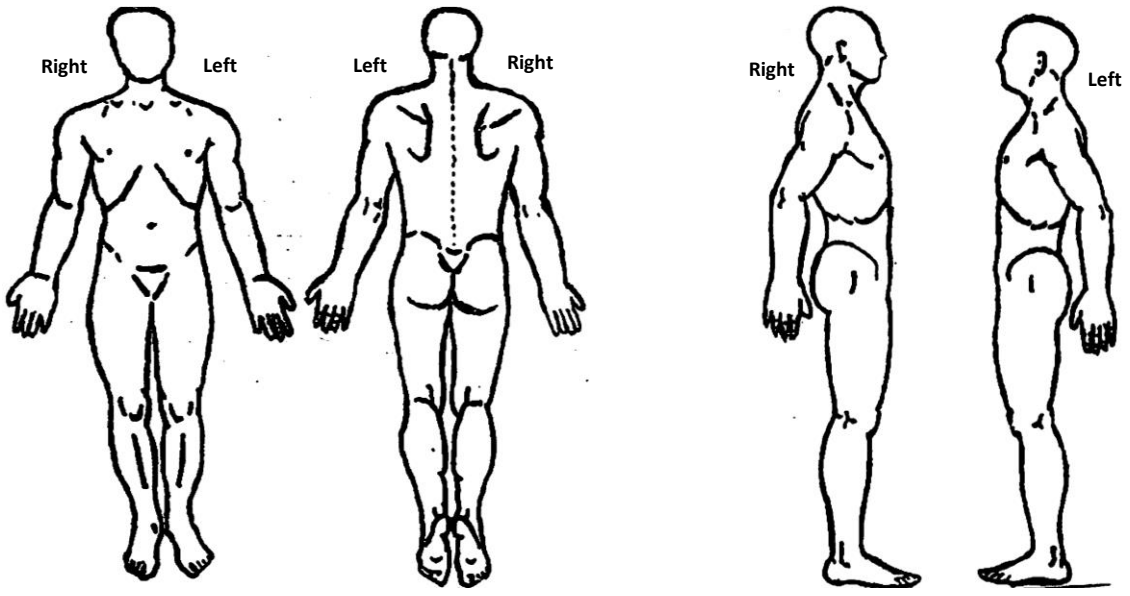
_____

What makes this pain better? ☐ Ice ☐ Heat ☐ Stretching/PT ☐ Exercise ☐ Acupuncture ☐ Massage ☐ Anti-Inflammatories

☐ Other:_____

PAIN SITES

Circle on the image below where you feel any pain or discomfort. It can be the main reason you're here or anything else.



PRIOR AUTO ACCIDENTS

Have you ever been involved in an Auto Accident (even fender benders and little bumps)? **Yes** **No**

When? _____ Injured? **Yes** **No** Explain injuries: _____

Explain the accident: _____

When? _____ Injured? **Yes** **No** Explain injuries: _____

Explain the accident: _____

SLEEPING HABITS

I have trouble: Falling Asleep / Staying Asleep / Waking Up Frequently

Hours of sleep per night: _____ Typical times sleep & awake: _____am/pm to _____am/pm

Wake _____x per night at _____ am / pm Do you wake feeling unrested? **Yes** | **No**

Reason: ☐ Waking to Urinate ☐ Difficulty Falling Asleep ☐ Restless Sleep ☐ Waking Up Early ☐ Disturbing Dreams

MEDICAL HISTORY

MAJOR SURGERIES, BROKEN BONES, INJURIES, HOSPITALIZATIONS (INCLUDING CANCER, C-SECTIONS, ETC):

Year	Type	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS, SUPPLEMENTS AND HERBS. Please list what you are taking:

Start Date	Item	Amount	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Circle **EVERYTHING** you have experienced in the **PAST** and the **PRESENT** or anything your family has experienced.

☐ A.D.H.D./A.D.D.	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Alcohol/Drug Abuse	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Anemic/Blood issue	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Arthritis/Joint Degeneration	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Blood Pressure: Low or High	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Cancer/ Pre-Cancer	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Diabetic: Which Type 1 2	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Emotional/Psychiatric Issues	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Epilepsy	Past	Present |	Mother	Father	Sibling |	Other:_____
☐ Scoliosis/Spondylosis	Past	Present |	Mother	Father	Sibling |	Other:_____

OTHER HEALTH ISSUES

Please check any areas you are experiencing issues with or have dealt with in the past:

TEMPERATURE

- ☐ Absence of thirst
- ☐ Cold hands/feet
- ☐ Excessive Thirst
- ☐ Hot flashes
- ☐ Unusual sweating

URINARY

- ☐ Cloudy / Bloody Urine
- ☐ Decrease in flow
- ☐ Difficulty start/stop
- ☐ Frequent/Urgent Urination
- ☐ Incontinence
- ☐ Pain/Burning

