Performance and Spine Chiropractic Center, LLC
19365 SW 65th Ave. Ste 104
Tualatin, OR 97062
Phone : (503) 486 – 5199

Dear New Patient:

Welcome to Performance and Spine Chiropractic Center. Thank you for choosing our office for all of your chiropractic needs. You have taken the first step towards a healthier you. We will strive to make your experience with us a pleasant and positive one.

The welcome packet we have included contains some forms that we would like you to have filled out before you arrive for your New Patient Appointment. Please fill out the forms using BLACK pen, only. This will assist us in getting you back to see the doctor on time as well as providing a courtesy to others who may be arriving after you.

Please come prepare with your insurance information.

- ➢ Driver's License or other form of photo identification.
- ➢ Health Insurance: Bring your current health insurance card. In addition, if your health plan requires a referral, we must have a copy in our office at the time of your visit, otherwise you will be asked to pay for your visit. If for some reason your referral does not arrive, you are free to re-schedule your appointment with 24 hours notice.
- ➢ On-the-Job-Injury: Bring your claim number, the name of your claim adjustor, and a referral from your attending physician. Bring your health insurance card in case your claim is closed.
- ➢ Motor Vehicle Accident: Bring all relevant information with you regarding the accident including:
    - ✓ Name of your insurance company & claim number
    - ✓ Date of injury
    - ✓ Name of your claim adjustor and phone number
    - ✓ The address to submit bills
    - ✓ Name of the other driver involved
    - ✓ Name of his/her insurance company & claim number
    - ✓ Name, Phone number & address of your attorney (if applicable)
    - ✓ If the PIP (Personal Injury Protection) benefits portion of your claim cannot be verified as open and payable, you will be expected to pay for your visits.

Your appointment is scheduled for: Time: _______ AM/PM Date: ____/____/____

Again, welcome to Performance and Spine Chiropractic Center and our unique approach to chiropractic.

If you have any questions, please feel free to view our website at:
www.performanceandspine.com

Performance and Spine Chiropractic Center
Jonathan Kinney, D.C. Member Heather Kinney, D.C. Member
19365 SW 65th Ave. Suite 104 Tualatin, OR 97062 PHONE (503) 486 – 5199 FAX (503) 486 – 5190

Confidential Patient Information

NAME:____ **GENDER M F**
Last Name **First Name, Legal** **M.I.**
ADDRESS:_____________________**CITY:**_______________**STATE:**_____**ZIP:**_________
EMAIL:______________________________**DOB:**___/___/_____ **SS#**______-______-______

HIPPA Phone Authorization: I authorize Performance and Spine Chiropractic Center, LLC (PSCC, LLC) to leave messages on my voicemail in regards to information regarding appointments, treatment related issues and billing issues.
At the following phone number(s) checked below (you must specify at least one):
□[H](____)____-_____ □ [W](____)____-_____ □ [C](____)____-_____

HIPPA PHONE Authorization **other than patient**: This authorization will remain in effect until you choose to revoke it. I authorize PSCC, PLLC to leave a message for, or speak to the specified individual(s) listed below in regards to information regarding appointments, treatment related issues and billing issues: (this person must provide us with your birth date)
At the following phone(s) checked below (you must specify at least one):

- At my home number (___-____-_____) with (name) ______________________________
- At another number (___-____-_____) with (name) ______________________________

You have the right to withdraw this authorization at anytime and such revocation must be in writing.

EMPLOYER:_________________________CITY:__________________STATE:______
MARITAL: Single / Married / Divorced / Widowed / Separated - PARTNER'S NAME:______________________
EMERGENCY CONTACT (not living w/you):________________________Phone: (____)____-______

Who may we thank for referring you?____

AUTHORIZATION TO RELEASE INFORMATION / ASSIGNMENT OF BENEFITS/ FINANCIAL AGREEMENT:
I hereby authorize Performance and Spine Chiropractic Center, LLC to release to the insurance company agencies any information Requested through paper or electronic records to process claims for payment. I also authorize the physician to release any information to referring/consulting physicians or other health care providers, as your physician deems appropriate to facilitate my /our care. *I hereby assign payment to be directly issued to Performance and Spine Chiropractic Center, LLC for any benefits available under my coverage and/or settlement for treatment and/or expenses incurred at this office*. I agree that this Assignment of Benefits and Authorization to release information is irrevocable and that I am waiving the statute of limitations for payment. I have been informed of the $20 fee on checks returned. In the event the account goes to collection I agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and any other costs involved in the collection process. I agree that I will not withhold/delay payment. I understand that I am responsible for knowing my medical benefits/limits/exclusions.

