

Whom may we thank for referring you to this office → \_\_\_\_\_?

### APPLICATION FOR CARE AT GRESHAM TOWN FAIR CHIROPRACTIC CLINIC (GTFCC)

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

HRN: \_\_\_\_\_

#### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status:  Single  Married E-mail Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Do you have Insurance:  Yes  No Insurance Company \_\_\_\_\_ Insurance Id #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_ # of children and Ages: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Contact Person: \_\_\_\_\_

#### HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_

Secondarily: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by *circling the number*:

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant OR  I experience it on and off during the day OR  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes If yes, when: \_\_\_\_\_ by whom? \_\_\_\_\_

How long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_

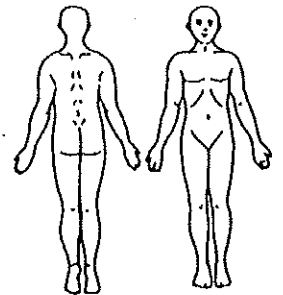
Name of Previous Chiropractor: \_\_\_\_\_  N/A

\*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T = Tingling

What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_



LIST of ACTIVITY CAN'T DO:	USUAL ACTIVITY LEVEL	GOAL ACTIVITY LEVEL
_____ :	_____	_____
_____ :	_____	_____
_____ :	_____	_____
_____ :	_____	_____

Is your problem the result of ANY type of accident?  Yes,  No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: \_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes If yes how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes If yes, please state what type of treatment: \_\_\_\_\_, and who provided it: \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results.  Favorable  Unfavorable → please explain. \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: \_\_\_\_\_

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the *Past*, C for *Currently* have and N for *Never have had*:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions:

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

**SOCIAL HISTORY**

- Smoking:  cigars  pipe  cigarettes → How often?  Daily  Weekends  Occasionally  Never
- Alcoholic Beverage: consumption occurs →  Daily  Weekends  Occasionally  Never
- Recreational Drug use:  Daily  Weekends  Occasionally  Never
- Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg 2- Activities of Life

**FAMILY HISTORY:**

- Does anyone in your family suffer with the same condition(s)?  No  Yes  
If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- Any other hereditary conditions the doctor should be aware of.  No  Yes: \_\_\_\_\_

I hereby authorize payment to be made directly to GTFCC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to GTFCC for any and all services I receive at this office.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date Form Reviewed

JDD,DC 5/2011

# Financial Policy

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest period of time.

**Fees:** Our service fees are based on values determined to be usual and customary for this geographic region. Our fee schedule for the most common services we provide is available upon request. There is a \$20 statement fee. Unpaid balances are subject to an 18% interest fee per annum (1.5% monthly). There is a \$20 fee for all returned checks.

**First Visit:** Fees for treatment rendered are payable, due in full, and expected at the completion of the first appointment.

**Missed Appointment:** A \$44.00 fee will be posted to your account for any missed or cancelled chiropractic appointment without 24 hour advance notice being given. A \$35.00 fee will be posted to your account for any missed or cancelled massage appointment without 24 hour advance notice being given. Payment for missed appointment fees is your responsibility and not the responsibility of your insurance company.

**Self-Pay Accounts:** Payment at the time of service is expected unless prior arrangements have been made. We accept Visa, MasterCard, and Discover, as well as cash payments and personal checks.

**Health Insurance:** As a courtesy, we will bill your personal health insurance company should you choose to assign payments directly to the doctor. Such payments will be applied directly to your account. You are required to pay your co-pay at the time of your visit. Estimated co-insurance portions and any unpaid deductible, (up to the amount of services rendered for that day, based upon our usual and customary fee schedule,) is due at the time of your visit. All necessary payments not made at the time of service, as directed above, are subject to a \$20.00 statement fee. Any amount remaining once your insurance company has paid is your responsibility, including any amount that they have denied payment for any reason. A statement will be sent to you for the remaining balance due on your account. All accounts are due 30 days net. If you do not pay your balance within 30 days of statement issue, a \$20.00 billing charge will be included for each additional 30-day billing cycle that your account remains unpaid. If you do not choose to assign payment directly to the doctor, your account will be handled as a self-pay account as described above. One monthly statement will be made available to you per month. Additional statements are \$20.00.

