North Portland Wellness Center – MVA 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:**

☐ Doctor/Clinic: _____
☐ Personal Referral: _____
☐ Event: _____
☐ Other: _____

☐ Live/Work in Neighborhood
☐ Internet Search
☐ Insurance Company
☐ Chinook Book

☐ Supportland
☐ Yelp
☐ Facebook
☐ Twitter

Motor Vehicle Accident Claim Information

Auto Insurance Carrier: _____ Claim #: _____ Claim Submitted: ☐ Y ☐ N

Date of Injury: ___/___/___ State where accident occurred: _____ Adjuster's Name: _____

Address for Claims: _____ Carrier or Adjuster's Phone #: _____

Attorney's Name: _____ Phone #: _____

If you do not currently have an attorney, do you plan to hire one in the future? ☐ Yes ☐No ☐Unsure

Primary Medical Insurance

Medical Insurance Carrier: _____ Plan Name: _____

ID/Subscriber #: _____ Group #: _____

Primary on Policy? ☐ Y ☐ N, answer following for Primary Insured: Legal Name: _____ DOB: ___/___/___

Insured's ID #: _____ Patient's Relationship to Insured: _____

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 an 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

Motor Vehicle Accident Intake

DESCRIPTION OF ACCIDENT

Date of injury: _____

Describe your vehicle involved in this accident (type, make, model): _____

State the location/address where the accident took place:

_____

Describe your experience of the accident:

_____

_____

_____

Driver, which of your hands were on the steering wheel: ☐ Right ☐ Left ☐ Both ☐ None

Passenger, were you sitting in: ☐ Front ☐ Right Rear ☐ Left Rear

Were you wearing a seat belt: ☐ Yes ☐ No

Approximate speed of your vehicle at the time of accident: _____ MPH Approximate speed of other vehicle: _____ MPH

Did your vehicle strike another vehicle: ☐ Yes ☐ No, the other vehicle struck your vehicle

COLLISION DETAILS

What was the angle of impact of the first collision: ☐ Front ☐ Back ☐ Right ☐ Left

If applicable, what was the angle of impact of the second collision: ☐ Front ☐ Back ☐ Right ☐ Left

Did you brace for impact, and how: ☐ Yes, with my hands ☐ Yes, with my feet ☐ No

Which way were you facing at the time of impact: ☐ Straight ahead ☐ Right ☐ Left

Did your body strike any of the following at the time of impact:
☐ Steering Wheel ☐ Dashboard ☐ Right-side Door ☐ Right-side Window ☐ Other: _____
☐ Windshield ☐ Roof ☐ Left-side Door ☐ Left-side Window ☐ No, I didn't strike anything

Did the seat back bend or break: ☐ Yes ☐ No
Did your airbag deploy: ☐ Yes ☐ No

SYMPTOMS FROM ACCIDENT

Did you get bleeding cuts or bruises? ☐ No

If yes, what bleeding cuts did you receive?_____

If yes, what bruises did you receive?_____

Please describe how you felt. **Please be specific.**

Immediately after the accident:_____

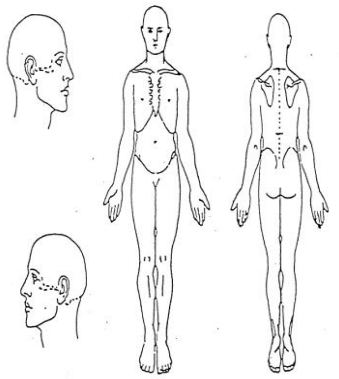
Later that ☐ Day ☐ Night _____

The next day(s)_____

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

Check the symptoms apparent since the accident:

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



WORK STATUS HISTORY

Occupation: _____ Employer: _____

Have you missed time from work? ☐ Yes ☐ No

If yes, full time off work _____

If yes, part time off work_____

☐ Been unable to work since accident

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go to seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

Doctor/Hospital/Clinic Seen: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Were you treated? ☐ Yes ☐ No or prescribed medication? Name of medication(s):_____

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Are you currently seeking treatment? ☐ Yes ☐ No

If yes, Provider name: _____ Specialty:_____

I hereby authorize NPWC to contact my provider(s) as necessary for my continued care and treatment.

