233 SE Washington St, Hillsboro, OR 97123 Phone # (503) 648-1088 Fax # (503)648-0748

Patient Intake Form

(Please Print) Mr. Mrs. Ms. _____ ___ _____
First Name MI Last Name

DOB: _____ M___ F___ SSN: _____

Address:_____

City: _____ State: _____ Zip Code:_____

Occupation:_____Employer:_____

Home #: _____Cell #: _____ Work #:_____

Email:_____

Emergency Contact:_____ Phone #:_____

Receipt of Privacy Notice

- ☐ I have received and/or reviewed a copy of NOTICE OF PRIVACY PRACTICES
- ☐ I consent to having detailed messages regarding my account or appointments left on my voicemail.
- ☐ I do not consent to having detailed messages regarding my account or appointments left on my voicemail.

Comments, if any:_____

To be completed by the patient or patient's representative, if necessary (e.g. if the patient is a minor or physically or legally incapacitated).

_____ _____
Print name Print name of patient's representative

_____ _____
Signature of patient Signature of patient's representative

_____ _____
Date Relationship to patient or authority of representative

_____ _____
Signature of Health care Practitioner Date

FINANCIAL AGREEMENT

☐ **SELF PAY/CASH**: Payment is due at the time of service. All cash patients will receive a "Time of Service" (TOS) discount. A detailed statement/receipt will be provided to the patient at their request for submission to any third parties for patient reimbursement.

_____ I understand that payment is due at the time of service.

☐ **AUTO INSURANCE**: If your injuries were sustained in a motor vehicle accident, your medical expenses are covered by any Personal Injury Protection (PIP) coverage of the vehicle you were in. We will submit bills on your behalf to the PIP insurance of the vehicle you were in, as is our office policy and according to the Oregon Statutes. We will not bill the PIP coverage of the other vehicle. You must complete and submit the PIP Benefits Application supplied by the insurance company in order for medical expenses to be paid to this office. Any medical expenses not covered or denied become the responsibility of the patient. Additionally, it is our office policy **not** to forward any denied or non-covered charges to group medical insurance for payment.

_____ I understand/agree that I am responsible for all charges; whether or not they are payable by insurance. I understand that if my PIP coverage has reached its maximum, I am fully responsible for any and all charges not covered by my insurance and that these non-covered/denied charges will not be forwarded to my group insurance policy.

☐ **WORKERS COMPENSATION INSURANCE**: If your injuries were sustained in a work-related incident, your medical expenses are covered by your employer's Workers Compensation Insurance once your claim has been accepted. Any medical expenses not covered or denied become the responsibility of the patient. Additionally, it is our office policy **not** to forward any denied or non-covered charges to group medical insurance for payment.

_____ I understand/agree that I am responsible for all charges; whether or not they are payable by insurance.

☐ **MEDICAL/HEALTH INSURANCE**: Any copay. deductible or co-insurance percentage agreement you have with your medical/health insurance are due at the time of service. Our office will provide you with an estimate of your financial responsibility for each appointment. We will make our best effort to provide you with a list of non-covered services. Any medical expenses not covered or denied become the responsibility of the patient, unless prohibited by our contract with the insurance.

_____ I understand/agree that I am responsible for all/any copay. deductible or co-insurance percentage and all charges, whether or not they are payable by insurance.

ADDITIONAL FEES:

- ✓ Credit Terms are 30 days from date of invoice. Outstanding balances are subject to 1.5% per month interest. The undersigned authorizes and releases all banks, persons, and companies listed on this application to furnish information and authorizes the checking of credit. The undersigned agrees to pay all collection costs, court costs, and legal fees incurred to collect delinquent balances.
- ✓ NON-SUFFICIENT FUNDS: $40
  A $40.00 processing fee will be charged to your account if your check is returned due to insufficient funds.

PATIENT/GUARDIAN _____ DATE_____

DISCLOSURE & CONSENT FOR CHIROPRACTIC CARE

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to ensure you have the appropriate information so you may give consent or withhold consent to the procedure.