**Medicare:** All Medicare billings will be handled by our account manager if you direct this office to do so. This office has chosen not to accept assignment. This means all services performed are the responsibility of the patient and due at the time of service. We will bill Medicare for you and direct them to send payment directly to you. It is also the patient's responsibility to bill their secondary insurance or Medicare supplement. Medicare does not provide for payments on: maintenance care, x-rays, examinations, physiotherapy, orthopedic supports or dietary supplements when provided by a chiropractor. Medicare may deny payments on all or part of any treatment received in this clinic based upon Medicare guidelines and "medical necessity". You are still responsible for payment.

**Automobile Insurance:** If your injuries were sustained in a motor vehicle accident, your medical expenses should be covered by the Personal Injury Protection (PIP) coverage of the vehicle you were in. It is our office policy and Oregon Statute to bill medical expenses to the PIP carrier of the vehicle you were in, not the other driver's insurance, regardless of fault. If you have any questions regarding this, we can refer you to the office of the Oregon Insurance Commissioner. 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. If you do not submit the PIP benefits application, all medical expenses in this office become your responsibility and are subject to the above stated policies. If your PIP benefits are denied for any reason, all incurred expenses become your responsibility. It is our office policy to not carry an account balance past one year of the motor vehicle accident. Representation of an attorney who has either signed an attorney lien or a letter of protection directing payment to this office out of the settlement is required. A minimum monthly payment of \$ 100.00 will be expected on account balances. A monthly statement fee of \$20.00 will apply on each monthly billing.

**Worker's Compensation Insurance:** If your injuries were sustained in a work related incident, your medical expenses may be covered by your company's Worker's Compensation Insurance. You and your employer must submit documentation of the incident to file a claim for benefit eligibility. Payments for supports and supplements are the patient's responsibility. Unaccepted claims are the patient's responsibility to maintain a zero account balance until the claim is either accepted or denied. Acceptance of the claim may take as long as 60 working days. During this time, the patient is responsible for all charges accrued in this clinic. In such a case of claim denial, any and all previously unpaid amounts will become immediately due in accordance with the above stated account policies. Patients will be refunded all amounts previously paid once this office has received in writing from the responsible insurance company that the claim has been accepted for the condition the patient was being treated for. If the claim is accepted for any condition other than the conditions being treated for in this clinic, any portions paid toward the non-accepted condition will be placed towards a self-pay account and will not be refunded.

Patient Printed Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

## **PLEASE REVIEW IT CAREFULLY!**

The effective date of this notice is April 14<sup>th</sup>, 2003

In this notice we use the terms "we", "us", "our" and Gresham Town Fair Chiropractic as noted in section V.

### **I. Uses and Disclosures**

**A.** We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes:

Treatment: Example: We may use your health information within our offices to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment: Example: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations: Example: We may use your health information to conduct internal quality assessment and improvement activities for business management and general administrative activities.

**B.** We may use or disclose your protected health information without your written consent, written authorization or oral agreement, under the following circumstances:

If we provide services to you while you are inmates.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we are unable to obtain your consent after attempting to do so.

If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend to us to treat you.

If we need to notify, assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.

If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.

If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.

If we are required to disclose your health information to a health oversight agency for oversight activities required by law.

If we are required to disclose your health information in response to a court order or a subpoena.

If we are required to disclose your health information to a coroner, medical examiner or funeral director.

For research purposes:

If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

**WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURES OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAYBE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.**

## **II. Your Rights**

**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

**Right to Receive Confidential Communications:** You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

**Right to Inspect and/or Copy:** You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official. If you agree, we will give you a summary or explanation of your PHI instead of providing copies. We may charge you a fee for the copies, summary or explanation. If we don't have the record you asked for, but we know who does, we will tell you who to contact to request it.