_____ _____

Patient Name (Please Print) Relationship to Patient (if not self)

_____ _____

Patient Signature (or Guardian if Patient is a minor) Date

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

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints **just before the accident**? ☐ Yes ☐ No

If yes, what physical symptoms did you have? _____

_____

PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? ☐ Yes ☐ No

If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.): _____

_____

ACTIVITIES OF DAILY LIVING

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 positions 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 AND ALLERGIES

Do you take or use?

☐ Laxatives ☐ Pain relievers ☐ Antacids ☐ Oral Contraceptives

☐ Cortisone ☐ Hormones ☐ Sleep Aids ☐ Blood Pressure medication

☐ Tranquilizers ☐ Thyroid medication ☐ Antidepressants/anti-anxiety ☐ Cholesterol medication

☐ Coumadin

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

_____

_____

If applicable, please list any medications, foods, environmental allergens (including latex) **you are hypersensitive or allergic to:**

_____

HOSPITALIZATION, SURGERIES, & ACCIDENTS

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

☐ Hospitalizations: _____

☐ Surgeries: _____

☐ Accidents: _____

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

DIAGNOSIS & EXPOSURE

Have you ever been diagnosed or exposed to the following:
☐ HIV Diagnosis & Treatment Dates: _____
☐ Hepatitis Diagnosis & Treatment Dates: _____
☐ Tuberculosis Diagnosis & Treatment Dates: _____

Have you ever been exposed in significant or long-term doses to:

☐ Chemicals ☐ Toxins ☐ Radiation ☐ Other: _____

Have you traveled outside of the USA within the last two years? (list countries): _____

HEALTH HISTORY

Date of most recent full physical exam: _____ Results: _____

Have you previously received: Acupuncture treatment ☐ Yes ☐ No Chiropractic treatment ☐ Yes ☐ No Massage ☐ Yes ☐ No

If you have ever had a listed symptom in the past, please check that symptom in the ***Past*** column. If you are presently troubled by a particular symptom, check that symptom in the ***Present*** column.

Past	Present	
☐	☐	Nervousness, irritability, anxiety
☐	☐	Mental tension
☐	☐	Moodiness, depression, melancholy
☐	☐	Tired, weak, lack of energy
☐	☐	Sleeplessness, sleep too much
☐	☐	Frequent colds or other illness
☐	☐	Don't sweat enough
☐	☐	Sweats too much
☐	☐	Night sweats
☐	☐	Swelling/stiffness of Joints
☐	☐	Fainting, visual disturbance, nausea
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular in-coordination
☐	☐	Tinnitus (ear noises)
☐	☐	Respiratory Problems
☐	☐	Rapid heartbeat
☐	☐	Chest pains
☐	☐	Loss of Appetite
☐	☐	Digestive Problems
☐	☐	Abnormal weight ☐ gain ☐ loss
☐	☐	Excessive thirst
☐	☐	Chronic cough
☐	☐	General fatigue
☐	☐	Loss of bladder control
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Frequent UTI
☐	☐	Gall Bladder problems
☐	☐	Abdominal pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Heartburn/indigestion
☐	☐	Dermatitis/eczema/rash

Past	Present	
		Male specific
☐	☐	Prostate exam, including blood test
☐	☐	Problems with prostate
		Female specific
☐	☐	Irregular Periods
☐	☐	Periods have ceased
☐	☐	Profuse Menstrual Flow
☐	☐	Vaginal Discharge
☐	☐	PMS
☐	☐	Use Birth Control: _____
☐	☐	Painful Menses
☐	☐	Gynecological or Abdominal Surgeries
☐	☐	Breast Soreness /Lumps
☐	☐	Pregnancy
		How many weeks?_____

