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

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?_____

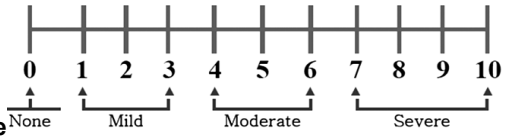
How were your results? □ Great □ Good □ Fair □ Mixed □ Poor □ Other _____

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

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

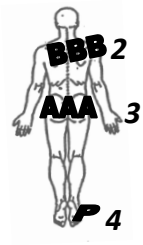
A) Letters to describe your pain

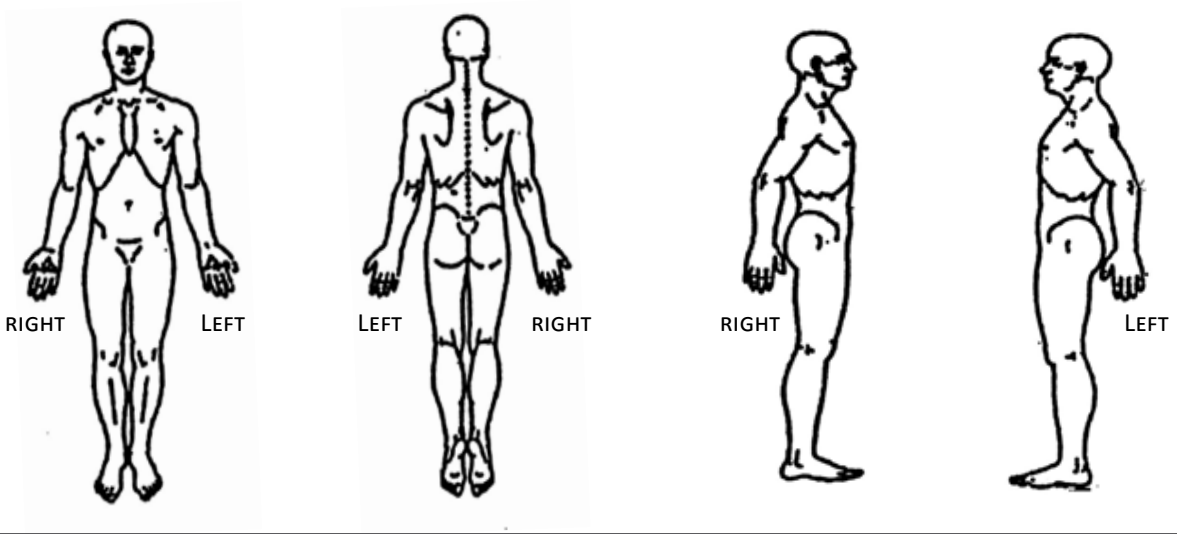
B) Numbers for the degree of pain using a scale from



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 ☐ 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
massage • strength rehab

Massage Informed Consent

I hereby authorize, any of the Chiropractic Assistants/ Licensed Massage Therapists that work at Heresco Chiropractic Clinic to administer Massage Therapy as deemed necessary for my condition.

Please discuss any questions or problems with the Chiropractic Assistants/ Licensed Massage Therapist/ or Doctor of Chiropractic, before signing this statement of policy. I have read, and understand the above. By signing this form I am stating that I am 18 years of age or older and I give my permission to receive treatment. If you are not 18 years of age or older please notify the receptionist.

_____ _____
Patient Name Printed Date of Birth

_____ _____
Patient Signature Date

HIPPA - 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*

_____
If legal Representative, indicate relationship

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.

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.**

_____ ***Initials*** **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*