Heresco CHIROPRACTIC

massage • strength rehab

Today's Date: ____/____/____

Legal Name: _____ What you preferred to be called?: _____
First Last MI

Birthdate: _____/_____/_____ Age: _____ Gender: _____ Email: _____

We offer a monthly health and wellness email newsletter. Please initial here if you'd like to receive this. ☐

Physical Address: _____ (STUDENTS– please put your local address here) City, State, Zip: _____

Cell Phone #: _____ Work Phone #: _____ Home Phone # _____

We offer Text Appointment Confirmations. Please initial here if you'd like to receive those. ☐

Relationship Status: _____ Do you have children? ❑No ❑Yes How Many: _____

Name of Employer: _____ Job Title: _____

Account Information: Person ultimately responsible for account.

Name: _____ Relation: _____ Phone: _____

Billing Address: _____ City, State, Zip: _____

(STUDENTS– please put your parents address here, if appropriate for billing)

_____ *I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.*
Initials *I fully understand I am solely responsible for any balance not paid by my insurance company.*

1. Is today's problem caused by:
□ Auto Accident □ Workman's Compensation Claim □ Neither

2. What is your main area of complaint? _____

_____

3. How often do you experience your symptoms?
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
□ Sharp □ Numb □ Sharp with motion
□ Dull □ Tingly □ Shooting with motion
□ Diffuse □ Achy □ Stabbing with motion
□ Burning □ Stiff □ Electric like with motion
□ Shooting □ Other:_____

5. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your condition?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. What concerns you the most about your problem; what does it prevent you from doing?

_____

_____

IN THE EVENT OF EMERGENCY

Who should we contact?
_____

Relationship to you:
_____

Phone: _____

Other #: _____

Who is your Medical Doctor?
_____

Medical Doctor's phone #:
_____

FOR OFFICE USE ONLY

Pt file #: _____

BP: _____

Pulse: _____

Patient Name:	Pt. File#:	Welcome

11. How long have you had this problem? _____

12. How do you think your problem began? _____

13. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No □ Bothersome

14. What aggravates your condition? _____

15. What alleviates your condition? _____

16. What is your: Height_____ **Weight** _____

17. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

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19. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ None
□ Heart Problems □ Cancer □ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

N/A	Past	Present	N/A	Past	Present	N/A	Past	Present
□	□	□ Headaches	□	□	□ High Blood Pressure	□	□	□ Diabetes
□	□	□ Neck Pain	□	□	□ Heart Attack	□	□	□ Excessive Thirst
□	□	□ Upper Back Pain	□	□	□ Chest Pains	□	□	□ Frequent Urination
□	□	□ Mid Back Pain	□	□	□ Stroke	□	□	□ Smoking/Tobacco Use
□	□	□ Low Back Pain	□	□	□ Angina	□	□	□ Drug Use
□	□	□ Shoulder Pain	□	□	□ Kidney Stones	□	□	□ Alcohol Use
□	□	□ Elbow/Upper Arm Pain	□	□	□ Kidney Disorders	□	□	□ Allergies
□	□	□ Wrist Pain	□	□	□ Bladder Infection	□	□	□ Depression
□	□	□ Hand Pain	□	□	□ Painful Urination	□	□	□ Systemic Lupus
□	□	□ Hip Pain	□	□	□ Loss of Bladder Control	□	□	□ Epilepsy
□	□	□ Upper Leg Pain	□	□	□ Prostate Problems	□	□	□ Dermatitis/Eczema/Rash
□	□	□ Knee Pain	□	□	□ Abnormal Weight Gain/Loss	□	□	□ HIV / AIDS
□	□	□ Ankle/Foot Pain	□	□	□ Loss of Appetite			**For Females Only**
□	□	□ Jaw Pain	□	□	□ Abdominal Pain		□	□ Birth Control Pills
□	□	□ Joint Pain/Stiffness	□	□	□ Ulcer		□	□ Hormonal Replacement
□	□	□ Arthritis	□	□	□ Hepatitis		□	□ Pregnancy
□	□	□ Rheumatoid Arthritis	□	□	□ Liver/Gall Bladder Disorder			
□	□	□ Cancer	□	□	□ General Fatigue			□ **Other:**
□	□	□ Tumor	□	□	□ Muscular In-coordination			
□	□	□ Asthma	□	□	□ Visual Disturbances			
□	□	□ Chronic Sinusitis	□	□	□ Dizziness			

