Wellness Doctor, Inc.
61555 Parrell Rd. Bend, OR 97702
P: 541-318-1000 * F: 541-318-7050 * E: Appointments@BendWellnessDoctor.com

First Name: _____ MI: _____ Last Name:_____

Mailing Address: _____ City: _____ State: ____ Zip:_____

Gender: ___M ___F ___Trans Age: _____ DOB: _____ Marital Status: __S __M __W __D __P

Cell Phone: _____ Work Phone:_____

E-mail:_____Occupation/Employer:_____

*Emergency Contact:* _____ *Phone:* _____ *Relation:* _____

Primary Care Doctor: _____ Who may we thank for your referral?_____

## PAYMENT INFORMATION

Please check the following payment methods that apply: ☐ Cash (Time of Service) ☐ Health Insurance

☐ Workers Compensation ☐ Auto Insurance (auto injury) Date of auto injury/accident: _____

## INSURANCE INFORMATION

**Subscriber/**Member Insured**:** ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ Gender: ☐M ☐F ☐T DOB: _____

First Name: _____ MI: _____ Last Name: _____

Insurance Company: _____ ID #: _____ Group #: _____

**Please be advised- physical therapy modalities may be applied when appropriate for treatment. *Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. ***

## Cancellation and No-Show Policy

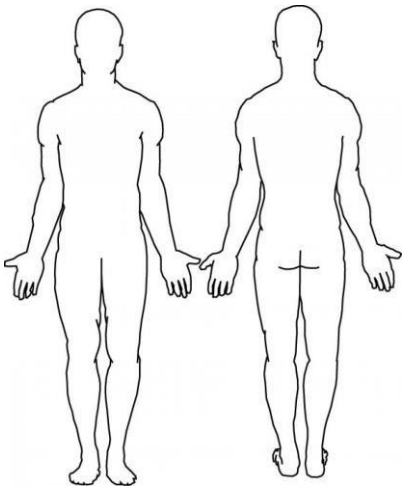
Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires 24 hours' notice to cancel an appointment. If 24 hours is not given, a charge of $35 will be billed to your account. If you do not show up for your appointment, you will be responsible for a **$35 no show fee**. Thank you, in advance, for giving us 24 hours notice. *Massage patients: please note failure to cancel a scheduled massage more than 24 hours in advance will result in a $35 charge for the first and second occurrence, any occurrence after the second will result in a charge for the full price of the massage ($85 for a 50 minute scheduled massage and $130 for an 80 minute scheduled massage). Initial_____

## Inclement Weather Policy

**Please be aware of the local forecast and if you feel that you are unable to come in for your scheduled appointment make sure to cancel 24 hours before. The above policies will be applied. If we close the office due to weather, you will receive a text or phone call from our reception staff and a cancellation fee will not be applied.** Initial_____

## Healthcare & Wellness Interests

**__Chiropractic** ( __Injury Care / __Maintenance Care) **__ Massage __Nutrition __Functional Medicine __Lab Testing __Shockwave Therapy __Infrared/Red Light Sauna __Sports Medicine __Prenatal/Pediatric Care __Aging Gracefully __Lab Testing** (__Annual Bloodwork __ Genetic Testing __ Digestive Health __ Heart Health __ Health Optimization)



## SYMPTOM SURVEY

1. What is your ***Primary*** complaint? _____
2. Was there trauma or a known cause? ☐NO ☐YES

   If yes, describe: _____
3. When did your symptoms begin? _____
4. How often and when do the symptoms bother you?

   ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional - ☐ ***Morning*** ☐ ***Night***
5. Has this condition bothered you before? ☐NO ☐YES
6. Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER:**_____

3. How severe is your pain/discomfort from **0** *(None)* to **10** *(Worst Imaginable)* – **1 2 3 4 5 6 7 8 9 10**
4. What makes it worse? _____What relieves it? _____
5. Any other symptoms associated with this complaint? _____
6. Treated for this in the past? ☐NO ☐YES When?_____Where?_____

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**Problem #2** _____ 1. Was there trauma or a known cause? ☐NO ☐YES

