

## NEW PATIENT REGISTRATION

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Acct# \_\_\_\_\_

Int \_\_\_\_\_  
Last First Middle

(Complete Mailing)

Address \_\_\_\_\_  
\*\*  
Street Apt# City State Zip

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*\* Work Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*\*

Cell Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*\* E-mail Address:  
\*\*

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is this visit routine/accident/illness/other: \_\_\_\_\_ If Accident (date) \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Name  
(Guarantor) \_\_\_\_\_  
Last First Middle

Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Insurance \_\_\_\_\_  
ID# \_\_\_\_\_ Grp# \_\_\_\_\_

(please complete other side)

**\*\*Please notify our front office staff if there is an alternate address / phone number or form of communication\*\* that you wish us to contact you by other than your listed information above.**

I have read and understand that this alternative is available to me

\_\_\_\_\_

Signature

Date

## **ACKNOWLEDGEMENT AND UNDERSTANDING**

**Please initial each item below.**

1. \_\_\_\_\_ I hereby authorize Total Health Chiropractic to provide Chiropractic Services for me.
2. \_\_\_\_\_ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Total Health Chiropractic.
3. \_\_\_\_\_ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.
4. \_\_\_\_\_ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Craig Total Health Chiropractic, 516 S.E. Morrison Street, Suite 212, Portland, OR
5. \_\_\_\_\_ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

**By signing this application I affirm under penalty that I have given true complete information.**

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Guarantor Signature

\_\_\_\_\_  
Relationship to

### **AUTHORIZATION TO TREAT A MINOR**

As a parent or legal guardian, I hereby authorize treatment for the following:



## CONSENT FORM

### To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

*I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.*

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

Please read the following carefully and initial each statement.

\_\_\_\_\_ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the supervising physician because it may affect care.

\_\_\_\_\_ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Total Health Chiropractic reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

→ **STOP HERE** ←

**Portion Below Used If Additional Information Requested & Received**

*I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment, and other alternative procedures or methods. I give my permission and consent to the procedure or treatment.*

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

## FINANCIAL POLICY

- 1) We accept cash, Visa and MasterCard.
- 2) All payments are due at the time of service, unless special arrangements have been agreed upon prior to visit.
- 3) All co-pays will be due at the time of service, once your insurance coverage has been verified and we have established what your responsibility is.
- 4) As a courtesy to our patients, we will bill your insurance company for you. Please keep in mind that if there is a discrepancy, we will let you know as soon as possible; however, we will not get involved with any dispute between you and your insurance carrier.
- 5) If you have a credit balance, we will reimburse you after payment has been received.
- 6) All supplements/vitamins, lab work, supports and other supplies **must** be paid for at the time they are received.
- 7) You are responsible for timely payment of you account.

### Workers Compensation Claims

- 8) All workers compensation cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out and a claim is filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, then you are responsible for prompt payment of your account.

### Personal Injury/Motor Vehicle Accidents

- 9) Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paper work has been done.
- 10) Keep in mind we do not do third party billings to other insurance companies.
- 11) If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.
- 12) Generally supplements/vitamins, lab work, supports and other supplies may not be covered by insurance companies, and must be paid for at the time they are received. Should the insurance company pay, we will reimburse you for the amount paid.

I have read, understand and agree with the above financial policy.

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Patient signature

Date