21. List all prescription medications you are currently taking: (If you have a list, we can copy it): _____

_____

22. List all of the over-the-counter medications & vitamins you are currently taking: _____

_____

23. List all surgical procedures you have had and approximate dates: _____

_____

24. What activities do you do at work or at home?

Sit:	□ Most of the day	□ Half the day	□ A little of the day
Stand:	□ Most of the day	□ Half the day	□ A little of the day
Computer work:	□ Most of the day	□ Half the day	□ A little of the day
On the phone:	□ Most of the day	□ Half of the day	□ A little of the day
Drives:	□ Most of the day	□ Half of the day	□ A little of the day

□ **Performs manual labor**
□ **Reads a lot**
□ **Travels Frequently**

25. What activities do you do outside of work? Activities or hobbies: _____

26. Have you ever been hospitalized? □ No □ Yes If yes, why _____

27. Have you seen a Chiropractor before? □ No □ Yes If yes, how long ago?_____

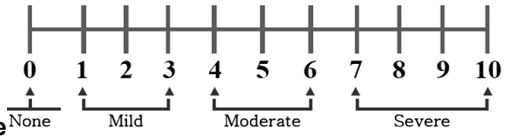
How were your results? □ Great □ Good □ Fair □ Mixed □ Poor □ Other _____

28. Have you had significant past trauma? □ No □ Yes

29. Please mark area(s) of injury or discomfort using

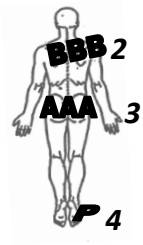
A) Letters to describe your pain

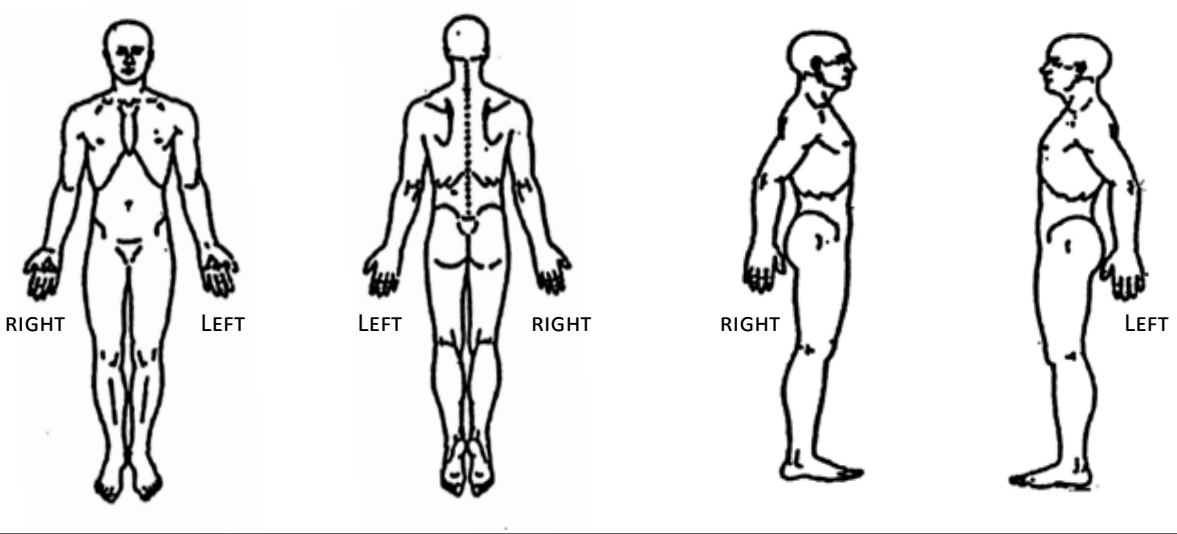
B) Numbers for the degree of pain using a scale from



1 (discomfort) to 10 (extre

- N = Numbing
- P = Pins & Needles
- B = Burning
- A = Aching
- S = Stabbing





30. Anything else pertinent to your visit today? _____

_____

_____

- 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 requests 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 responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- 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 to the information I have provided.

☑ **Patient Signature**_____ **Date:** _____

Patient Name: **Pt. File#:**

Would you be willing to help us out?

If so, please answer each question. Check all that apply.

For helping us out, we will donate $1 to a local non-profit group! **Help us, so we can help others!**

1. Pick a (ONE) local non-profit group for $1 to be donated from Heresco Chiropractic for answering the following questions.

☐ Linn Benton Food Share ☐ Jackson Street Youth Shelter ☐ Philomath Youth Activities Club ☐ Corvallis Aquatic Team

☐ CARDV ☐ SafeHaven Humane Society ☐ Home Life ☐ Girls on the Run Willamette Valley

2. I heard about Heresco Chiropractic from my (answer all that apply)?

☐ Clinic Reputation ☐ Another Chiropractor ☐ Family Member ☐ Other _____

☐ Family Physician ☐ Insurance Agent/Company ☐ Friend ☐ I did NOT hear about Heresco

☐ Attorney ☐ Claims Adjustor ☐ Co-Worker Chiropractic from any of these resources.

