

North Portland Wellness Center – Worker’s Comp New Patient Info

Welcome to the North Portland Wellness Center. Please print clearly and answer all questions as completely as possible.

Full Name: _____ / _____ / _____
(Legal Last Name) (Legal First Name) (Middle) (Preferred First Name)

Date of Birth: ___/___/___ Age: _____ Sex/Gender: Female Male Transgender (circle: FtM/MtF) Other: _____

Address: _____ / _____ / _____
(Street/PO box) (City) (State) (Zip Code)

Phone #: (_____) _____ (_____) _____ (_____) _____
(Home) (Work) (Cell/Other)

As a courtesy, we can notify you of upcoming appointments. Please check your preference:

Phone Text message/**Cell Phone carrier (required for text):** _____ Email

Email address: _____

May we send you monthly newsletters and/or occasional coupons and event notices via email? Y N

Occupation: _____ Employer: _____ Full-time Part-time Student Retired Unemployed

Are you: Single Married Partnered Divorced Widowed Partner’s Name: _____

Emergency Contact: _____ Phone #: (_____) _____ Relationship: _____

Is there anyone you wish to authorize to have full access to your medical information without restriction (**including but not limited to making/cancelling appointments on your behalf**)? This authorization is **optional** and you may revoke it in writing at any time.

No Yes If yes: _____
(Name) (Relationship)

How did you hear about our clinic? Please check **ALL** that apply. Referrals are appreciated and important to us; **please let us know whom specifically to thank:**

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Doctor/Clinic: _____ | <input type="checkbox"/> Live/Work in Neighborhood | <input type="checkbox"/> Supportland |
| <input type="checkbox"/> Personal Referral: _____ | <input type="checkbox"/> Internet Search | <input type="checkbox"/> Yelp |
| <input type="checkbox"/> Event: _____ | <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Facebook |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Chinook Book | <input type="checkbox"/> Twitter |
| | <input type="checkbox"/> Gay & Lesbian Yellow Pages | <input type="checkbox"/> Instagram |

EMPLOYER INFORMATION

Employer Name: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Contact Person : _____ Phone #: _____

WORKERS COMPENSATION CARRIER

Workers Compensation Carrier: _____ Adjuster’s Name: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Claim Number: _____ Phone #: _____

By signing below, I verify that the above information is correct and true to the best of my knowledge. I hereby authorize North Portland Wellness Center to submit claims, along with any necessary chart notes, to my insurance carrier(s) or their intermediaries for all services rendered by North Portland Wellness Center and direct them to issue payment directly to North Portland Wellness Center. **I understand I am responsible for all charges not covered by my insurance company.**

Patient Signature (or Guardian if Patient is a minor)

Date

Informed Consent to Treatment

The purpose of this form is to present risks and benefits of the therapies offered at North Portland Wellness Center. While the chances of experiencing most of these complications listed below are small, it is the practice of this clinic to inform patients about them. This form must be signed before treatment is rendered. Please discuss any questions/concerns you may have with our staff or your practitioner.

ACUPUNCTURE

Acupuncture involves using very thin needles and/or pressure to stimulate special points on the body that affect different organ systems. Our acupuncturists are gentle and effective and combine traditional Chinese bodywork and other techniques to aid in energy flow. Side effects may include bruising, minor bleeding, discomfort, and on the rare occasion, fainting. More commonly, relaxation and pain relief are experienced. Your acupuncturist may use acupressure and Chinese bodywork, which stimulates or sedates the points by hand.

CHIROPRACTIC CARE/MANIPULATION

Chiropractic examinations and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. However, there are occasions when a procedure intended to help may have complications. These complications may include but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications, such as strokes and disc herniations, are extremely rare.

MASSAGE THERAPY

The purpose of massage/soft tissue therapy is to decrease pain, tension and tenderness, while increasing blood and lymph flow. Your health concern may be caused by poor body mechanics and/or repetitive stress, in which case, exercises or stretches may be indicated. Massage may cause initial soreness, bruising or lightheadedness, but usually pain relief, increased mobility, and relaxation are experienced.

