ADVANCED CHIROPRACTIC

readjust your life.

Patient Name: _____

Please provide us with YOUR INSURANCE CARRIER information. If there was another vehicle involved, please let the receptionist know to provide you with a second form.

Your Vehicles Insurance Carrier:

Insurance Name: _____

Address: _____

City/State/Zip: _____

Adjuster Name: _____

Phone: _____ Fax: _____

Claim #: _____

Date of Accident: _____

Dr. James Yewchuk, D.C. Chiropractic Physician

541-2-RELIEF (541-273-5433) • FAX: 541-850-2461 • 3150 South 6th Street • Klamath Falls, OR 97603

ADVANCED CHIROPRACTIC

3150 South Sixth St - Klamath Falls - OR 97603
Tel: 541.273.5433 Fax: 541.850.2461
www.advancedchiroklamathfalls.com

Personal Injury Form

Please complete all the following information as accurately as possible

How did you hear about our office? ☐ Internet/Web ☐ Sign ☐ Friend ☐ Patient ☐ Other:

If referred by a patient, please advise by whom: Today date:

Patient Information

Full Name:		DOB:	
Home Phone:	Cell Phone:	Work Phone:	
Email:		Marital Status:	
Address:	City:	State:	Zip:
Employer:		Occupation:	
Employer Address:	City:	State:	Zip:
SSN:			

Primary Insurance

Company Name:	ID#:	Group #:
Insured's Name:		Telephone #:
Insured's DOB:	Insured's SSN:	
Relationship to Patient:	Insured's Employer:	

Personal Injury History

Date of Accident: Time: State:

Where were you seated?

In your own words, please describe the accident:

Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Other:

During impact did your body come in contact with any other objects in the vehicle? ☐ Yes ☐ No

Please explain:

Did you see the accident coming? ☐ Yes ☐ No Did you brace for impact: ☐ Yes ☐ No

Were seatbelts worn? ☐ Yes ☐ No Was your car braking? ☐ Yes ☐ No

Head/Body Position at time of impact: ☐ Head turned left/right ☐ Head looking back ☐ Head straight forward ☐ Body straight in sitting position ☐ Body rotated right/left ☐ Other:

What was the approximate speed at the time of impact? Your vehicle_____ Other vehicle_____

What were the road conditions: ☐ Wet ☐ Dry ☐ Icy

Were both hands on the steering wheel? ☐ Yes ☐ No If no, which one was? ☐ Right ☐ Left

As a result of the accident were you: ☐ Rendered unconscious ☐ In shock ☐ Dazed, confused ☐ Other:

Were you able to get out of the care and walk unaided? ☐ Yes ☐ No If no, why not?

Did you go the hospital? ☐ Yes ☐ No If yes, how did you get there?

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Personal Injury Form

Please complete all the following information as accurately as possible

How did you hear about our office? ☐ Internet/Web ☐ Sign ☐ Friend ☐ Patient ☐ Other: _____

If referred by a patient, please advise by whom: _____

Patient Information

Full Name:			
Home Phone:	Cell Phone:	Work Phone:	
Email:		Marital Status:	
Address:	City:	State:	Zip:
Employer:		Occupation:	
Employer Address:	City:	State:	Zip:
SSN:			

Primary Insurance

Company Name:	ID#:	Group #:
Insured's Name:		Telephone #:
Insured's DOB:	Insured's SSN:	
Relationship to Patient:	Insured's Employer:	

Personal Injury History

Date of Accident:	Time:	State:

Where were you seated?

In your own words, please describe the accident:

Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Other:

During impact did your body come in contact with any other objects in the vehicle? ☐ Yes ☐ No

Please explain:

Did you see the accident coming? ☐ Yes ☐ No | Did you brace for impact: ☐ Yes ☐ No

Were seatbelts worn? ☐ Yes ☐ No | Was your car braking? ☐ Yes ☐ No

Head/Body Position at time of impact: ☐ Head turned left/right ☐ Head looking back
☐ Head straight forward ☐ Body straight in sitting position
☐ Body rotated right/left ☐ Other:

What was the approximate speed at the time of impact? Your vehicle_____ Other vehicle_____

What were the road conditions: ☐ Wet ☐ Dry ☐ Icy

Were both hands on the steering wheel? ☐ Yes ☐ No If no, which one was? ☐ Right ☐ Left

As a result of the accident were you: ☐ Rendered unconscious ☐ In shock ☐ Dazed, confused
☐ Other:

Were you able to get out of the care and walk unaided? ☐ Yes ☐ No If no, why not?

