**Please answer all questions completely**

Tracy & Keim Chiropractic, LLC
1000 River Rd
Eugene, OR 97404
Phone: 541. 689.0935

**Please fill out COMPLETELY using blue or black ink** **Date** _____

Name_____ Sex M F Date of Birth _____Age ____

Address_____City_____ State_____ Zip_____

H. Phone (_____) _____W. Phone (_____) _____ C. Phone (_____) _____

Referred by: _____Email: _____ _____ Social Security _____

Occupation_____ Employer_____

Marital Status S M D P W Spouse name _____Employer_____

Nearest friend not living with you: Name _____ Phone # _____

Nearest relative not living with you: Name _____ Phone # _____

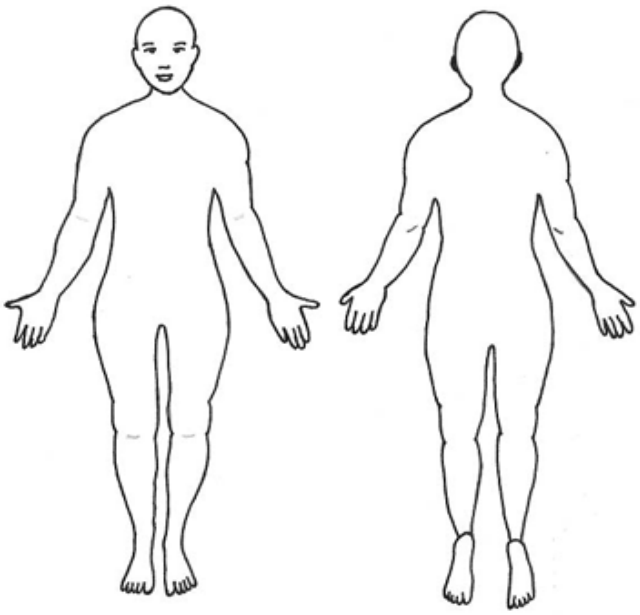
Race/Ethnicity: White/Caucasian ____ Hispanic/Latino ____ Black/African American ____ American Indian/Alaska Native_____
Asian ___ Native Hawaiian/Other Pacific Islander ___ Decline to Answer ___

Language: English ___ Spanish ___ Japanese ___Chinese ___ French ___ Korean ___ German ___ Russian ___ Other _____

Method of Payment: Private Ins ___ Self Pay ___ Worker's Comp ___ Motor Vehicle Accident___ Medicare ___ Other _____

Insurance Company Name: _____ ID# _____Insured's name:_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____



Please place an X or X's on the areas of the diagram that are bothering you. There is room to describe your pain quality, intensity and frequency on the following page.

Height: _____

Weight: _____

Blood pressure: _____
(If taken recently)

**Page 2, Name** _____

**1. Chief Complaint:** _____

Location of Complaint: _____

Complaint began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

**Secondary complaint:** _____

Location of Complaint: _____

Complaint began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

**2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**_____

_____

**3. Past Health History:**

**A. Previous illnesses you've had in your life:** _____

_____

**B. Previous injury or trauma:**_____

Have you ever broken any bones? Which bone(s)? Date?_____

**Page 3 Name** _____

**C. Allergies** _____

**D. Medications:**

Medication and dosage — Reason for taking

_____ _____

_____ _____

_____ _____

**E. Surgeries:**

Date — Type of Surgery

_____ _____

_____ _____

_____ _____

**F. Females: Pregnancies and outcomes:**

Pregnancies/Date of Delivery — Outcome

_____ _____

_____ _____

What was the date of the beginning of your last menstrual period? _____

**4. Family Health History:**

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death — Age at death

_____ _____

_____ _____

_____ _____

**5. Social and Occupational History:**

**A. Level of Education:**

___High school ___ Some college ___ College graduate ___Post graduate studies

**B. Job description:** _____

**C. Work schedule:** _____

**D. Recreational activities:** _____

**E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):** _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help patients experience good health and we wish to spend our time toward that end. Therefore, we would like to inform you of our financial policy.

- Any estimates for patient treatment fees, are just an estimate
- Payment is due at the time of your visit
- Nutritional supplements and other supplies must be paid as you take them
- We accept cash, check, VISA, MasterCard and Discover card

**SELF PAY PATIENTS** If you are paying for services on the day of your visit and we are not billing your insurance company, filling out any type of forms or paperwork or waiting for payment, we offer a bookkeeping discount on some services.