SUPPLEMENTS, HERBALS, HOMEOPATHICS, ETC.

Your practitioner may suggest a product to aid your healing. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly, allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, and/or orthotics may be suggested for your particular health issue.

IMAGING, REFERRALS

Further lab work (x-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during your care. If you would like additional information on side effects/complications that could result from treatment or product use, please discuss these with your practitioner.

I have read and understand the above statements concerning treatment side effects and risks, and I also understand that there is no guarantee for a specific cure or result. I understand both my rights and responsibilities in this practitioner/patient relationship.

I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

DESCRIPTION OF ACCIDENT

Please provide a full description of how the accident happened:

WORKER'S COMPENSATION MECHANISM OF INJURY FORM

Date of Injury ___/___/___ **Time:** ___ AM PM **Place of Injury** _____

Accident reported to employer? No Yes **Name of person you reported the accident to:** _____

Have you lost time from work because of this accident? No Yes **If yes, how much time?** _____

Other doctors seen for this condition (Doctor's Name) _____

Diagnosis _____

Did you go to the hospital: At the time of accident Next day No, did not go to the hospital

How were you transported to the hospital: Ambulance Police car Private transportation

Were you admitted to the hospital: Yes No

If yes, how long were you there: _____

Name of Hospital: _____ **Attended by Dr.** _____

What treatment given? (Check all that apply) None X-rays Pain Medication Cervical Collar Bandaged Stitches

Muscle Relaxants Physical Therapy Instructed Regarding Concussion Instructed Regarding Sprains & Strains

Instructed to Call a Private Physician Referred to this office Chiropractic Care Acupuncture Massage Therapy

Other _____

Any previous Workers Compensation Injuries? No Yes **If yes, date(s) of previous injuries** _____

Describe previous Workers Compensation Injury _____

SYMPTOMS FROM ACCIDENT

Please describe how you felt. *PLEASE BE SPECIFIC.*

Immediately after the accident: _____

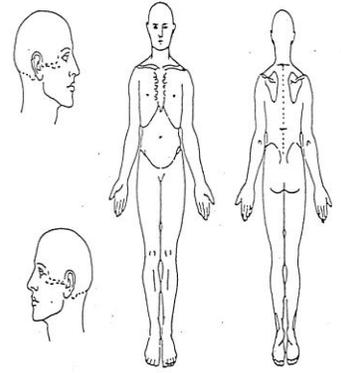
Later that Day Night _____

The next day(s): _____

Patient Name (Print): _____ **DOB:** _____ **Date:** _____

Check the symptoms apparent since the accident:

- Headache
- Neck pain/stiffness
- Midback pain
- Low back pain
- Eyes sensitive to light
- Pain behind eyes
- Blurred vision
- Dizziness
- Fainting
- Ringing/buzzing ears
- Loss of balance
- Loss of smell
- Loss of taste
- Nausea
- Loss of memory
- Fatigue
- Tension
- Shortness of breath
- Irritability
- Depression
- Sleeping problems
- Numbness in toes
- Numbness in fingers
- Cold hands
- Cold feet
- Diarrhea
- Constipation
- Chest pain
- Nervousness
- Cold sweats
- Anxious
- Other _____
- Shoulder pain
- Elbow pain
- Wrist/hand pain
- Hip pain
- Knee pain
- Ankle/Foot pain
- Jaw pain



DUTIES UNDER DURESS SUMMARY

What is your job description? _____

Do you notice any activities of your home daily routines that are different now than from before the accident? Yes No

If yes, list them as:

Those activities that you are now unable to do are (be specific): _____

Those activities that are now painful to do are (be specific): _____

Those activities that are now difficult to do are (be specific): _____

What activities or position aggravate your symptom(s)/condition/pain?

