



**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? \_\_\_\_\_

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### 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 **\$50** will be billed to your account. If you do not show up for your appointment, you will be responsible for a **\$50** 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.

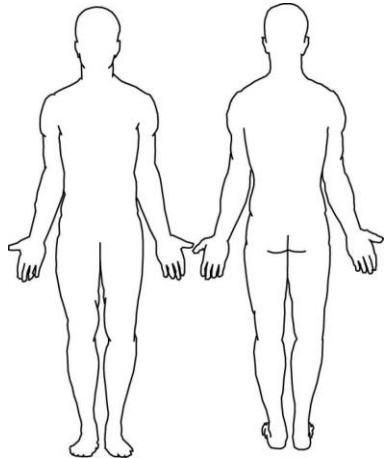
**Signature of Patient or Responsible Party** \_\_\_\_\_



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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
- Light Labor
- Repetitive Movements
- Prolonged Sitting
- Prolonged Standing
- High Mental Stress

**Do you EXERCISE on a regular basis?**  NO  YES

How often? \_\_\_\_\_ How long? \_\_\_\_\_

What types? \_\_\_\_\_

**Do you SLEEP WELL at night?**  NO  YES





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**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?

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**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?

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**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.**

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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: \_\_\_\_\_