armington
chiropractic

Armington Chiropractic LLC
61555 Parrell Rd. Bend, OR 97702
P: 541-318-1000 * F: 541-318-7050 * E: Appointments@BendWellnessDoctor.com

Please bring completed paperwork to your first appointment.
(If paperwork is not completed, arrive 15 min prior to appt.)

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: _____ Cell phone carrier (for appt text reminders):_____

E-mail: _____ Occupation/Employer: _____

Emergency Contact: _____ Phone: _____ Relation: _____

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

PRIMARY INSURED INFORMATION

If you are the primary insured, mark "self" and move down to "Payment Information".

Primary insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

First Name: _____ MI: _____ Last Name: _____

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

Gender: ☐M ☐F DOB: _____Cell Phone: _____ E-mail: _____

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: _____

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. Patients that cancel 24 hours before their scheduled appointment or whose appointment needed to be rescheduled by our office will NOT be subject to a cancellation fee. Thank you, in advance, for giving us 24 hours' notice.

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.

Signature of Patient or Responsible Party _____

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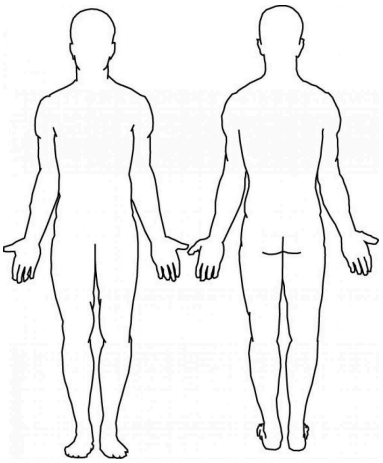

What is your ***Primary*** complaint? _____
Was there trauma or a known cause? ☐NO ☐YES
If yes, describe: _____
When did your symptoms begin? _____
How often do the symptoms bother you?
☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional
Has this condition bothered you before? ☐YES ☐NO
Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER:** _____
How severe is your pain from **0 (*none*) to 10 (*worst imaginable*)**? _____
What makes it worse? _____What relieves it? _____
Any other symptoms associated with this complaint? _____

Treated for this in the past? ☐NO ☐YES When?_____Where?_____

Problem #2 _____ Was there trauma or a known cause? ☐NO ☐YES
If yes, describe: _____
When did your symptoms begin? _____
How often do the symptoms bother you? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional
Has this condition bothered you before? ☐YES ☐NO
Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER** _____
Where is your pain/discomfort from 0 (*none*) to 10 (*worst imaginable*)? _____
What makes it worse? _____What relieves it? _____
Any other symptoms associated with this complaint? _____
Treated for this in the past?☐NO ☐YES When?_____Where?_____
Problem #3 _____ **Problem #4** _____
Are you pregnant? ☐NO ☐YES EDD _____ Care provider name/office _____
Have you been pregnant before?☐NO ☐YES number of pregnancies _____

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

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

What do your DAILY ACTIVITIES consist of?
☐ Heavy Labor ☐ Prolonged Sitting
☐ Light Labor ☐ Prolonged Standing

Do you EXERCISE on a regular basis? ☐NO ☐YES
How often?_____ How long?_____
What types?_____

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☐ Repetitive Movements ☐ High Mental Stress **Do you SLEEP WELL at night?** ☐NO ☐YES

Medical History

Do you have a **Primary Care Provider?** ☐YES ☐NO When was your **Last Physical**?_____

Past or Present Concerns:

__ Arthritis	__ Eyes, Ears, Nose, Throat problems	__ Skin problems
__ Allergies/Hay Fever/Asthma	__ Environmental Sensitivities	__ Sinus problems
__ Alcoholism	__ Fibromyalgia	__ Stroke
__ Alzheimer's/Dementia	__ Food Intolerance _____	__ Thyroid problems
__ Autoimmune disorder	__ Gastroesophageal Reflux Disease	__ Ulcer
__ Blood Pressure problems	__ Genetic Disorder_____	__ OTHER (list below)
__ Bronchitis	__ Glaucoma	
__ Cancer_____	__ Gout	
__ Carpal Tunnel Syndrome	__ Heart Disease	
__ Celiac Disease	__ Infection, Chronic	WOMEN
__ Chronic Fatigue Syndrome	__ Irritable Bowel Syndrome	__ Menstrual irregularities
__ Cholesterol, High	__ Kidney or Bladder Disease	__ Endometriosis
__ Circulatory Problems	__ Liver or Gallbladder Disease (stones)	__ Infertility
__ Contact Lenses	__ Lyme Disease	__ C-Section
__ Dental problems	__ Migraine Headaches	__ Breast cancer
__ Depression	__ Neurological Problems	__ Menopause
__ Diabetes/Pre diabetic	__ Obesity	MEN
__ Drug Addiction	__ Osteoporosis	__ Prostate cancer
__ Diverticulitis/IBD/Colitis	__ Pneumonia	__ Infertility
__ Epilepsy	__ Seasonal Affective Disorder	__ BPH

Family Health History - Do your parents or grandparents or siblings have/had any of the following?

__ Cancer __ Heart Disease __ High blood pressure __ Stroke

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__ Diabetes/Pre-diabetic __ Obesity __ Autoimmune disorder __ Arthritis

Medications/Supplements (CURRENT)

Med/Sup	Dosage	Reason

Past traumatic Injury/Surgery/Car accidents

Year	Trauma/Surgery

How would you describe your diet? Do you follow any specific nutritional regimen?

_____

_____

FOR PATIENTS UNDER THE AGE OF 5:

Is there anything you'd like Dr. Armington to know about your child's history that isn't written anywhere else?

_____

_____

_____

Is your child being treated by another practitioner? (lactation, physical therapy, medical/pediatrics, massage, acupuncture, etc?) ___ NO ___ YES name of other care provider(s) :

_____

_____

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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. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, soft tissue therapies, corrective exercises, or active stretching may also be utilized.

> **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 incidents could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burn, or minor complications.

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 Armington Chiropractic, 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: _____

Consent To Treat A Minor

I hereby authorize Armington Chiropractic, LLC to administer Chiropractic care, as deemed necessary, to my child.

Name of Child: _____ Age: _____ Date: _____

Parent /Guardian Signature: _____

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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. ***

_____ **Infant parent ONLY: The child HAS been added to our insurance policy.**

_____ **Infant parent ONLY: The child has NOT yet been added to our insurance policy. Failure to do so within the policy's deadline (typically 30 to 60 days after birth) could result in your child's visits not being covered by your policy. When this happens, you will be responsible for 100% of services.**

_____ **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 adjuster/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 current pricing. This discount is given only on the date of services rendered. A balance cannot be carried for "cash" patients. Cash, check, or credit card is accepted at the time of service.

*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**

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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 Armington Chiropractic, 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 or 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 Armington Chiropractic, 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 Armington Chiropractic, LLC's NOTICE OF PRIVACY PRACTICES in effect will be posted in the waiting/reception area.

Special Permission Request:

I give my permission for Armington Chiropractic, LLC to leave messages regarding appointments on my home/cell phone messaging system. Initial: _____ Date: _____

I give my permission to speak with/leave messages regarding treatment, billing and regarding appointment status left with my spouse, partner, caregiver.
Initial: _____ Date: _____Name of person: _____

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 be revoked by written permission only.

I understand that I must send a written request to Armington Chiropractic, LLC to revoke this release.

Signature: _____Date: _____