NORTH PORTLAND
WELLNESS GROUP

2205 N. LOMBARD ST. UNIT 101
PORTLAND, OR 97217

PATIENT REGISTRATION FORM

(PLEASE COMPLETE ALL SECTIONS OF THIS FORM)

GENERAL

FRIST NAME _____ LAST NAME _____ MIDDLE INITIAL __

DATE OF BIRTH _____ SEX _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

MARITAL STATUS _____ SPOUSE NAME _____

OCCUPATION

EMPLOYER _____

WORK PHONE _____ ADDRESS _____

CITY_____ STATE _____ ZIP _____

EMERGENCY CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO PATIENT _____

HOW DID YOU HEAR ABOUT US? _____

ATTENDING PHYSICIAN

PATIENT PRIMARY CARE PROVIDER NAME _____

CLINIC NAME _____ CITY _____

PHONE _____

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

NAME OF POLICY HOLDER _____ INSURER _____

POLICY #_____ GROUP #_____

DO YOU HAVE AN HSA OR FLEX ACCOUNT? _____

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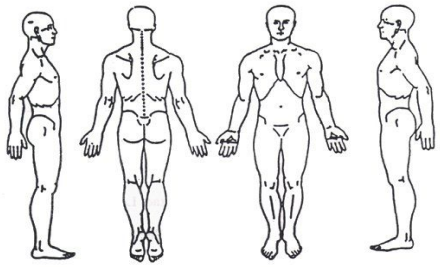
1. WHAT IS TODAY'S PAIN CAUSED BY: □ Auto Accident □ Worker compensation □ Other

2. WHERE IS YOUR PAIN?



3. IS THERE REFERRING PAIN PAST YOUR ELBOWS OR KNEES? _____

4. HOW OFTEN DO YOU EXPERIENCE PAIN?
□ Intermittently (1-25% of the time) □ Occasionally (26-50% of the time
□ Frequently (51-75% of the time)) □ Constantly (76-100% of the time)

5. HOW WOULD YOU DESCRIBE THE TYPE OF PAIN YOU'RE EXPERIENCING?
□ Sharp □ Diffuse □ Numb □ Achy □ Dull □ Stiff □ Tingly □ Sharp with motion
□ Shooting with motion □ Burning □ Other: _____

6. HOW ARE YOUR SYMPTOMS CHANGING WITH TIME?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. USING A SCALE FROM 0 TO 10, WITH 10 BEING THE WORST, WHERE IS YOUR PAIN LEVEL TODAY?
(Please circle) 0 1 2 3 4 5 6 7 8 9 10

8. HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR WORK?
□ Not at all □ A little bit □ Quite a bit □ Extremely

9. HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR SOCIAL ACTIVITIES?
□ Not at all □ A little bit □ Moderately □ Quite a bit

10. WHO ELSE HAVE YOU SEEN FOR THIS ISSUE?
□ Chiropractor □ Neurologist □ ER Physician □ Orthopedist □ Primary Care Physician
□ Massage Therapist □ Physical Therapist □ Acupuncturist □ No one □ Other_____

11. HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

12. HOW DO YOU THINK YOUR SYMPTOMS BEGAN? _____

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13. WHAT IS YOU APPROXIMATE:
Height ____ Weight ____

14. WHAT MAKES YOUR SYMPTOMS WORSE? _____

15. WHAT MAKES YOUR SYMPTOMS BETTER? _____

16. HOW MUCH EXERCISE DO YOU DO PER WEEK?
□ 5-6 days a week □ 3-4 days a week □ 1-2 days a week □ None

17. WHAT MEDICATIONS YOU ARE CURRENTLY TAKING _____
_____

18. PLEASE LIST ALL THE SURGICAL PROCEDURES YOU HAVE HAD: _____
_____

19. HAVE YOU EVER BEEN HOSPITALIZED?
□ No □ Yes (When? _____, Why? _____)

20. DO YOU DRINK ALCOHOL? _____ How often? _____

21. DO YOU SMOKE CIGARETTES OR USE TOBACCO PRODUCTS? _____
How much per day? _____

22. DO YOU HAVE THE FOLLOWING:
□ Allergies □ Anxiety □ Arthritis □ Bursitis □ Cancer □ Carpal Tunnel Syndrome □ Diabetes (type? _____)
□ Digestive Disorder (GERD/Reflux, IBS, Crohn's, Ulcers, etc...) □ Fibromyalgia □ Heart Disease
□ High Cholesterol □ High Blood Pressure □ Knee Pain □ Lower Back Pain □ Neck Pain □ Numbness
□ Osteoporosis □ Plantar Fasciitis □ Rheumatoid Arthritis □ Sciatica □ TMJ/Jaw Pain □ Upper Back Pain

23. DO ANY OF YOUR IMMEDIATE FAMILY MEMBERS HAVE THE FOLLOWING:
□ Allergies □ Anxiety □ Arthritis □ Bursitis □ Cancer □ Carpal Tunnel Syndrome □ Diabetes (type? _____)
□ Digestive Disorder (GERD/Reflux, IBS, Crohn's, Ulcers, etc...) □ Fibromyalgia □ Heart Disease
□ High Cholesterol □ High Blood Pressure □ Knee Pain □ Lower Back Pain □ Neck Pain □ Numbness
□ Osteoporosis □ Plantar Fasciitis □ Rheumatoid Arthritis □ Sciatica □ TMJ/Jaw Pain □ Upper Back Pain

24. PLEASE CHECK ANY OF THE FOLLOWING SERVICES YOU'D LIKE MORE INFORMATION ABOUT
□ Medical Weight Loss □ Massage □ Decompression Disc Therapy □ Knee Regeneration Therapy
□ Acupuncture

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INFORMED CONSENT TO TREATMENT

To the patient or their parent, legal guardian: Please read this entire form prior to signing it. It is important that you understand the information contained in this form. Please ask any questions prior to signing this form if you are unclear about anything in this form.