I, _____ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic. This also extends to those working at the clinic or office who now or in the future treat me while employed by, working for or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic treatment there are some risks to the exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient or patient's representative, if necessary (e.g. if the patient is a minor or physically or legally incapacitated)

_____ Print name

_____ Print name of patient's representative

_____ Signature of patient

_____ Signature of patient's representative

_____ Date

_____ Relationship to patient or authority of representative

To be completed by doctor or clinic employee

_____ Witness signature

_____ Date signed

NON-COVERED SERVICES

When we verify eligibility and benefit coverage, your insurance company issues the following disclaimer, "**Benefits quoted are not a guarantee of payment**". We bill your insurance company based on the information received at the time of verification. By signing below, you acknowledge that you have been advised that our health insurance may not/does not provide coverage for the services/supplies listed below. **The "Patient Bill of Rights" provides you with the opportunity to decline any services, including those you are unwilling to pay for out-of-pocket.**

Should you decide to receive non-covered services, you are financially responsible for the charges listed below for services/supplies rendered and payment must be made at the time of service. A "Time of Service" discount is applied for all self-pay/cash patients.

CODE	PROCEDURE	CHARGE	TOS DISCOUNT
99201-25	NP Exam Brief	$63.00	$54.00
99202-25	NP Exam Expanded	$142.00	$121.00
99203-25	NP Exam Detailed	$207.00	$176.00
99204-25	NP Exam Comprehensive	$319.00	$272.00
99211-25	Re-Exam Brief	$38.00	$33.00
99212-25	Re-Exam Expanded	$83.00	$71.00
99213-25	Re- Exam Detailed	$138.00	$118.00
99214-25	Re- Exam Comprehensive	$206.00	$176.00
98940/S8990	Adjustment	$50.00	$43.00
98941	Adjustment	$72.00	$60.00
98942	Adjustment	$92.00	$76.00
98943	Extra-Spinal	$46.00	$39.00
97014	Electric Muscle Stimulation	$26.00	$23.00
97035	Ultrasound	$26.00	$23.00
97110	Therapeutic Exercises	$54.00	$46.00
97112	Neuromuscular Re-education	$57.00	$48.00
97140	Manual Therapies Technique	$50.00	$43.00
97530	Therapeutic Activities	$58.00	$49.00
97535	Activities of Daily Living	$58.00	$49.00
S8948	Laser	$50.00	
97124	Massage 15 min	$32.50	$28.00
A4556	Electrodes	$15.00	
	Supplies	Varies	

**Prices quoted are subject to change with industry standard changes.

_____ _____

Signature of patient/Guardian Date

No-Show / Late Cancellation Policy

Quality care for our patients is our priority. Please take a few minutes to review our policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No Show / Late Cancellation"

Active Chiropractic and Rehabilitation defines a "No-show" appointment as any scheduled appointment in which the patient either:

- ✓ Does not arrive to the appointment
- ✓ Cancels with less than 24 hours' notice (excluding holidays and weekends)

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Impacts the daily flow of the clinic team and providers

How to Avoid Getting a No Show / Late Cancellation Status

- ✓ **Opt In** for Appointment reminders (calls and/or texts)
- ✓ Arriv**e** 10 minutes early
- ✓ Give **24 hours'** notice to cancel appointment (excluding holidays and weekends)

1. Opt In for reminder calls and/or texts

Active Chiropractic and Rehabilitation will make a reminder call or text you two business days before your scheduled appointment. This is a courtesy service many busy patients elect to have provided.

2. Always Arrive 10 Minutes Early

When you schedule an office visit with us, please plan to arrive 10 minutes prior to your scheduled appointment time. This allows time for you and our team to address any insurance or billing questions and or to complete/update any necessary paperwork before your appointment.

3. Give 24 Hours' Notice if You Need to Cancel/Reschedule

When you need to cancel or rebook a scheduled appointment, please contact our office at least 24 hours' (excluding holidays and weekends) before the appointment. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call. (We understand that emergencies do happen and consideration may be given and fee waived.)

Consequences of a No Show / Late Cancellation Status

- ✓ **A $50 "No Show/Late Cancellation" fee will be applied to your account.**
- ✓ If you miss 3 or more appointments within a year you may be dismissed from the clinic. Patient dismissal is at the discretion of your provider and management.
- ✓ If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled.
- ✓ Reapplication to the clinic after a six month period after initial dismissal letter will be considered by your provider and management.

I have read and understand the Active Chiropractic and Rehabilitation "No Show" policy as described above.

Signature & Date