KLAMATH FALLS
—CHIROPRACTIC—

Patient Quality of Life Survey

Company Information: _____

Name: _____ **Date:** _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): _____

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Some Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ Haven't Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

04 **What are you afraid this might be (or beginning) to affect (or will affect)?**

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

05 **Are there health conditions you are afraid this might turn into?**

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

_____

_____

_____

_____

07 **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

1. _____
2. _____
3. _____

08 **What are you most concerned with regarding your problem?**

09 **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

10 **What would be different/better without this problem? Please be specific.**

11 **What do you desire most to get from working with us?**

12 **What would that mean to you?**

KLAMATH FALLS
—CHIROPRACTIC—
Telephone 541-273-7120

CONDITIONS OF SERVICES RENDERED

Financial Agreement

I agree, whether I sign as agent or as patient, that in consideration of the services rendered to the patient, I hereby individually obligate myself to pay the account with Klamath Falls Chiropractic in accordance with the regular rates and terms. Late fees may occur when payments are not made on time. No-show fees may occur when appointments are missed. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. In addition, professional courtesies may be removed.

Assignment of Insurance Benefits

I authorize, whether I sign as agent or as patient, direct payment to Klamath Falls Chiropractic of any insurance benefits otherwise payable to or on behalf of the patient for the visit or for these outpatient service at a rate not to exceed Klamath Falls Chiropractic's actual charges. I understand that I am financially responsible for charges, deductibles, and co-insurance not covered by insurance.

Health Plan Obligations

Klamath Falls Chiropractic maintains a list of health plans with which it contracts. Klamath Falls Chiropractic has not contracted, expressed or implied, with any plan that does not appear on that list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by Klamath Falls Chiropractic if he/she belongs to a plan, which does not appear on the above-mentioned list.

Release of Information

I authorize Klamath Falls Chiropractic to release any information necessary to provide medical treatment to me. I allow Klamath Falls Chiropractic to bill and be paid for services they provide. I understand that releasing information for any reason other than those listed above requires a separate authorization by me. I also understand that I have the right to request restrictions on the use of my health information, but Klamath Falls Chiropractic is not obligated to honor that request unless required to do so by State or Federal regulations. This consent shall be effective if necessary, to obtain payment.

Insurance Benefit Verifications

Klamath Falls Chiropractic will verify your insurance benefits as a courtesy. Verifications do not guarantee payment from your insurance company.

The terms and conditions of this agreement are not binding until the patient receives care and treatment from Klamath Falls Chiropractic. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Name: _____ **Date:** _____

Signature: _____

If signed by representative for patient, indicate relationship: _____

IMPLIED CONSENT

It is prudent for us to obtain your informed consent prior to examination and treatment. The purpose of this information is to inform you, not to alarm you. What you are being asked to sign is simply a notice of possible injury.

Associations and Assistants: In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, and treatment. Occasionally when your doctor is unavailable, another clinic doctor may treat you. We also use chiropractic assistants to aid with other forms of treatment.

Treatment: The Chiropractic adjustment: The chiropractor will use their hands upon your body in such a way as to move your joints. This procedure may cause an audible "pop" or "crack" much as you have experienced when you "crack" your knuckle. There are some material risks involved in doing this and they are as follows:

Inherent Risks: Pain: It is common for an adjustment as well as traction, massage therapy, exercise, in fact, almost any treatment, to result in temporary increase in soreness in the region being treated.

Soft Tissue Injury: Soft tissue, such as ligaments and muscle may be stretched or torn during an adjustment. The result is a temporary increase in pain. However, there are no long term effects. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fracture: The force of an adjustment might "crack" a rib. This can happen with anyone; however, it occurs most often in patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that there are no available statistics to quantify their probability.

Disc Herniation: Occasionally treatment will aggravate or cause a problem if the disc is in a weakened state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that there are no available statistics to quantify their probability.

Stroke: Even though strokes happen with some frequency in our world, strokes resulting from chiropractic adjustments are rare. So rare that you have the same chance of getting hit by lightning: one in a million.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, etc., then noted above. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advance of treatment.

Other Treatment Options (non-chiropractic)

Medication: Medication may be used to relieve pain and swelling. However, medication can mask progress and the efficiency of chiropractic treatment. Caution should be used since the danger of side effects and damage to the health of the person taking the medication is well documented.

Hospitalization: Hospitalization has proven expensive and dangerous. The documentation of such is overwhelming.

Surgery: Surgery is always a possibility. The expense, danger and ineffectiveness of such treatment is more a probability than a possibility.

Non-Treatment: Remaining untreated, results in adhesions, pain, and reduction in assorted joint mobility. The probability that these adhesions will interfere with the motion, function and enjoyment of life is very high.

I hereby authorize and direct the physician with associates or assistants to provide such additional services as they may deem reasonable and necessary.

