

158 NE 2nd Ave. Hillsboro, OR 97123 Phone # (503) 648-1088 Fax # (503)648-0748

**Patient Intake Form**

(Please Print) Mr. Mrs. Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Name MI Last Name

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M🗆 F🗆 SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Receipt of Privacy Notice**

* I have received and/or reviewed a copy of NOTICE OF PRIVACY PRACTICES
* I consent to having detailed messages regarding my account or appointments left on my voicemail.
* I do not consent to having detailed messages regarding my account or appointments left on my voicemail.

Comments, if any:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be completed by the patient or patient’s representative, if necessary (e.g. if the patient is a minor or

physically or legally incapacitated).

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Print name Print name of patient’s representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Signature of patient’s representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Relationship to patient or authority of representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Health care Practitioner Date

Active Chiropractic & Rehabilitation, LLC 158 NE 2nd Ave Hillsboro, OR 97124

Phone: (503) 648-1088 Fax: (503) 648-0748

**FINANCIAL AGREEMENT**

* **SELF PAY/CASH**: Payment is due at the time of service. All cash patients will receive a “Time of Service” (TOS) discount. A detailed statement/receipt will be provided to the patient at their request for submission to any third parties for patient reimbursement.

\_\_\_\_\_\_\_\_\_ I understand that payment is due at the time of service.

* **AUTO INSURANCE**: If your injuries were sustained in a motor vehicle accident, your medical expenses are covered by any Personal Injury Protection (PIP) coverage of the vehicle you were in. We will submit bills on your behalf to the PIP insurance of the vehicle you were in, as is our office policy and according to the Oregon Statutes. We will not bill the PIP coverage of the other vehicle. You must complete and submit the PIP Benefits Application supplied by the insurance company in order for medical expenses to be paid to this office. Any medical expenses not covered or denied become the responsibility of the patient. Additionally, it is our office policy **not** to forward any denied or non-covered charges to group medical insurance for payment.

\_\_\_\_\_\_\_ I understand/agree that I am responsible for all charges; whether or not they are payable by insurance. I understand that if my PIP coverage has reached its maximum, I am fully responsible for any and all charges not covered by my insurance and that these non-covered/denied charges will not be forwarded to my group insurance policy.

* **WORKERS COMPENSATION INSURANCE**: If your injuries were sustained in a work-related incident, your medical expenses are covered by your employer’s Workers Compensation Insurance once your claim has been accepted. Any medical expenses not covered or denied become the responsibility of the patient. Additionally, it is our office policy **not** to forward any denied or non-covered charges to group medical insurance for payment.

\_\_\_\_\_\_\_ I understand/agree that I am responsible for all charges; whether or not they are payable by insurance.

* **MEDICAL/HEALTH INSURANCE**: Any copay. deductible or co-insurance percentage agreement you have with your medical/health insurance are due at the time of service. Our office will provide you with an estimate of your financial responsibility for each appointment. We will make our best effort to provide you with a list of non-covered services. Any medical expenses not covered or denied become the responsibility of the patient, unless prohibited by our contract with the insurance.

\_\_\_\_\_\_\_ I understand/agree that I am responsible for all/any copay. deductible or co-insurance percentage and all charges, whether or not they are payable by insurance.

 **ADDITIONAL FEES**:

* Credit Terms are 30 days from date of invoice. Outstanding balances are subject to 1.5% per month interest. The undersigned authorizes and releases all banks, persons, and companies listed on this application to furnish information and authorizes the checking of credit. The undersigned agrees to pay all collection costs, court costs, and legal fees incurred to collect delinquent balances.
* NON-SUFFICIENT FUNDS: $40

A $40.00 processing fee will be charged to your account if your check is returned due to insufficient funds.

