hawthorne chiropractic & healing arts
1222 se division street, portland, oregon 97202, p: 503-231-9879 f: 503-233-4732 amy lennon, dc • cliff marhoefer, dc

MASSAGE INTAKE

Welcome to Hawthorne Chiropractic!
Please take a moment to provide us with the following information.
If you have any questions, please let one of us know.

TODAY'S DATE_____

ABOUT YOU

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Age _____ Date of Birth: _____

SSN: _____

Occupation _____ Daily # of hrs worked: _____

Work Activities: _____

Employer _____

How did you hear about us? _____

_____

If a person referred you, we will thank them with a free 30-minute massage or chiropractic treatment.

INSURANCE INFORMATION

(Some insurance companies have massage coverage. We would be happy to check for you.)

Name of insured? _____

Birth Date (of insured): _____

SSN#: _____

Relationship to patient: _____

Insurance Co: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional Insurance? _____

Subscriber's Name: _____

Birth Date: _____ SSN#: _____

Relationship to patient: _____

Insurance Co: _____

Address: _____

(We must have a photocopy of both sides of your insurance card(s)

PHONE NUMBERS

Home: _____

Work: _____

Is it OK to call you at Work ☐Yes ☐No

Mobile: _____

E-mail: _____

Emergency Contact

Name: _____

Relationship: _____

Home #: _____

Work #: _____

Primary Care Physician: _____

GENERAL INFORMATION

Have you had a professional massage before?

_____

Have you had any recent surgeries or injuries?

_____

_____

Where do you feel you hold stress?

_____

_____

Are you currently seeing other health care providers (acupuncturist, chiropractor, naturopath, md, etc)?

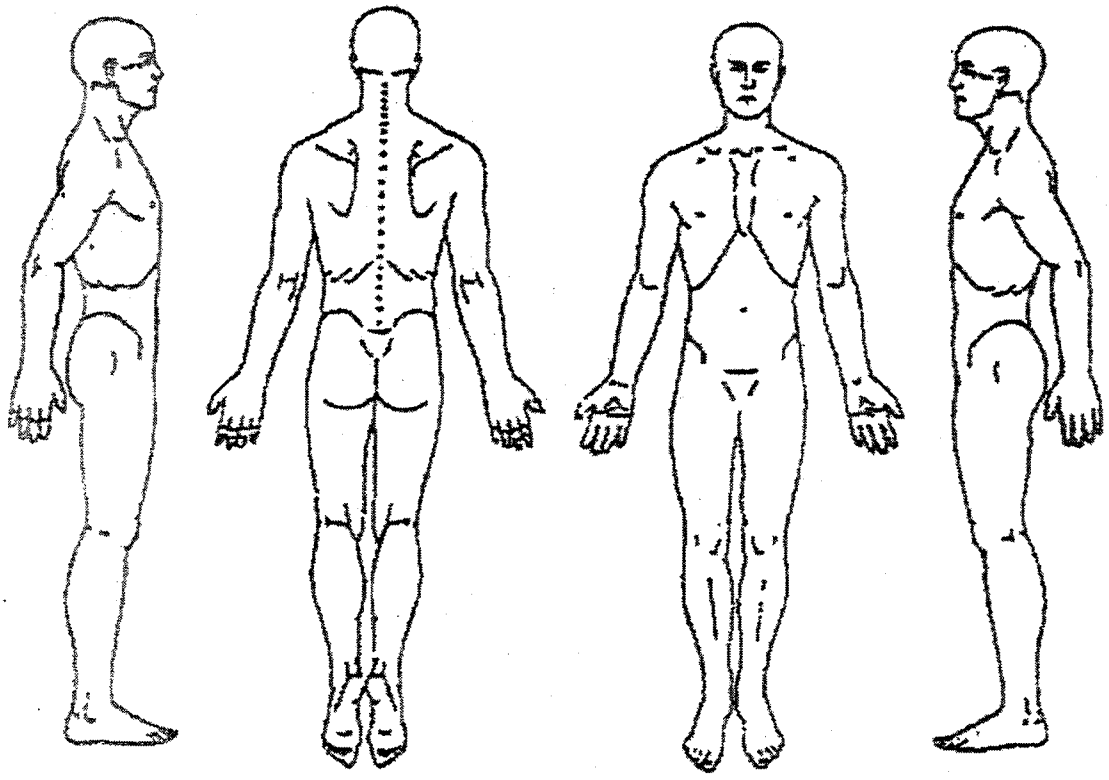
_____

Check all that apply to your current health...