If yes, describe: _____

2. When did your symptoms begin? _____
3. How often do the symptoms bother you? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional
4. Has this condition bothered you before? ☐YES ☐NO _____
5. Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER** _____
6. How severe is your pain/discomfort from **0** *(None)* to **10** *(Worst Imaginable)* – **1 2 3 4 5 6 7 8 9 10**
7. What makes it worse? _____What relieves it? _____
8. Any other symptoms associated with this complaint? _____
9. Treated for this in the past? ☐YES ☐NO When?_____Where?_____

**Problem #3** _____ **Problem #4** _____

| **What do your DAILY ACTIVITIES consist of?** | | **Do you EXERCISE on a regular basis?** ☐YES ☐NO |
|---|---|---|
| ☐ Heavy Labor | ☐ Prolonged Sitting | How often?_____ How Long?_____ |
| ☐ Light Labor | ☐ Prolonged Standing | What Types?_____ |
| ☐ Repetitive Movements | ☐ High Mental Stress | **Do you SLEEP WELL at night?** ☐YES ☐NO |

**Special Imaging and/or Tests (MRI, CT, X-Ray, etc):**

Year: _____ Test: _____ Findings: _____
Year: _____ Test: _____ Findings: _____
Year: _____ Test: _____ Findings: _____

**Other:**_____

**Traumatic Injury/Surgery**

| Year | Trauma/Surgery |
|---|---|
| | |
| | |
| | |
| | |

**MEDICAL HISTORY**

__ Arthritis
__ Allergies/Hay Fever/Asthma
__ Alcoholism
__ Alzheimer's Dementia
__ Autoimmune _____
__ Blood Pressure Problems
__ Bronchitis
__ Cancer _____
__ Carpal Tunnel Syndrome
__ Celiac Disease
__ Chronic Fatigue Syndrome
__ Cholesterol Issues
__ Circulatory Problems
__ Colitis
__ Contact Lenses
__ Dental Problems
__ Depression
__ Diabetes (Type 1 or Type 2)
__ Diverticulitis
__ Disc Bulge/Herniation
__ Drug Addiction
__ Eating Disorder _____
__ Epilepsy
__ Emphysema
__ Eyes, Ears, Nose, Throat Problems
__ Environmental Sensitivities
_____
__ Fibromyalgia
__ Fibroids/Ovarian Cysts
__ Food Intolerance _____
_____
__ Gastroesophageal Reflux
__ Genetic Disorder_____
__ Glaucoma
__ Gout
__ Heart Disease
__ Infection, Chronic
__ Inflammatory Bowel Disease
__ Irritable Bowel Syndrome
__ Kidney or Bladder Disease
__ Liver or Gallbladder Disease (stones)
__ Lyme Disease
__ Migraine Headaches
__ Neurological Problems _____
__ Obesity
__ Osteoporosis/Osteopenia
__ Pneumonia
__ Seasonal Affective Disorder
__ Sexually Transmitted Disease
__ Skin Problems _____
__ Sinus Problems
__ Sleep Issues _____
__ Stroke
__ Thyroid Problems
__ Ulcers
__ Other _____
_____

**Medical (Men)**
__ Benign Prostatic Hyperplasia
__ Prostate Cancer
__ Decreased Sex Drive
__ Infertility
__ Other_____

**Medical (Women)**
__ Menstrual Irregularities
__ Endometriosis
__ Infertility
__ Fibrocystic Breasts
__ Fibroids/Ovarian Cysts
__ Premenstrual Syndrome
__ Frequent Yeast Infections
__ Decreased Sex Drive
__ C-Section
__ Menopause

**Family Health History**
__ Autoimmune
__ Arthritis
__ Alcoholism
__ Alzheimer's/Dementia
__ Celiac Disease/Gluten Intolerance
__ Migraine Headaches
__ Eating Disorder
__ Genetic Disorder
__ Glaucoma
__ Heart Disease
__ Cancer _____
__ Neurological Disorders _____
__ Obesity
__ Osteoporosis
__ Stroke
__ Mental Illness
__ Diabetes (Type 1 or Type 2)

## Medications/Supplements

| Medication/Supplement | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

# FINANCIAL POLICY

To ensure your treatments are as stress free as possible we have established a clear financial policy.