- Bending
- Sitting
- Driving
- Lifting
- Getting up/down
- Sneezing
- Twisting
- Walking
- Coughing
- Standing
- Lying down
- Straining
- Typing
- Other _____

What activities or positions relieve your symptom(s)/condition/pain?

- Nothing
- Stretching
- Lying Down
- Rest
- Exercise
- Massage
- Ice
- Acupuncture
- Chiropractic
- Heat
- Standing
- Sitting
- Medication: _____
- Other _____

CURRENT MEDICATIONS & ALLERGIES

Do you take or use?

- Laxatives
- Cortisone
- Tranquilizers
- Coumadin
- Pain relievers
- Hormones
- Thyroid medication
- Antacids
- Sleep Aids
- Antidepressants/anti-anxiety
- Oral Contraceptives
- Blood Pressure medication
- Cholesterol medication

Please list any medications (prescribed and over-the-counter), vitamins, herbs and supplements you are currently taking:

Please list any medications, foods, environmental allergens (including latex) to which **you are hypersensitive or allergic**:

HOSPITALIZATION, SURGERIES, & ACCIDENTS

Have you experienced any previous (if yes, please include description and dates):

Hospitalizations: _____

Surgeries: _____

Accidents: _____

Patient Name (Print): _____ DOB: _____ Date: _____

HABITS/LIFESTYLE

HABITS/LIFESTYLE	TYPICAL FOOD INTAKE
How do you rate your stress level on a scale of 1-10? 0 = lowest, 10 = highest: _____	Do you typically eat three meals per day? _____
Do you consume: <input type="checkbox"/> Cigarettes or tobacco _____ packs a day <input type="checkbox"/> Coffee/tea/soda _____ cups a day <input type="checkbox"/> Sugar _____ times a day <input type="checkbox"/> Processed/Fast foods _____ times a day <input type="checkbox"/> Alcohol _____ drinks per week <input type="checkbox"/> Marijuana/other drugs _____ times per week	Do you feel you have a healthy diet? _____ Any foods you do not eat? _____ _____
How much water do you drink a day? _____	Do you strongly dislike any particular foods? _____ _____
Do you exercise regularly? What and how often? _____ _____	Do you strongly desire any particular foods? _____ _____
	Are there any foods that aggravate any of your symptoms? _____

FAMILY HISTORY

Please check here if you are adopted or otherwise unaware of your family's medical history

Please Check All that Apply	Self	Mother	Father	Siblings	Children	Spouse
Cancer						
Heart Disease/Angina/Heart Attack						
Diabetes/Pre-diabetic						
Hypoglycemia						
Thyroid Disease						
Low/High Blood Pressure						
Anemia						
Arthritis/Rheumatoid Arthritis						
Lupus						
Migraines						
Stroke						
Epilepsy						
Asthma/Hay Fever						
Kidney Disease						
Blood Disorder						
Mental Health Issues/Concerns						
Substance Dependency						
Other:						
Cause of Death	NA					
Age at Death, if applicable	NA					

Patient Name (Print): _____ DOB: _____ Date: _____

Office Policies

Please take the time to read, initial, and sign our *Office Policies* to acknowledge your understanding of them. If you have any questions regarding these agreements, please discuss them with NPWC staff.

_____ Oregon Workers Compensation benefits are available to you through your employer. Your benefit coverage is a contract between you, your employer, and their workers compensation insurer. North Portland Wellness Center is not a party to that contract. As a service to you and upon your request we can bill your workers compensation insurance provider. It is your responsibility to provide our office with your insurance details and present all paperwork to our staff so we can bill your workers compensation insurance carrier completely and accurately. When possible, our staff will call to verify your benefit coverage prior to your appointment. Please be aware that an estimate of benefits is not a guarantee of payment. If an insurance company provides you or our staff with inaccurate information they may not honor the benefits that were quoted.

_____ Your insurance provider may pay only a portion of the charges for your treatment. You are responsible to pay for any balance on your account. Any account that carries a balance beyond 30 days, will incur a monthly billing administration fee of \$5-\$10. Considerably delinquent accounts are subject to collection procedures. Any collection fees will become the patient's responsibility.