_____ headaches
_____ fatigue
_____ allergies (lotions/balms)
_____ blood clots
_____ diabetes
_____ pain meds
_____ teeth grinding
_____ chronic pain
_____ bruises
_____ high/low bp
_____ sprains/strains
_____ infectious conditions (athlete's foot, etc.)

Patient _____ Date: _____ DOB: _____

Please indicate where you are feeling pain...



Describe your pain. (sharp, burning, stiff, sore, dull, achy, shooting, stabbing, weak, numb, tingly)

_____

_____

How frequently do you feel pain? (constantly, often, occasionally, intermittently)

_____

_____

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ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to the Doctors at Hawthorne Chiropractic insurance benefits, if any, otherwise payable to me for services rendered. I fully understand that I am financially responsibly for all charges whether or not paid by insurance. Possession of a medical insurance member ID card is **NOT** a guarantee of coverage. I hereby authorize the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

In the event of non-payment, the responsible party shall bear the cost of collection and/or court costs and reasonable legal fees, should this be required. **Accounts past due will be assessed a 18% annual service charge.**

CARE AGREEMENT

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsibly for any expenses incurred in collecting your account.
- **Cancellations and rescheduling must be made 24 hours in advance or we reserve the right to bill you a $50.00 NO SHOW FEE for the price of your visit. Short notice does not allow us opportunity to fill your appointment time.**
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Risk and consent for treatment

*Chiropractic manipulation is very safe form of therapy that is performed in selected cases. Like any form of therapy, there is a benefit-to-risk ratio. Cervical (neck) manipulation is the region with the greatest risk of mortality. Depending upon the source, the risk has been reported to be one in four million (1:4,000,000) to one in 25 million (1:25,000,000). As a comparison, an exercise stress test performed during a physical examination on the general population is approximately one in ten thousand 1:10,000).

*ACSM Guidelines for Exercise Testing and Prescription, 3rd edition

Responsible Party Signature ***Date***

EMERGENCY CARE

In the event that our office is closed and an urgent situation arises, please consider calling 911. You may also leave a message on our voice mail. We make it a priority to review our messages regularly, and do our best to serve you in these situations. Emergency numbers are listed on our voicemail.

Name: **DOB:**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I .also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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Financial Policy

Due to the numerous changes to the insurance industry we are encouraging ALL our patients to check their own benefits. You may not be aware of recent changes made to your specific plan. Insurance companies are making it more and more difficult for us to keep up with tracking changes to everyone's plan. For your convenience we have an updated questionnaire on our website to help guide you through the process of figuring out your "alternative care" benefits. We will continue to bill your insurance company for you however, because your policy is a contract between you and your insurance company, you may need to be more involved in negotiating for yourself to ensure timely payment.

PLEASE INITIAL EACH LINE BELOW AND SIGN:

- I understand that I am financially responsible for any portion not covered or declined by my insurance company is my responsibility. _____
- I understand all payments are due at the time of service, unless special arrangement have been agreed upon prior to visit. _____
- I understand that all supplements, vitamins, or any other DME supplies must be paid at the time they are received. _____
- I understand that I am responsible for the timely payment of my bill. _____
- I understand that Hawthorne Chiropractic has a 24 hour notice policy for appointments that must be cancelled or rescheduled and that there is a charge of $50.00 for New Patient and $50.00 for Existing Patent appointments for missed or late-canceled appointments. _____
- I understand that if I am involved in a personal injury, auto accident, or workers' compensation case it will be billed directly to my auto or wc insurer provided the appropriate paperwork has been filled out and a claim is filed. If the claim is denied, I understand my private carrier may be billed if applicable but that I am ultimately responsible for payment of my account. _____
- I understand that Hawthorne Chiropractic will only bill third party on a case-by-case basis. _____
- I understand that I may have to pursue reimbursement directly from my insurance company or third payer if the billing and re-billing has gone over and above the usual and customary amount of time spent to process and follow-up on a claim. _____

I have read, understand and agree to Hawthorne Chiropractic and Healing Arts' financial policy. In addition, I authorize the payment of benefits to Hawthorne Chiropractic and all practicing providers.

_____ _____
Print name Date of Birth

_____ _____
Patient or Guardian Signature Date