**Please read and initial next to the policy that applies to you. If you have any questions don't hesitate to ask!**

____ **Insurance:** We will bill your insurance as a courtesy for you. If you provide us with your current insurance information we will do our best to verify your benefits prior to receiving care, however insurance companies will never allow a quote of coverage to be a guarantee of payment. We will collect 100% of services not covered by your insurance carrier. If you have a copay, co-insurance, or unmet deductible you will be responsible for payment at time of service. **We do offer services that may not be covered by your insurance and you will be responsible for the balance.** Please be aware that some patient's policies are written to where they may have a deductible for certain services and or a copay for certain services. ***Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. ***

_____ **Auto Accident/Personal Injury/Workman's Compensation:** Most Personal Injury and Workman's Compensation claims are covered 100%. However, it is **YOUR** responsibility to provide our office with the documentation necessary to prove a valid claim which includes your claim number, as well as the name(s) of any claims adjustor/attorney, etc. handling the case, their phone and fax number and the mailing address to send bills. Failing to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt. We can send any unpaid claims to your personal health insurance if it was in effect during your treatment as long as you provide us with current insurance information. If you miss more than two appointments and do not call within the 24-hr. cancellation period, appointments with our facility may be terminated.

____ **Cash: Payment is due at the time of service.** A prompt pay incentive discount is offered for patients that do not have insurance or choose to not use their insurance. Please speak with our front desk staff to go over those prices.

*Unpaid balances greater than 120 days will be sent to collections and you will be charged an additional 35% to cover the cost of collections (this amount will be added to your bill). *

**I have read and understand the above Financial Policy.**

_____ _____

**Signature of Patient or Responsible Party** **Date**

# HIPAA Acknowledgement of Notice of Privacy Practices

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

*My health information may be created or received by Wellness Doctor, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

*We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.

*I understand that I have the right to receive and review a written description of how Wellness Doctor, LLC will handle my health information. This written description is known as a NOTICE OF PRIVACY PRACTICES and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Wellness Doctor, LLC and my rights regarding my health information.

*I understand that the NOTICE OF PRIVACY PRACTICES may be revised periodically. We will not disclose your health information unless we have received written consent. I understand that a copy of summary of the most recent version of Wellness Doctor, LLC's NOTICE OF PRIVACY PRACTICES in effect will be posted in the waiting/reception area.

**Special Permission Request:**

I give my permission for Wellness Doctor, LLC to leave messages regarding appointments on my home/cell phone answering machine. Initial: _____

I give my permission to speak with/leave messages regarding treatment, billing and regarding appointment status left with my spouse, partner, caregiver. Initial: _____
Name (optional): _____

By signing this agreement, I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before signing this consent. This release will revoke by written permission only.

I understand that I must send a written request to Wellness Doctor, Inc. to revoke this release.

Signature: _____ Date: _____

## INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

**The Nature of Chiropractic Manipulation**: The doctor will often use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or a "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

> **Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular incident could occur upon sever injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

**Other Treatment Options**: May include over-the-counter analgesics, prescription medications, injections, and surgery.

**Risks of Remaining Untreated**: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**No Warranty**: I understand that my doctor at Wellness Doctor, cannot make any promises or guarantees regarding a cure for or improvement of my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment options with me before I consent to treatment.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.**

Printed Name: _____ Signature_____ Date: _____

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## CONSENT TO TREAT A MINOR

**I** hereby authorize Wellness Doctor to administer Chiropractic care, as deemed necessary, to my child.

Name of Child:_____ Age:_____ Date:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____

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## MASSAGE CLIENT WAIVER FORM

**Please read and initial the following information if you think you would like/need massage at our clinic.**

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular and fascial tension, improvement of circulation, and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform the licensed massage therapist (LMT) so that pressure/ strokes can be adjusted to my level of comfort. I will not hold Wellness Doctor or the LMT responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that the LMT, is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat physical or mental illness.
- I affirm that I have notified the LMT of all known medical conditions, medications, and injuries.
- I agree to inform the LMT of any changes in my health and medical condition. I understand that there shall be no liability on the LMT should I forget to do so.

By signing this release, I hereby waive and release Wellness Doctor and the LMT from any and all liability, past, present, and future relating to massage therapy and bodywork.

Patient Signature:_____ Date_____