Did you go the hospital? ☐ Yes ☐ No If yes, how did you get there?

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Personal Injury History-Continued

Check all symptoms that became apparent since the accident:

☐ Headache	☐ Chest pain	☐ Depression	☐ Loss of taste
☐ Eye light sensitive	☐ Anxious	☐ Tension	☐ Breath shortness
☐ Fainting	☐ Low back pain	☐ Diarrhea	☐ Ringing/buzzing
☐ Numbness in toes	☐ Neck pain/stiffness	☐ Nervousness	☐ Cold hands
☐ Loss of memory	☐ Pain behind eyes	☐ Facial pain	☐ Constipation
☐ Irritability	☐ Sleeping problems	☐ Mid back pain	☐ Cold sweats
☐ Loss of balance	☐ Loss of smell	☐ Dizziness	☐ Clicking/popping jaw
☐ Cold feet	☐ Fatigue	☐ Finger numbness	☐ Other (please describe below)

If you selected Other, please describe:

Have you missed time from work? ☐ Yes ☐ No

If yes, full time off work: to | If yes, part time off work: to

Did you seek medical help immediately after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone drove me ☐ Drove myself ☐ Other:

Doctor #1: Name: Date of first visit:

Were you examined? ☐ Yes ☐ No | Were x-rays taken? ☐ Yes ☐ No

Did you receive treatment? ☐ Yes ☐ No

If yes, what kind of treatment did you receive?

What benefits did you receive from the treatment? Date of last treatment?

Do you have an attorney on this claim? ☐ Yes ☐ No

If yes, who?

Address: City: State:

Zip: Phone:

Are you pregnant? ☐ Yes ☐ No ☐ Not sure | Do you have a pacemaker? ☐ Yes ☐ No

Medications list:

Diseases, describe:

Other, describe:

Please describe how you felt -

Immediately after the accident:

Later in the day:

The next day:

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Patient Name:_____ **Date:**_____

Check any of the following that pertain to you medical history and current condition

Please complete all the following information as accurately as possible

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Blurred/double vision
- ☐ Broken bones
- ☐ Cardiovascular disease
- ☐ Cervical spine spondyolosis
- ☐ Chicken pox
- ☐ Collapsing
- ☐ Confusion
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Falls
- ☐ Goiter
- ☐ Head injuries
- ☐ Hearing loss
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hypertensions
- ☐ Influenza
- ☐ Loss of vision
- ☐ Lumbago
- ☐ Measles
- ☐ Mental disorder
- ☐ Mumps
- ☐ Neck injury
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Smoking
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Ringing in ear(s)
- ☐ Slurred/difficult speech
- ☐ Tuberculosis
- ☐ Use of oral contraceptives
- ☐ Venereal infections
- ☐ Whooping cough

Please indicate whether you have had any of the following and its location

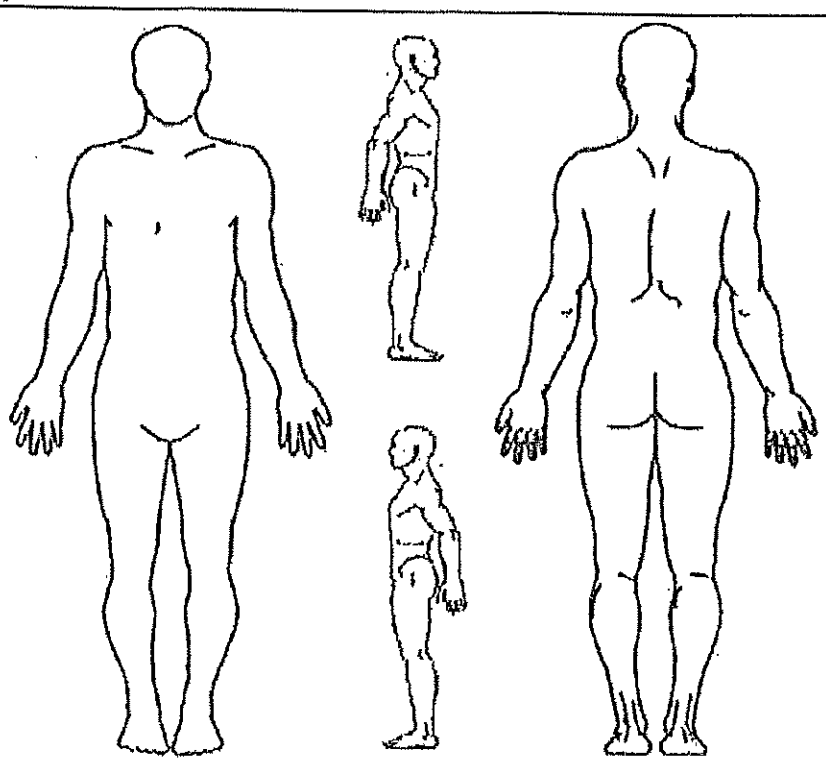
☐ Surgeries: ☐ Weakness: ☐ Numbness:

Pain Level

On a scale of 1-10, please indicate your pain level:

Normal:	☐	0							
Mild Pain:	☐	1	☐	2	☐	3			
Moderate Pain:	☐	4	☐	5	☐	6			
Intense Pain:	☐	7	☐	8	☐	9			
Severe:	☐	10							

Directions:
Using the Discomfort Symbols below, please mark your areas of discomfort as it pertains to your current condition and area of the body.



Discomfort Symbols

A= Aching
B= Burning
C= Cold
H= Hypersensitivity
N= Numbness
R= Throbbing
S= Stabbing
T= Tingling

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Oswestry Low Back Pain Questionnaire

This questionnair is designed to help us better understand how your pain affects your ability to manage everyday-life activities. Although you may consider that two of the statements in any one section relate to you, please mark the one box that most closely describes your current pain.

Patient Printed Name

How long have you had this pain?

Pain Intensity

- ☐ My pain is mild to moderate. I do not need pain killers
- ☐ The pain is bad, but I manage without pain killers
- ☐ Pain killers give me complete relief from pain
- ☐ Pain killers give me moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain

Personal Care

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally, but it causes extra pain
- ☐ It is painful to look after myself, and I'm slow and careful
- ☐ I need some help, but manage most of my personal care
- ☐ I need help everyday in most aspects of self-care
- ☐ I don't get dressed, I was with difficulty and stay in bed

Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned
- ☐ Pain prevents me from lifting heavy weight but I can manage to lift medium weight if conveniently positioned
- ☐ I can lift only very light weight
- ☐ I cannot lift or carry anything at all

Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than 1 mile
- ☐ Pain prevents me walking more than 1/2 mile
- ☐ Pain prevens me walking more than 1/4 mile
- ☐ I can I can only walk using a stick or crutches
- ☐ I am in bed or a chair for most of the day

Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than 1/2 hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 1/2 hour
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Sleeping

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using tablets
- ☐ Even when I take tablets I have less than six hours sleep
- ☐ Even when I take tablets I have less than four hours sleep
- ☐ Even when I take tablets I have less than two hours sleep
- ☐ Pain prevents me from sleeping at all

Sexual life

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly abset because of pain
- ☐ Pain prevents any sex life at all

Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, like dancing ect.
- ☐ Pain has restricted social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Traveling

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys of less than 1/2 hour
- ☐ Pain prevents me from traveling except to the doctor

Patient Signature

Date

ADVANCED CHIROPRACTIC

3150 South Sixth St - Klamath Falls - OR 97603
Tel: 541.273.5433 Fax: 541.850.2461
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Neck Disability Index

This questionnair is designed to help us better understand how your pain affects your ability to manage everyday-life activities. Although you may consider that two of the statements in any one section relate to you, please mark the one box that most closely describes your current pain.

Patient Printed Name

How long have you had this pain?

Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Personal Care

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally, but it causes extra pain
- ☐ It is painful to lookafter myself, and I'm slow and careful
- ☐ I need some help everyday in most aspects of self-care
- ☐ I need help every day in most aspects of self-care
- ☐ I don't get dressed. I wash with difficulty and stay in bed

Lifting

- ☐ I can lift heavy weights without causing extra pain
- ☐ I can lift heavy weights, but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned .
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if light weights if they are conveniently positioned
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

Reading

- ☐ I can read as much as I want with no pain
- ☐ I can read as much as I want with slight pain
- ☐ I can read as much as I want with moderate pain
- ☐ I cannot read as much as I want due to moderate pain
- ☐ I cannot read as much as I want due to severe pain
- ☐ I cannot read at all

Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches that come frequently
- ☐ I have moderate headaches that come infrequently
- ☐ I have moderate headaches that come frequently
- ☐ I have severe headaches that come frequently
- ☐ I have headaches almost all the time

Concentration

- ☐ I can concentrate fully with no difficulty
- ☐ I can concentrate fully with slight difficulty
- ☐ I have a fair degree of difficulty concentrating
- ☐ I have a lot of difficulty concentrating
- ☐ I have a great deal of difficulty concentrating
- ☐ I cannot concentrate at all

Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I cannot do any work at all

Driving

- ☐ I can do as much driving as I want
- ☐ I can only do usual driving, but no more
- ☐ I can only do most of my usual driving, but no more
- ☐ I can't do my usual driving
- ☐ I can hardly do any driving at all
- ☐ I can't do any driving at all

Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is disturbed for less than 1 hour
- ☐ My sleep is disturbed for 1-2 hours
- ☐ My sleep is disturbed 2-3 hours
- ☐ My sleep is disturbed 3-5 hours
- ☐ My sleep is disturbed 5-7 hours

Recreation

- ☐ I have no neck pain during all recreational activities
- ☐ I have some neck pain with all recreational activities
- ☐ I have some neck pain with a few recreational activities
- ☐ I have neck pain with most recreational activities
- ☐ I can't hardly do recreational activities due to neck pain
- ☐ I can't do any recreational activities due to neck pain

Patient Signature

Date

Score

ADVANCED CHIROPRACTIC

Please read carefully and inquire with the front office staff if you have any questions

Notice of Facility Policies:

INFORMED CONSENT FOR CHIROPRACTIC CARE:

The nature of Chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" such as the noise when a knuckle is "cracked', and you may feel movement o the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation or therapeutic ultrasound may be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. These could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke 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, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at on in one million to one in twenty million, and can be ever further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Risks of remaining untreated: Delay of treatment allows formation of adhesions scare 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.

Please ask your Chiropractor for other treatment options that could be considered

By signing below I acknowledge that I have read and understand the above explanation of chiropractic treatment. I have had the opportunity to evaluate the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent of treatment.

Printed Name	*Signature*	*Date*

ASSIGNMENT, LIEN AND AUTHORIZATION
FOR DIRECT PAYMENTS BY MY PAYERS TO JAMES M. YEWCHUK P.C.

Purpose: The purpose of this Assignment & Lien is to assist the office in obtaining proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all payers as follows:

Definitions, In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to James M. Yewchuk Chiropractic P.C./Advanced Chiropractic/ Dr. James M. Yewchuk located at 3150 S. 6th Street, Klamath Falls, OR 97603; "Assignment & Lien Document", "Assignment & Lien", and "Assignment" shall refer to this document, "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans or coverage's: Individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Offices goods and services (including without limit treatment, diagnostics services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization request, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment and Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law of at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre-and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsiderations, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms, I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ('Claims to Proceeds'), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filed with the secretary of state or other government agency relating to such security interests, and to make such filings in all relevant Jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these items, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases, In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provided immediate notice to the Office regarding such Proceeds, to promptly pay the Office in-full out of such Proceeds, and to provided a full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives, I hereby direct each and every Payer to immediately release to the Office any Pertinent information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. 'Pertinent information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

Miscellaneous, Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable , or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Name (print):_____ Patient Signature:_____ Date:___/___/___

Name of Custodial Parent of Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ___/___/___

ADVANCED CHIROPRACTIC

Notice of Facility Policies

DISCLOSURE POLICY:

I, _____ authorize: *Advanced Chiropractic* to release to:
(Patients printed name)

_____
(Name of persons to access information)

_____

The following information:

a.) ☐ **All health information pertaining to my medical history, mental of physical conditions and treatment received; OR**

b.) ☐ **Only the following records or types of health information (including any date):**

_____

c.) ☐ **Only disclose my dates of service and charges/balances on my account.**
(Please note: We will always accept payments but will not disclose account balances or services rendered without your permission.)

_____ _____
(Patient Signature) (Date)

PRIVACY POLICY:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Uses and Disclosures: We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by mail, e-mail, fax, or other methods. We may use or disclose identifiable information about you without your authorization in several situations, but beyond those situations, we will ask you for your written consent before disclosing such information.