3. In reference to question 2, what is the name of the person/company who referred you to our clinic?

_____

4. Have you seen Heresco Chiropractic at an event? Which events have you seen us at?

☐ Run/Walk Events ☐ Community Health Fairs ☐ OSU Events ☐ Other _____

☐ Sporting Events ☐ Business Health Fairs ☐ Lunch and Learn Presentation ☐ I have NEVER seen Heresco Chiropractic at any local events.

5. In reference to question 4, what is the name of the event you saw Heresco Chiropractic at?

_____

6. Were you referred to one of the chiropractors in this office? (answer all that apply):

☐ Dr. Frank Heresco ☐ Dr. Joseph Shepro ☐ Dr. Cory Imhof ☐ Dr. Michael McDonald ☐ Dr. Don Peterson ☐ Other _____

7. I have heard or found Heresco Chiropractic through the following media sources:

☐ Facebook ☐ Name of internet search ☐ Drove By the office ☐ Newspaper

☐ Heresco website engine: _____ ☐ Student Survival Guide ☐ Other _____

☐ Googled "chiropractor" ☐ Printed Advertisement ☐ Telephone Book ☐ I have NOT heard of Heresco

☐ Yelp ☐ Radio Advertisement ☐ Magazine Chiropractic from any of these media sources.

Thank you for helping us out!

Heresco Chiropractic: Informed Consent to Chiropractic Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent when starting treatment.

I _____(Legal Name), of _____(Town of Residence) hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/ adjustments involving the movement of the joints and soft tissues. These manipulations/adjustments may be **performed by any of the chiropractors on staff** at this office. Physical therapy and exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

_____ Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Initials

_____ Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Initials

_____ Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from
Initials osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. If a tendon is weak or partially torn, manipulation may cause it to tear the rest of the way.

_____ Stroke/ Cervical Artery Dissection Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware
that nerve or brain
Initials damage including stroke or Cervical Artery Dissection is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as
getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

_____ Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is
Initials obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

_____ Tests have been performed on me to minimize the risk of any complications from treatment and I freely assume these risks.
Initials

_____ Treatment Results I also understand that there are beneficial effects associated with these treatment procedures including decreased pain,
Initials improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree with the performance of these procedures by my doctor and such other persons of the doctor's choosing including other chiropractors that work for this office and certified assistants.

_____ Alternative Treatments Available
Initials Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, and possible surgery.

_____ Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for
Initials concern. Drugs may mask pathology, produce inadequate or short-term relief, undesired side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

_____ Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and
Initials pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

_____ Surgery: Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain
Initials or reaction to anesthesia, and prolonged recovery.

_____ Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted mo
Initials motion possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

_____ Health care should be shared by the doctor and the patient. You have a responsibility to tell the doctor if your health changes, such as but not
Initials limited to, new medications, a new condition such as diabetes, any surgeries, etc. Please do your part so we can help keep you healthy and safe.

_____ COVID –19: While Heresco Chiropractic and Associates are taking many steps to disinfect, clean, and practice social distancing the best we are
Initials able, there is always a risk of infection. By signing this, you acknowledge that and wish to proceed with care.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ *Patient#*_____ _____/_____/2020
Signature of Patient *Date*

_____ _____
Signature of Guardian *Signature of Witness*

Heresco Chiropractic

HIPAA - Notice to Patient

Acknowledgement of Receipt of *Notice of Privacy Practices* - *This form will be retained in your medical record.*

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Heresco Chiropractic and Associates. I understand that the Notice describes the uses and disclosures of my protected health information by Heresco Chiropractic and Associates and informs me of my rights with respect to my protected health information. I also understand that I can find this entire form on **www.Heresco.com** website.

_____ _____ _____

Signature of Patient or the Legal Representative *Printed Name of Patient or the Legal Representative* *Today's Date*

For OFFICE use ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____

Employee's Name **Today's Date**

This form is based on current federal law, is subject to change based on changes in federal law, and the content may need to be modified to adhere to state law or subsequent guidance or advisories. Doctors are advised to consult with their state licensing Board or local counsel.