**PATIENT/GUARDIAN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_

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**DISCLOSURE & CONSENT FOR CHIROPRACTIC CARE**

**TO THE PATIENT:** You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to ensure you have the appropriate information so you may give consent or withhold consent to the procedure.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by Dr. Patrick Bourlon or other licensed Doctors of Chiropractic. This also extends to those working at the clinic or office who now or in the future treat me while employed by, working for or associated with, or serving as a backup for Dr. Patrick Bourlon.

I have had the opportunity to discuss with the Dr. Patrick Bourlon, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic treatment there are some risks to the exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient or patient’s representative, if necessary (e.g. if the patient is a minor or physically or

legally incapacitated)

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Print name Print name of patient’s representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Signature of patient’s representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Relationship to patient or authority of representative

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 **NON-COVERED SERVICES**

When we verify eligibility and benefit coverage, your insurance company issues the following disclaimer, “**Benefits quoted are not a guarantee of payment**”. We bill your insurance company based on the information received at the time of verification. By signing below, you acknowledge that you have been advised that our health insurance may not/does not provide coverage for the services/supplies listed below. **The “Patient Bill of Rights” provides you with the opportunity to decline any services, including those you are unwilling to pay for out-of-pocket.**

Should you decide to receive non-covered services, you are financially responsible for the charges listed below for services/supplies rendered and payment must be made at the time of service. A “Time of Service” discount is applied for all self-pay/cash patients.

|  |  |  |  |
| --- | --- | --- | --- |
| CODE | PROCEDURE | CHARGE | TOS DISCOUNT |
|   |   |   |   |
| 99202-25 | NP Exam Expanded | $142.00 | $121.00 |
| 99202-25 | NP Exam Expanded | $142.00 | $121.00 |
| 99203-25 | NP Exam Detailed | $207.00 | $176.00 |
| 99204-25 | NP Exam Comprehensive | $319.00 | $272.00 |
|   |   |   |   |
| 99211-25 | Re-Exam Brief | $38.00 | $33.00 |
| 99212-25 | Re-Exam Expanded | $83.00 | $71.00 |
| 99213-25 | Re- Exam Detailed | $138.00 | $118.00 |
| 99214-25 | Re- Exam Comprehensive | $206.00 | $176.00 |
|   |   |   |   |
| 98940/S8990 | Adjustment | $50.00 | $43.00 |
| 98941 | Adjustment | $72.00 | $60.00 |
| 98942 | Adjustment | $92.00 | $76.00 |
| 98943 | Extra-Spinal | $46.00 | $39.00 |
|   |   |   |   |
| 97014 | Electric Muscle Stimulation | $26.00 | $23.00 |
| 97035 | Ultrasound | $26.00 | $23.00 |
| 97110 | Therapeutic Exercises | $54.00 | $46.00 |
| 97112 | Neuromuscular Re-education | $57.00 | $48.00 |
| 97140 | Manual Therapies Technique | $50.00 | $43.00 |
| 97530 | Therapeutic Activities | $58.00 | $49.00 |
| 97535 | Activities of Daily Living | $58.00 | $49.00 |
| S8948 | Laser | $50.00 |   |
|   |   |   |   |
| 97124 | Massage 15 min | $32.50 | $28.00 |
|   |   |   |   |
| A4556 | Electrodes | $15.00 |   |
|   | Supplies | Varies |   |

\*\*Prices quoted are subject to change with industry standard changes.

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Signature of patient/Guardian Date

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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purposed of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food & Drug Administration requirements: Legal proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker’s Compensation: Inmates: Required Uses and Disclosures of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required uses and Disclosures will be made only with your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.**

**Your Rights:** Following is a statement of your rights with respect to your protected health information-

**You have the right to request a restriction of your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state this specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted. You then have the right to use another healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even you have agreed to accept this notice alternatively, i.e., electronically.**

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Oregon State Chiropractic Board if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint.

**We will not retaliate against you for filing a complaint.**

**This notice was published and becomes effective on/or before April 1, 2019**

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 503.648.1088.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Print Name of Patient’s Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Signature of Patient’s Representative

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