Patient Signature: _____ **Date:** _____

Patient Acknowledgement

Receipt of Joint Notice of Privacy Practices

By my signature below, I hereby acknowledge that I have received a copy of Klamath Falls Chiropractic Notice of Privacy Practices. Klamath Falls Chiropractic is permitted to use or disclose my health information to carry out treatment, payment or health care operations. Health information means any and all information relating to health care services provided to me, including information related to services provided to me prior to the date I sign the acknowledgement form.

I understand the Klamath Falls Chiropractic's Notice of Privacy Practices explains the types of uses or disclosures that Klamath Falls Chiropractic may make and my rights with respect to my health information. I understand that if I have any questions or concerns about this Notice, I may contact the Office Manager at the telephone number listed below. I further understand Klamath Falls Chiropractic may change the terms of the Notice of Privacy Practices from the time, and that I may contact the Office Manager to obtain a revised version of the notice at any time.

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

Patient's Signature: _____ **Date:** _____

If signed by representative for patient, indicate relationship: _____

Representative's Signature: _____

You may contact our office regarding your privacy by calling 541-273-7120

Chiropractic and Massage Cancelation and No-Show Policy

Your appointments are very important to Southern Oregon Chiropractic. They are reserved especially for you. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24-hour notice for cancellations or rescheduling of appointments.

A "No-Notice/No-Show" is someone who misses an appointment without notice. We have voicemail which can receive messages 24 hours a day. Please understand that when you forget, cancel, or change your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and clients on our waitlist miss the opportunity to receive the care they need.

If arriving late to your scheduled appointment, please understand that our providers require a specific amount of time to treat and provide you with excellent care. Arriving late may result in a loss of appointment and incur a fee.

Please read the following statements and initial:

_____ If a patient "No-Show/No-Notices" their New Patient Appointment the patient must pay a $50 fee in order to reschedule New Patient Appointments.

_____ Patient must arrive to new patient appointment with paperwork completed. If New Patient Paperwork is not complete 10 minutes past appointment start time, patient cannot be seen and will be asked to reschedule.

_____ If a patient No-Notice/No-Shows a Massage or follow up Chiropractic adjustment a $40 fee will be billed out to the patient directly.

_____ After 2 statements are sent out (60 days) without payment of fees, the patient will be sent to inhouse collections and must pay balance before being allowed to reschedule follow-up appointments.

_____ If patient arrives more than 5 minutes late for a chiropractic appointment patient is unable to be seen and will be charged as a "No-Show/No-Notice" occurrence. Late arrivals for a follow-up chiropractic appointment may be subject to a $40 fee.

By signing below, I acknowledge that I understand the terms of this form. I understand that these fees have nothing to do with my co-pay or deductible and in fact cannot be billed to my insurance company.

Massage and Chiropractic Sanitation Policy

Southern Oregon Chiropractic requires and states that any patient, being treated within our clinics, must arrive showered and personal hygiene must be free from any visible unsanitary matter or illnesses. Unsanitary matter includes, but is not limited to, dirt, bodily fluids, animal feces, etc. Specific illnesses include, but not limited to, lice, scabies, rash, vomiting, and diarrhea, etc.

If appointment reason required manual therapy or massage, patient may be asked to use a disinfecting towelette to wipe themselves prior to treatment. In some cases, if the patient's hygiene or condition is not within our policy and proceeding with treatment will cause an unsanitary environment, the patient may be asked to reschedule their appointment.

Disclosure Authorization

_____ By initialing here, I authorize Klamath Falls Chiropractic and Southern Oregon Practice Management (billing office) I voluntarily consent to authorize my health care provider to use or disclose my health information to the recipient(s) that I have identified below.

Patient's Name: _____ **Phone:** _____

Address: _____

Authorized Person's Name: _____ **Phone:** _____

Address: _____

I authorize the release of the following health information: (check the applicable box below)

☐ All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ Only the following records or types of health information:

_____

_____

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE READ AND ACCEPT THE TERMS LISTED ABOVE. I HEREBY STATE THAT I HAVE CONSENTED TO TREATMENT, KNOW AND UNDERSTAND THE CLINIC PRIVACY PRACTICES, THAT I UNDERSTAND THE NO-SHOW/NO-NOTICE POLICY, AND UNDERSTAND AND WILL ABIDE BY THE SANITATION POLICY.

IF I HAVE ANY QUESTIONS ABOUT THIS CONTRACT WITH MYSELF AND SOUTHERN OREGON CHIROPRACTIC, I UNDERSTAND THAT THE CONTRACT IS AVAILABLE ONLINE FOR MY VIEWING OR I CAN REQUEST A COPY FROM THE OFFICE.

Patient's Name: _____ **Date:** _____

Patient's Signature: _____

If signed by representative for patient, indicate relationship: _____

Patient Registration Form

Patient Name _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ SSN ___ - ___ - ____

DOB ___ / ___ / _____ Gender _____

Emergency Contact

Name _____

Relationship _____ Phone _____

Medical Insurance Information

Primary Insurance _____

ID Number _____ Group Number _____

Insured Name _____ DOB _____

Secondary Insurance _____

ID Number _____ Group Number _____

Insured Name _____ DOB _____