Sunstone Chiropractic, LLC
200 NE 20th Ave, Suite 20, Portland, OR 97232
PH: 971-229-1384 Fax: 971-229-1397

PATIENT INFORMATION

NAME:_____ DATE: _____

ADDRESS:_____CITY/ST_____ZIP _____

PHONE:_____E-MAIL: _____

DATE OF BIRTH:_____AGE:_____ Gender identity: _____

Sex assigned at birth:_____Pronoun Preference: _____

EMPLOYER:_____OCCUPATION:_____

RELATIONSHIP STATUS: ☐ MARRIED ☐ PARTNERED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

SPOUSE/PARTNER NAME:_____PHONE:_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____PHONE:_____

WHOM MAY WE THANK FOR THE REFERRAL? _____

AUTHORIZATION TO TREAT A MINOR

If the patient is under the age of 18, or is otherwise unable to sign, please complete the following.

Patient is_____years of age OR unable to sign because: _____

SIGNATURE:_____DATE:_____RELATIONSHIP TO PATIENT:_____

**** ANY PATIENT 15 YEARS OR YOUNGER MUST HAVE A PARENT/GUARDIAN PRESENT IN THE BUILDING DURING TREATMENT ****

INSURANCE INFORMATION

Present your insurance card(s) and ID to a Sunstone Chiropractic front desk employee for photocopying.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I AGREE TO NOTIFY SUNSTONE CHIROPRACTIC IMMEDIATELY WHENEVER I HAVE CHANGES IN MY PERSONAL INFORMATION LISTED ABOVE, INCLUDING MY INSURANCE STATUS. INITIAL HERE: ____

CANCELLATION POLICY

Sunstone Chiropractic requires a 24-hour advance cancellation for all appointments. If I am unable to give 24 hours advance notice, I accept that the following fees will be charged: **$50.00** for a chiropractic appointment, **$95.00** for a massage. I have read and understand the cancellation policy.

PATIENT SIGNATURE:_____ DATE: _____

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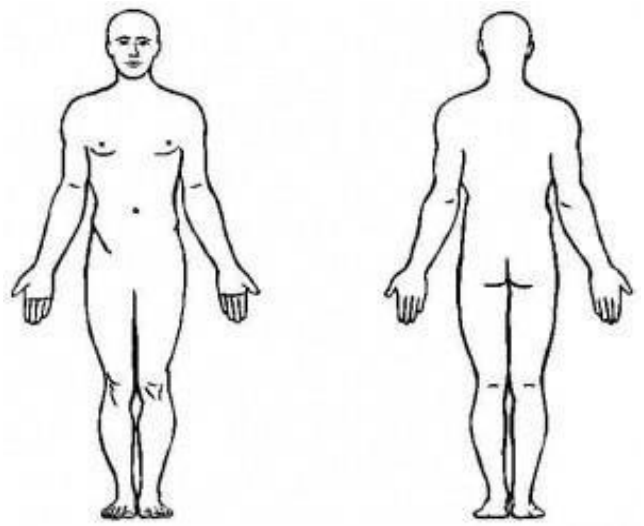
PATIENT NAME: _____ **DATE:** _____

PLEASE MARK OR LIST ALL SYMPTOM AREAS ON THE BODY DIAGRAM BELOW (key provided):

> Numbness - Burning * Ache + Stabbing O Pins & Needles



For Provider Use Only

Please rate your symptom intensity right now from 1-10:
(1 being no pain at all, 10 being unbearable pain)

When did your symptoms begin? _____

Work-related? Y / N Motor Vehicle Collision? Y / N

How did your pain begin? (circle) Bending Lifting Fall

Other: _____

Prior treatment for your symptoms? (circle)

Chiropractic Acupuncture Massage PT Medical

Date: _____ Results: _____

Diagnoses Given To You: _____

Anti-inflammatory /Pain Meds? (circle)

Ibuprofen Acetaminophen Other: _____

Pain Chronology: (circle):

Improved Worsened Constant Intermittent

Other: _____

Has this happened in the past? NO / YES when? _____

Treatment? _____ results? _____

How do the following affect your pain? (circle)

Cough/sneeze:	worse	better	no difference
Sitting:	worse	better	no difference
Sit to stand:	worse	better	no difference
Bending forward:	worse	better	no difference
Bending back:	worse	better	no difference
In the morning:	worse	better	no difference
Night time:	worse	better	no difference
Lifting:	worse	better	no difference
Standing:	worse	better	no difference
Walking:	worse	better	no difference
Lying face down:	worse	better	no difference
Looking down:	worse	better	no difference
Looking up:	worse	better	no difference
Turning head:	worse	better	no difference

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Have you been under the care of a primary care physician in the last year?