**MEDICAL INSURANCE** As a courtesy to patients, we will bill your primary insurance carrier, however we do not bill secondary companies except for Medicare patients. Please be aware that any insurance quote for coverage is not a guaranty of benefits. Co-payments, deductibles and percentages that are patient responsibility are due at the time of service. By signing this form, you are authorizing the release of your records to facilitate claims processing and for continuity of care. You are also authorizing that payments be made directly to Tracy & Keim Chiropractic, LLC. We reserve the right to refuse to do business with any insurance company that requires completion of forms regarding permission for us to carry out our patient treatment plan.

**PERSONAL INJURY/AUTO INSURANCE** Regardless of who the responsible party is a claim will be established with your auto insurance company. Please contact your agent, inform them of your care and request forms to set up a claim. You are still personally responsible for your bill but you will not be required to pay as services are rendered. If your balance reaches $800 and your insurer is withholding payment for any reason, you will be required to start paying for services: we do not hold balances over $800. We require that you sign a lien form assigning payment to Tracy and Keim Chiropractic, LLC from an insurance company or from an attorney in cases where one has become necessary.

**WORKER'S COMPENSATION** You are not personally responsible for the account unless your claim is partially or totally denied by Worker's Comp. At that point, we can bill your private insurance if you have chiropractic benefits with that company, or we begin collecting from you if no benefits are available.

**MEDICARE** We are non-participating providers but do accept Medicare patients. Medicare only pays toward spinal manipulation related to an incident or injury, and they will send payment to you. You will be required to pay at the time of service for all services or supplies in our office.

Thank you for taking the time to read this policy. If you have any questions, please don't hesitate to ask.

Signature Date

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, (patient name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Tracy & Keim Chiropractic, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date Signature

_____

Print Name

## PATIENT INFORMED CONSENT FORM

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain informed consent before starting treatment.

I, _____consent to examination and to the performance of conservative noninvasive treatments for my condition, by Dr. Sharell Tracy, Dr. Richard Keim, and/or Dr. Megan Wagner. I understand that the procedures may consist of manipulations involving movement of my joints and soft tissues, along with physical therapy modalities, rehabilitative exercises, x-rays and nutraceuticals.

Although spinal and extremity manipulation is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that, as with any form of therapy, there are possible risks and complications associated with these procedures, which are as follows:

**Soreness**: I am aware that like exercise it is common to experience muscle soreness after a few treatments.

**Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

**Joint injuries**: I understand that in isolated cases, underlying physical defects, deformities of pathologies like weak bones from osteoporosis may render that patient susceptible to injury. When osteoporosis, discal degeneration, or other abnormality is detected, extra caution will be employed.

**Physical Therapy burns**: Some of the therapies used in this office generate heat and may rarely cause burns. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

**Strokes**: Although strokes happen with some frequency in our world, strokes from chiropractic manipulation are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments, the same chance as being struck by lightning or having a normal dose of Tylenol cause death.

Tests will be performed on me prior to treatments to minimize the risks of these or any other complication from treatment, and I freely assume these risks. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, reduced muscle spasm, increased mobility, and improved neurological function. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of all forms of medicine, including chiropractic, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures or alternative treatments available have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely.

Patient Name _____ DOB _____

Patient Signature _____Date _____

Doctor/Witness Signature _____Date_____

Tracy & Keim Chiropractic, LLC
1000 River Road
Eugene, OR 97404
541.689.0935

# AUTHORZATION TO DISCLOSE MEDICAL RECORDS

Oregon Revised Statute 192.525, 1997

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. I authorize_____(name of hospital/health care provider) to release a copy of the medical information for_____. Date of birth_____. (name of patient)

**TO: Tracy & Keim Chiropractic, LLC**
**1000 River Road**
**Eugene, OR 97404**

The information will be used on my behalf for the following purpose: **EVALUATION**
By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist.

_____ All hospital records (including nursing records and progress notes)
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five year history
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Clinician office chart notes
_____ Dental records
_____ Physical therapy records
_____ Emergency and urgency care records
_____ Billing statements
_____ X-ray of the spine
_____ Other

_____ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable Charges associated with providing this record.

____ *HIV/AIDS-related records
____ *Mental health information
____ *Genetic testing information
____*Must be initialized to be included in other documents
____ **Drug/alcohol diagnosis, treatment or referral information
____**Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.
____ This authorization is limited to the following treatment: _____
____ This authorization is limited to the following time period: _____
____ This authorization is limited to a worker's compensation claim for injuries of _____ (Date)

This authorization may be revoked at any time. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Date) (Signature of Patient)

_____ _____
(Date) (Signature of person authorized by law)