• A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, X-rays, diagnostic ultrasound, range of motion testing, muscle strength testing, various neurological and orthopedic testing, and other testing. Radiology is the use of x-rays on the human body and is used to gain an inside perspective of the human body that cannot be obtained from a physical examination. Additionally, there may be referrals to other doctors as necessary.

• The vast majority of our patients tend to achieve good to excellent improvement in their physical conditions with the use of physical medicine and in conjunction with other modalities. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and other ways. It must be remembered that different people get different results; different people have pre-existing conditions, and are of different ages and occupations (with different types of physical stress). Your situation is unique, and no guarantees are given.

• I understand and am informed that, as in the practice of medicine and all healthcare, the practice of physical medicine, massage therapy, acupuncture carries some risk to treatment; some including, but limited to: fracture, disc injuries, strokes and sprains.

• I understand acupuncture is a safe therapy, but there are some possible side effects. I may experience bruising, tingling, discomfort and pain close to the sites of needling or cupping that may last for several days. Nausea, lightheartedness or dizziness occasionally occur following treatment. I understand it is best to eat a snack or light meal 1-2 hours prior to treatment, to avoid these symptoms.

• I understand if I am receiving massage therapy, physical medicine, or acupuncture, I do not expect the physicians to be able to anticipate and explain all risks and complications.

Further, I wish to rely on the physician(s) to exercise judgment during the course of the procedure with what the physician feels are in my best interests at the time, based upon the facts then known.

BY: _____ DATE: _____ (Patient/ Responsible Party Signature)

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FINANCIAL DISCLOSURE

Because clarity about financial matters is essential for you to receive optimum benefit from your care, we have outlined our financial policies and agreements below. Please read carefully and sign or initial where indicated. I, _____, understand and agree to the following:

A. I am solely responsible for the expenses of my care and/or the care of my dependents. While I may assign payment benefits to North Portland Wellness Group (NPWG), any uncovered services, deductibles, and co-payments are my financial obligation, to the extent allowed by the terms of the NPWG's provider contracts with insurance plans. (While most insurance plans cover chiropractic, massage, acupuncture, medical, naturopathic medicine your health and accident policies are a contract between you and your insurance company. We are happy to prepare any necessary reports and forms to assist you in making a collection from your insurance company. See our Fee Schedule for current fees. Prices are subject to change.)

B. Insurance non-covered service disclosure and agreement

1. Potential reasons for non-covered status include: The service is or may be deemed (a) investigational or experimental under the carrier's internal guidelines; (b) not medically necessary under the carrier's internal care or cost management guidelines; (c) not actually covered under the plan to which you are subscribed; (d) not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

2. The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.

3. I acknowledge that the Non-Covered status of the proposed service(s) has been explained and that a certain portion of my care may not be covered by or has not been authorized by my insurance plan. If any portion of the care provided is not, or may not be covered by insurance, then I shall be responsible for payment and shall make the necessary financial arrangement with the healthcare provider to pay for these services. (Initial)_____

C. Assignment, group accident and health insurance

Any amount authorized to be paid directly to North Portland Wellness Group will be credited to your account upon receipt.

D. Choice of payment options

We are happy to provide the following payment options. If you are choosing to use your insurance you will need to pick a second option for any services not covered by your insurance.

□ **Insurance Coverage: Coverage varies with individual plans; generally, only a portion of the recommended care plan will be covered.**

□ **Cash/Credit Per Visit: Includes money orders, personal checks, credit and debit cards; generally, a 20% discount applies; a copy of a Fee Schedule will be provided if you wish for more details.**

□ **Payment Plans: monthly or yearly payment plans are available with an approximate savings of 25-30%.**

□ **Care Credit Card: A zero-or-low-interest health care credit card which you may apply for and use here in our office upon your request.**

Please mark your two choices above and initial here: _____

BY: _____ DATE: _____
(Patient/ Responsible Party Signature)

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ACKNOWLEDGMENT AND CONSENT

I understand that North Portland Wellness Group will use and disclose health information about me. I understand that my health information may include information both created and received by North Portland Wellness Group may be in the form of electronic or written records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that North Portland Wellness Group may use and disclose my health information in order to:

- Make decisions regarding my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.
- Send and receive prescription information electronically and verbally from pharmacies

I also understand that I have the right to receive and review a written description of how North Portland Wellness Group will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information, the information practices followed by the employees, staff and other office personnel of North Portland Wellness Group and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

I also understand that a copy or a summary of the most current version of Portland Wellness Care's Notice of Privacy Practices is posted in the waiting room/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices

I understand that North Portland Wellness Group is not required by law to agree to such requests. By signing below,

I agree that I have reviewed and understood the information above and that I have received a copy of the Notice of Privacy Practice

BY: _____ DATE: _____
(Patient/ Responsible Party Signature)