Condition of Patient at Time of Consent Process

Based on my personal observation and direct conversation with the patient, I conclude that throughout the consent process he/she was:

- ☐ Of legal age
- ☐ Under the age of 18. The legal guardian of the patient has given consent to the treatment of this youth. Guardian Name: _____
- ☐ On prescription/OTC medication but unimpaired.
- ☐ Resolute in denying the use of alcohol and/or recreational drugs prior to consent.
- ☐ Oriented as to time and place.
- ☐ Coherent and lucid.
- ☐ Able to understand the language used.
- ☐ Assisted in understanding by use of an interpreter. Interpreter's name: _____
- ☐ Assisted in consent process by family members: Name: _____ Relationship: _____
- ☐ Assisted in consent process by staff member. Name: _____
- ☐ I encouraged and answered questions regarding this form with the patient.
- ☐ PARQ films:_____

Patient had the following questions and was supplied with the following answers:

Comments: _____

I certify that the above accurately described the consent process in this case.

_____ _____

Signature of Doctor Date

Heresco Chiropractic

Financial Policy

Patient Name (please print):_____ Pt File #_____

_____ ***Initials*** **ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE -**Payment is required at the time services are rendered, unless other arrangements have been made in advance. Our Payment Account Representative can establish a payment plan if needed. We offer 3 different payment options: cash, check, and all major credit cards.

_____ ***Initials*** **APPOINTMENTS -**If you need to reschedule an appointment, please give us a 24 hour notice. Our phones are available 24 hours a day, 7 days a week at (541)757-9933.

_____ ***Initials*** **MASSAGE APPOINTMENTS -*If you need to reschedule or cancel a massage you must give at least 24 hours notice.*** If you fail to give a 24 hour notice, your account will be charged the full price of the missed massage.

_____ ***Initials*** **INSURANCE BILLING -**Please provide us a copy of your insurance card so that we can complete a complementary insurance verification to check for stipulations your policy places on your care. We will bill your health, automotive, or workers compensation insurance companies dependent on your source of injury. **It is your responsibility to inform us of any changes to your policy. Failure to notify us of changes to your insurance may result in denials and charges will become your responsibility.**

INSURANCE MAXIMUMS -Most insurances have a set maximum number of visits and/or a max dollar amount that they will pay towards your chiropractic treatment each year. Our primary focus is to take care of you and your health condition. We do our best to help you spend your healthcare dollars wisely and effectively. We treat our patients, not your insurance company. If recommended treatment of your condition goes beyond your insurance company's maximum for the year, we will try to notify you of it as soon as we know. Be aware that when we bill your insurance company, it can take up to 45-60 days to get a response from your insurance. **Please be advised that any treatment accrued during this lag time will be your responsibility. You are responsible for tracking your maximums.** If you have concerns about the maximums allowed by your insurance company, we encourage you to call Kim in our Insurance Department. Kim is available Monday through Friday from 8 AM - 4:30 PM 541-367-6147. If she is not available when you call, please leave her a message and she will call you back.

Your insurance maximum is: _____.

SELF PAY -If you do not have insurance or if you have insurance that does not cover chiropractic, you will be considered self pay. You will be required to pay each visit in full at the time of treatment. There are several discounts for payment received at the time of treatment and even bigger discount for payments in advance. Please ask our front desk receptionists for details or if you have any questions.

PERSONAL INJURY -When a Personal Injury occurs, your insurance will send you a Personal Injury Protection (PIP) application. **The PIP form must be completed before your insurance will pay on your claim.** Our billing department will contact your insurance company to verify coverage. If you have any questions regarding your personal injury please contact our billing department at 541-367-6147.

In Oregon, when an automotive collision occurs, regardless of who's at fault we are required to bill **your** auto insurance. Your auto insurance will recoup payment from the opposing insurance company.

WORKERS' COMPENSATION -Workers' Compensation requires specific information when handling claims like your address, employers name and full address, claim number, and claim manager's name. You will be asked to provide the name and address of your private insurance company on your initial visit. **In the event your claim is denied, we will have an alternate source to bill for services rendered.**

MEDICARE -Medicare ONLY covers the cost of the chiropractic adjustments designed to help correct a vertebral subluxation. An examination is necessary to identify a vertebral subluxation. Medicare requires this and doesn't pay for the cost of the exam or any needed x-rays. Procedures like massage, traction, electric muscle stimulation or other therapies are **NOT COVERED** by Medicare. Medicare does not pay for chiropractic care to maintain your progress or help prevent problems. Most patients see the value of some type of wellness care, Medicare does not pay for the coverage of it.

BILLING AND CREDIT -Statements will be mailed monthly and are due for payment within 10 days. Monthly statements will follow until the account is paid in full. If you have not paid your bill, or have not set up a payment plan, we will ask for the assistance of a collection agency.

CONSENT: *I have read, initialed and understand the Heresco Chiropractic and Associates Financial Policy. I fully understand that I am ultimately responsible for all services provided by Heresco Chiropractic and Associates.*

_____ _____ _____

Signature of Patient *Date of Birth* *Date*

_____ _____

Signature of Guardian *Signature of Witness*