Your rights: In most cases, you have the right to look at or get copies of your health information. If you request copies, a fee may be charged. You have the right to receive a list of certain types of disclosures of your information. If you believe that information in your records is incorrect, you have the right to request that we correct the existing information.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If a significant change is made to our policies a posting will be made in our waiting area. You can request a copy of these notices at any time and for more information please ask our front office staff or our Privacy Officer*.

Complaints: If you are concerned that we have violated any privacy rights, or you disagree with a decision we made about your records, please notify the Privacy Officer* or you may send it in writing to: U.S. Dept. of Health and Human Services.

*Privacy Officer: Dr. James Yewchuk, D.C.
3150 South Sixth St
Klamath Falls, OR 97603

Tel: 541.273.5433
Fax: 541.850.2461

By signing below, I agree to the **Privacy Policy** set in place by Advanced Chiropractic

_____ _____
Signature *Date*

ADVANCED CHIROPRACTIC

PAYMENT POLICY:

As a courtesy to our valued patients, Advanced Chiropractic can bill both your primary and secondary insurance. We will obtain a copy of your insurance cards and ID to get a quote of benefits. Patients are responsible for knowing their policies and upholding their agreement with their insurance company. Remember, your insurance company works for you. Some insurance providers require additional paperwork to be filled out initially or on subsequent visits for compliance purposes.

Please be advised that benefits quoted are not a guarantee of payment and are subject to plan limitations and deductibles. Contact your insurance provider for additional information.

Each patient is responsible for their contracted deductible amounts, co-pays and co-insurance at the time services are rendered. For your convenience we will work with you to establish a payment plan to help you meet your deductible. On occasion, insurance payment may have been issued to you from your insurance company. Please endorse it to us and provide the check with the attached EOB. We hope to avoid any mishap with appropriate "assignment of benefits" paperwork which clarified payment entitlement. Mistakes do happen and any remaining unpaid claims will become your responsibility.

Medicare Patients:

We do accept Medicare assignment. We must follow appropriate guidelines which are strict and non-negotiable. It is designed to protect all involved and to make sure treatment is medically necessary. At the time of treatment, you will be notified of the Medicare covered services. You or your secondary insurance will be responsible for any non-covered services. This should be outlined in writing with our ABN form upon your first visit. Patients with Medicare cannot choose the cash option, by law.

Cash Patients:

If you choose to not use your insurance of if you do not have insurance, we do accept cash, check, or credit card for payment of services. This is to be paid at the time services are rendered. On occasion, and at the discretion of the doctor, arrangements can be made for a payments.

Personal Injury:

Advanced Chiropractic is accustomed to working with patients involved in car accidents and job injuries. Should you be involved in one of these we are happy to follow through on the billing and possible legal paperwork. We trust you will settle any debts with us upon receipt of your settlement including any charges NOT covered by insurance. We will require a copy of private health insurance just in case claims are denied of coverage has maxed. **You will be responsible for any fees unassociated with your current claim such as missed massages.**

By signing below, I agree to the **Payment Policy** set in place by Advanced Chiropractic

_____ _____

Signature *Date*

3150 South Sixth Street - Klamath Falls - OR - 97603 - (541)273-5433

ADVANCED CHIROPRACTIC

Notice of Facility Policies

FRAGRANCE POLICY:

Due to certain allergies and sensitivities, Advanced Chiropractic requests that when visiting our office you **do not** wear strong fragrances or perfumes.

Please see front office staff with questions or concerns.

By signing below, I agree to the **Fragrance Policy** set in place by Advanced Chiropractic

_____ _____

Signature *Date*

MASSAGE POLICY:

This policy is used so all patients may receive additional treatment if recommended by your doctor, and to ensure that our scheduling flows smoothly and without error. Please be advised, it is common for our massage therapy schedule to be booked out a few weeks.

Please read and initial the following:

_____ I understand that due to billing guidelines, a chiropractic appointment will be scheduled 15 minutes prior to my scheduled massage.

_____ I understand a $25 fee will be charged to my account upon any missed massage or less than 24 hour cancellation notice.

_____ I understand the above will be applied if I do not arrive the required 15 minutes prior to my scheduled massage.

By signing below, I agree to the **Massage Policy** set in place by Advanced Chiropractic

_____ _____

Signature *Date*

3150 South Sixth Street - Klamath Falls - OR - 97603 - (541)273-5433