**Right to Amend:** You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

**Right to Receive an Accounting:** You have the right to receive an account of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. This accounting will not include the following disclosures:

- Disclosures made to carry out treatment, payment and health care operations;
- Disclosures made to you;
- Disclosures made in our facility directory;
- Disclosures made to individuals involved with your care;
- Disclosures made for national security or intelligence purposes;
- Disclosures made to correctional institutions or law enforcement officials; and
- Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

**Right to Receive Notice:** You have the right to receive a paper copy of this Notice upon request.

## **III. Our Duties**

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

## **IV. Complaints**

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address listed below. We will not take any action against you for filing a complaint.

## **V. How to Contact US**

If you would like further information about our privacy practices, please contact:

Gresham Town Fair Chiropractic Clinic  
592 NW Eastman Parkway  
Gresham, OR 97030  
503-667-6744

**DR. ROBERT W. RAMSEY, DC PC**  
**592 NW EASTMAN PARKWAY**  
**GRESHAM, OR 97030**  
**(503) 667-6744**

*This Notice is in effect as of April 14, 2003.*

***ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES:***

*I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient file and maintained for six years.*

\_\_\_\_\_  
*Patient Name (Please print)*

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

\_\_\_\_\_  
*Signature (minor)*  
*Parent, Guardian or Patient's legal representative*

\_\_\_\_\_  
*Date*

DR. ROBERT W RAMSEY, DC PC  
592 NW EASTMAN PARKWAY - GRESHAM, OR 97030  
Phone: 503-667-6744 Fax: 503-661-7896

### Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

**Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion of disappointment.

**Adjustment:** the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine, this may cause an audible "pop" or "click" and you may feel or sense the movement. The material risks inherent in the chiropractic adjustment include, but are not limited to, soreness, or a temporary worsening of symptoms. More serious complications are rare, and additional information is available upon request.

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

**Vertebral Subluxation:** a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer the advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.**

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**DR. ROBERT W RAMSEY, DC PC**  
**592 NW EASTMAN PARKWAY - GRESHAM, OR 97030**  
**Phone: 503-667-6744 Fax: 503-661-7896**

**PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN  
AND TREATMENT AGREEMENT.**

**Consideration:** In order to facilitate the ability of the Office to collect its charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows:

**Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien,** I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action that I might have now or in the future against the Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive and proceeds from any Payer to the Office and further grant a contractual lien to the Office with any respect to my charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the Secretary of State or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this Agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my Charges.

**Other Terms:** I understand that I remain personally responsible for my Charges. Consistent with law or contract, I agree to pay the full amount of my Charges to the Office upon its demand. Unless mutually agreed in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitation, which may apply to the collection of my Charges.

**In the event** that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my charges to any and all Payers, including, without limit, my health benefit plan. I understand, however that in the event that my charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write-offs or discounts issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee, which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents regardless of whether these other Charges are related to my condition.

**This Agreement** shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

**This Agreement** shall be governed under the laws of the state where the Office is located and performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-convenes.

I agree that each and every provision of this Agreement is reasonable necessary for the protection of the rights and interest of the Office and myself. However, should any provision of this Agreement be found to be "invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless; remain in full force and effect"

**Definitions:** For the purpose of this Agreement, the following terms shall have the following meaning: "Office" shall refer to Gresham Town Fair Chiropractic Clinic located at 592 NW Eastman Pkwy Gresham, OR 97030. "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at fault party, tortfeasor, individual, and any other entity, which may elect to be obligated to payer disburse Proceeds to me, either now or in the future, for any reason. "Proceeds" shall include, without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to payer reimburse, and the proceeds relating to the following benefits, plans, or coverage: individual and group health benefits, Medicare, Medicaid, Worker's Compensation, disability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony), any Collections Costs incurred by the Office, 18% interest on outstanding Charges, and any other Charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre and post judgment court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or any Payer.

Patient Name (please print) \_\_\_\_\_

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

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_