NO/ YES (physician name, reason): _____

Do you or any of your immediate family members have any of the following health conditions? NO / YES (circle and indicate whom below)

heart disease cancer diabetes strokes high blood pressure arthritis scoliosis other: _____

If you are working, please circle all of the following items that pertain to your job / jobs:

Full Time (>35 hrs/wk) Part Time (<35 hrs/week) Sitting Standing Heavy Lifting Air Travel

Have you taken a leave from work because of your injuries?

NO / YES (when? _____ restrictions? _____)

If you are currently exercising, please circle activities that pertain:

Frequent (>5 times/week) Moderate (3-4 times/week) Infrequent (1-2 times/week)
Aerobic Exercise (> 30 mins) Aerobic Exercise (<30 mins) Weight Lifting Yoga/Pilates
Other: _____

Do you currently smoke/drink alcohol/use recreational drugs? (circle)

NO/YES (How much and how frequent? _____)

Please list any surgeries and/or hospitalizations you have had:

Procedure: _____ Year: _____ Result: _____
Procedure: _____ Year: _____ Result: _____
Procedure: _____ Year: _____ Result: _____

Please list any medications you are currently taking:

Name: _____ Dosage: _____ Date started taking: _____
Name: _____ Dosage: _____ Date started taking: _____
Name: _____ Dosage: _____ Date started taking: _____

In the past 5 years have you had any major accidents (e.g. car crash, falls, sprains, breaks etc.)?

Event: _____ Date: _____
Event: _____ Date: _____

Please circle any of the following symptoms/complaints you have experienced in the past 6 months:

fever night sweats unexplained weight loss changes in bowel/bladder function headaches
change in vision change in hearing difficulty swallowing chest pain poor circulation
cough difficulty breathing nausea vomiting bruise easily swollen/painful joints
dizziness allergies depression anxiety difficulty sleeping skin rashes/irritation

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including massage and various modes of physical therapy on me (or the patient named below, for whom I am legally responsible) by a Sunstone Chiropractic physician and/or other licensed Doctor of Chiropractic who may treat me now or in the future while employed by, working for or associated with Sunstone Chiropractic.

I understand that the doctor will conduct a full exam with a complete report of findings. I have had or will have an opportunity to discuss with the doctor and/or other office or clinic, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon facts then known, to be in my best interest.

AUTHORIZATION FOR DIRECT PAYMENT OF INSURANCE BENEFITS TO THE HEALTHCARE PROVIDER AND CLINIC: I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering services during this visit or any insurance benefits payable to me.

AUTHORIZATION TO RELEASE INFORMATION: In obtaining payment for services, I authorize my healthcare provider and the clinic to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in the processing of the claim. If I have been referred by, or am being referred to another healthcare provider, I authorize the release of my clinical information to this provider for continuing care.

PROTECTED DIAGNOSIS: If my medical record contains information about drug or alcohol diagnosis or treatment, or HIV testing, I specifically authorize the release of this information for billing purposes ONLY. Any other release of such information may only be released with another specific consent form.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. I HAVE ALSO HAD OR WILL HAVE AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW I AGREE TO THE CONDITIONS STATED ABOVE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF TREATMENT FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

_____

Patient name – PLEASE PRINT DATE Patient signature – PLEASE SIGN

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Sunstone Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, a collection agency, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you. Including information needed for independent collection agencies.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment, and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your voicemail or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in the following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide authorization for the release of the information you have the right to revoke thatauthorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to

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whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy practices you should direct your complaint to:

Lori Brown, D.C.

If you would like further information about our privacy policies and practices, please contact Lori Brown D.C.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue, and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of: December 2, 2014

Your signature below acknowledges that you have read a copy of this notice.
You have the right to a paper copy of this notice at any time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that by signing below that I have received a copy of this office's Notice of Privacy Practices.

Patient name – PLEASE PRINT DATE Patient signature – PLEASE SIGN