MOISTURE

- ☐ Dandruff
- ☐ Dry Brittle Nails
- ☐ Dry mouth
- ☐ Dry Itchy Skin
- ☐ Lungs-asthma, cough
- ☐ Dry Nose/Nosebleeds
- ☐ Oily Hair/Skin
- ☐ Pimples
- ☐ Rashes

ENERGY/EXTREMITIES

- ☐ Bleed/bruise easily
- ☐ Blood pressure high/low
- ☐ Difficulty concentrating
- ☐ Dizziness/Lightheaded
- ☐ Fatigue/Sudden Exhaustion
- ☐ Heart palpitations
- ☐ Poor memory
- ☐ Shortness of breath
- ☐ Stimulant dependence

BODY

- ☐ Body/limbs feel weak
- ☐ Chest Pains/ Pressure
- ☐ Disc pain/herniated
- ☐ Kidney issues
- ☐ Liver issues/hepatitis
- ☐ Low back pain
- ☐ Neck pain/discomfort
- ☐ Numbness in feet/toes
- ☐ Numbness in legs
- ☐ Pinched nerve(s)
- ☐ Restless Leg Syndrome
- ☐ Sciatica pain down leg(s)
- ☐ Sinus Trouble/Allergies
- ☐ Sores that won't heal
- ☐ Weight Gain or Loss
- ☐ Sore throat

DIGESTION

Bowel movements:
How often?
_____ per _____

- ☐ Bloating
- ☐ Constipation
- ☐ Gas
- ☐ Heartburn/indigestion
- ☐ Hernia
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain with BM
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Diarrhea
- ☐ IBS/Crohn's Disease

VISION

- ☐ Cough
- ☐ Dry Itchy Eyes
- ☐ Night Blindness
- ☐ Poor vision
- ☐ Sinus congestion

EMOTIONS

Which dominate your experiences?

- ☐ Anger
- ☐ Anxiety/Depression
- ☐ Grief
- ☐ Irritability
- ☐ Nervousness
- ☐ Obsessive thoughts

MALE FOCUS

(We have natural supplements for some of the below issues)
Sexually active?
___yes ___no
Changes in sex drive?
___yes ___no

- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Prostate disease
- ☐ Vasectomy

FEMALE FOCUS

- ☐ I am pregnant. Due _____
- ☐ Hysterectomy Date _____
- ☐ Irregular Cycles
- ☐ Last Cycle Date _____
- ☐ Last Mammogram
- ☐ Menopause
- ☐ PMS
- ☐ Severe Cramping
- ☐ Unusual Lumps on Body
- ☐ Using Birth Control

Other concerns or conditions you would like to share with the Doctor:

FITNESS & HEALTH HABITS

Do you exercise regularly (excludes work)? **Yes** | **No** How much? ☐ Weekly ☐ _____ days/week ☐ Everyday

How do you exercise? ☐ Yoga ☐ Weights ☐ Cardio Machines ☐ Run ☐ Bike ☐ Walk ☐ Ski/Snowboard ☐ _____

Are you on a special diet now or have you had one in the past? _____

	Yes	No	Amount per Day/Week	Age Started	Age Quit
☐ Coffee/Tea	_____	_____	_____	_____	_____
☐ Caffeine Drinks:	_____	_____	_____	_____	_____
☐ Alcohol	_____	_____	_____	_____	_____
☐ Cigarettes	_____	_____	_____	_____	_____
☐ Marijuana	_____	_____	_____	_____	_____
☐ Chew Tobacco:	_____	_____	_____	_____	_____

ACKNOWLEDGEMENT

When a patient seeks Chiropractic healthcare and Elk Ridge Chiropractic & Wellness Center accepts a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, which causes alterations of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate (in born) ability to express its maximum health potential (reduce the body's function).

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

Health: A state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

We primarily treat and diagnose neuromusculoskeletal disorders. If during the course of Chiropractic spinal examination, we encounter non-Chiropractic unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those non-Chiropractic unusual findings, we will recommend that you seek the services of another healthcare provider. Though we work to treat and eliminate the primary complaint, we cannot guarantee outcomes or results.

We utilize a Postural Screening Analysis to identify structural anatomical issues by analyzing your posture, using a program meant specifically for this purpose. In order to create this screening, photographs will be taken using 2-4 views of your body standing in a neutral position. For the best results, we ask that you wear shorts and a tank top. These photos will be used for the practitioner to assess your posture and will be viewed only by office staff. The screening will be saved to your patient file and email to the email address you provided.

I **(Print Your Name)** _____ have read and fully understand the above statements. All questions regarding the Doctor's objectives pertaining to my care, in this office, have been answered to my complete satisfaction. I therefore consent to Chiropractic care and treatment on this basis.

PATIENT/ GUARDIAN SIGNATURE: _____ **DATE:** _____