_____ **PLEASE NOTE:** There is a **\$50.00 fee** for each no-show and/or appointment cancellation with less than 24 hours notice. This fee cannot be billed to insurance and is fully the patient's responsibility. If you need to cancel or reschedule an appointment, please be sure to notify us at least 24 hours in advance to avoid being charged.

_____ Patients must be responsible for following the referral, prescription, or treatment plan prescribed by their physician, practitioner, and/or insurance provider. Insurance companies may not pay for services when the treatment plan is not followed, thus patients are responsible for scheduling and attending appointments accordingly.

_____ Patients are responsible for notifying NPWC staff if their insurance coverage or details change.

_____ Patients are financially responsible for the cost of supplements, herbal products, supplies and equipment - to be paid at the time of pick up. Special orders, however, must be paid at the time the order is placed. Where applicable, consider using your health savings account for the purchase of these items. We can supply you with an itemized receipt to provide proof of purchase. We are unable to give refunds or credits on any supplements or herbal products, opened or unopened. We cannot re-sell products that have left the office as we cannot guarantee that these items were protected from conditions that might affect their quality or integrity.

_____ For your convenience, we accept payment in cash, Visa, MasterCard and Discover. We also accept local (in-state) checks with photo ID that lists the address matching the check and the Patient Info form. Please note, there is a **\$30 fee** for each returned check.

_____ As a courtesy to our patients, we ask that you **silence your cell phone and other personal devices** when entering the center and step outside to take a phone call. We also ask that you use a soft voice while in the building, so as not to disturb other patients receiving treatment.

As a patient of North Portland Wellness Center, I acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

Privacy Practices

As our patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

In-Office Security

Notes taken during appointments are kept in your chart and are secured in our clinic at all times. If patient charts are in public areas, they are kept private with the names covered. Access to this office is limited to practitioners, employees, preceptors, and supervised guests.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health only in the office setting to protect your privacy and to ensure that important information is kept in your chart.

Consultations

North Portland Wellness Center practitioners may consult with each other, other healthcare practitioners and/or clinical/laboratory specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, fax, or email are confidential and names are not used unless necessary and consent is provided from you either verbally or in writing.

Records Released

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. Copies of released records are sent by mail or fax and are accompanied by a confidential patient information cover sheet, if faxed. This clinic is not able to email patient records at this time.

Definitions and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) Is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse in the normal course of business, and 2) Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual. This information may reside in any medium: paper, disc, fax, email, and/or digital voice message.

Voicemail & Email Policy

Practitioners and staff will not leave detailed information when leaving a voicemail or email message unless authorized by the patient to do so, so as to protect confidentiality.

I authorize the NPWC to leave appointment reminders and detailed medical and insurance messages via (please check all that apply and provide appropriate contact information):

- | | |
|---|---|
| <input type="checkbox"/> Home Phone _____ | <input type="checkbox"/> Email _____ |
| <input type="checkbox"/> Cell Phone _____ | <input type="checkbox"/> I DO NOT authorize the NPWC to email or leave any |
| <input type="checkbox"/> Work Phone _____ | <u>detailed</u> information via voicemail. |

****Please note, should circumstances change consent can be revoked in writing at any time****

I have read and understand my right to privacy, as stated above, and agree to have the practitioners/staff of North Portland Wellness Center maintain my records confidentially in accordance with the law. I agree to inform the practitioners and/or staff of North Portland Wellness Center if I need any special arrangements pertaining to this issue.

North Portland Wellness Center has the right to update the terms described in this Privacy Practices notice. I may obtain a revised Privacy Practices notice by calling the office and requesting a revised copy be sent in the mail, or by asking for one at my next appointment.

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

FOR OFFICE USE ONLY: WE ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WERE UNABLE TO DO SO AS DOCUMENTED BELOW:

Date: _____ Reason: _____ Staff Initials: _____