Your current weight: _____lbs. / Height: _____feet _____inches

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

HABITS/LIFSTYLE

HABITS/LIFESTYLE

How do you rate your stress level on a scale of 1-10?
0 = lowest, 10 = highest: _____

Do you consume:
☐ Cigarettes or tobacco _____ packs a day
☐ Coffee/tea/soda _____ cups a day
☐ Sugar _____ times a day
☐ Processed/Fast foods _____ times a day
☐ Alcohol _____ drinks per week
☐ Marijuana/other drugs _____ times per week

How much water do you drink a day? _____

Do you exercise regularly? What and how often?_____

_____

TYPICAL FOOD INTAKE

Do you typically eat three meals per day? _____

Do you feel you have a healthy diet? _____

Any foods you do not eat? _____

Do you strongly dislike any particular foods? _____

_____

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: _____

Motor Vehicle Accident Treatment Policies

Thank you for choosing to seek treatment at The North Portland Wellness Center. As navigation of a car accident, insurance companies, attorneys and treatment policies can sometimes be complex, we've pulled together this list of items to make sure you have a clear understanding of your prescribed care and responsibilities.

Please take the time to read, initial each section, and sign our *Treatment Policies* to acknowledge that you understand them. If you have any questions regarding these agreements, please discuss them with the NPWC staff. We've found that a clear understanding of our policies and procedures helps to create a strong foundation of confidence and communication toward your path of healing and recovery.

_____ Your insurance policy is a contract between you and your insurance company. Therefore, it is your responsibility to be fully aware of your PIP (Personal Injury Protection) coverage & deductibles and to track how close you are to reaching your treatment maximum. This is especially important if you are treating at multiple clinics as we cannot track services that another clinic may have billed on your behalf. In Oregon you may have $15,000 in PIP coverage, but there are many factors that affect payment limits. For the most up-to-date information about your coverage, we advise that you keep in touch with your adjustor and/or attorney.

_____ 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.

_____ Due to the potential complexities of dealing with insurance claims, we highly recommend that you seek legal counsel immediately after any motor vehicle accident. Most attorneys work on contingency and may offer a free consultation so you can fully understand your rights and how an attorney may be able to help you.

_____ At the North Portland Wellness Center we typically recommend a treatment plan that includes a combination of Acupuncture, Chiropractic and Massage to aid in your recovery from injuries sustained in a motor vehicle accident. We find that this combination of therapies works synergistically to speed your healing process and offer the best chance of complete recovery.

_____ Patients are responsible for following the referral, prescription, or treatment plan prescribed by their physician or provider. Most PIP policies require a referral for massage. If you are treating with a Chiropractor at the NPWC, they will be responsible for managing your massage referral but it is your responsibility to follow it as prescribed. Insurance companies may not pay for services when the referral is not followed.

_____ Patients are responsible for informing the clinic and their practitioner about any scheduled Independent Medical Exams (IMEs) as future treatment payment may be dependent upon the outcome. Many insurance companies will suspend payment on claims until the IME is completed and some will deny all coverage/payment after the IME is performed, so this is very important.

_____ Your practitioner may suggest and/or prescribe supplements, herbs or therapeutic products to aid in your treatment and some of these may not be covered by your insurance policy. You are responsible for any products not covered by your policy at the billed rate. We are unable to give refunds or credits on any supplements or herbal products, opened or unopened.

_____ Should you need to pay for products, fees or services, we accept payment forms in cash, Visa, MasterCard and Discover. We also accept local (in-state) checks with photo ID that lists the address provided on both your ID and 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 make or take any phone calls. We also ask that you use a soft voice while in the building, so as not to disturb other patients receiving treatment.

_____ There is a **$50.00 fee** for each no-show and/or appointment cancellation with less than 24 hours notice. 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. This fee cannot be billed to your insurance claim and is fully your responsibility.

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 by my insurance. 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 that are 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):

☐ Home Phone _____
☐ Cell Phone _____
☐ Work Phone _____

☐ Email _____
☐ I **DO NOT** authorize the NPWC to email or leave any detailed 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: _____