WAIVER FOR PAYMENT OF NON-COVERED OR EXCLUDED MEDICAL SERVICES: Non-covered or excluded medical Services are identified in the information your health care plan provided to you. Additional examples of non-covered services may include: "maintenance or palliative care" chiropractic treatment(s), manual massage, manual, traction, trigger point therapy, exercise instruction , re-exams, medical equipment, supplements, treatment without a referral and/or authorization, and missed Massage appointments. Medicare follows the guidelines under Section 1862 (a)(1)of the Social Security Act to determine which medical services are reasonable and necessary. Medicare will only cover spinal manipulations. Workers' Compensation does not cover supplies. I understand that there may be certain procedures/ supplies/charges that are not covered by my insurance/ 3rd party settlement, and Agree that I am financially responsible for those charges.

CONSENT TO TREATMENT OF A MINOR: As parent or legal guardian, I have the authority to authorize, and do hereby grant the Chiropractor(s) at Performance and Spine Chiropractic Center, LLC, to administer chiropractic care as he/she deems necessary to my Son/daughter/ward. I also agree to massage therapy by the LMT(s):

➔ (Name of Minor)____
➔ (Print Adult Name)______________________________________

My signature below acknowledges that I have reviewed, understand and agree to the HIPAA phone authorization, authorization to release information/assignment of benefits, financial policy, waiver for payment of noncovered/ excluded services, & consent to the treatment of a minor. By refusing to sign I understand that I, or my child will not be able to receive care in this office.
➔PATIENT (or Legal Guardian signature):__________________________ **DATE**:_____/_____/________

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Heather Kinney D.C., Member

INITIAL COMPLAINT

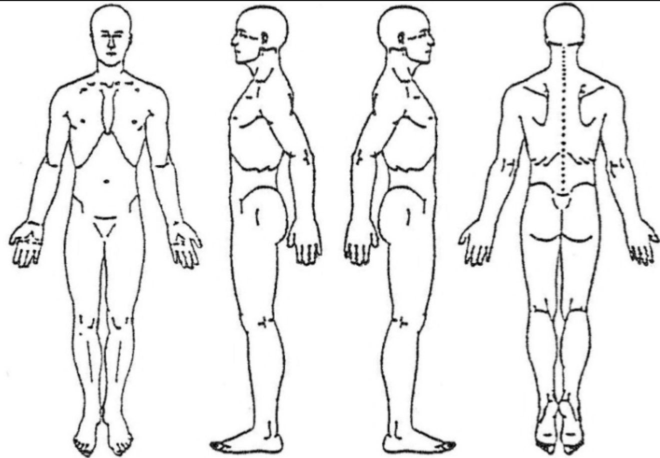
Patient Name:____ **Date:**______/______/_________
Primary Care Physician & Clinic: ____ **Phone: (   )**_______________
Doctors treating you for this condition: ____ **Phone: (   )**_______________
Therapists treating you for this condition: ______________________________________ **Phone: (   )**______________
Date of initial onset for this condition:_______________ **If reoccurrence, date of current aggravation:**________________
Describe how the injury occurred:____

When did your problem begin? ☐**Immediately after a specific incident** ☐**Multiple incidents** ☐**Gradually developed**
☐ **No specific incident - Please list the "incident/s":** ____

Pain Diagram: Use symbols below to mark the figures.

Description:
XX = Aching
/ / / = Numbness
>>> = Stabbing
= Burning
000 = Pins/Needles
TTT = Throbbing

Frequency (overall):
☐ Constant (76-100%)
☐ Frequent (51-75%)
☐ Occasional (26-50%)
☐ Intermittent (25% or less)



Rate Intensity as Follows (This Section):

0 None
1 Maybe
2 Mild, forgotten w/activity
4 Moderate, bothers during work/activities
6 Limiting, prevents full activity
8 Intense, preoccupied, seeks relief instead of activity
10 Severe—on bed rest, stops all activity

Is it getting ☐ **Better** ☐ **Worse** ☐ **No Change?**

Complaint (I.e. Neck Pain, Low Back Pain, etc) **Place "X" for average pain, "O" worst pain, "☐" pain now**
1.____**0….1..…2..…3..…4..…5…..6..…7..…8..…9…..10**
2.____**0….1..…2..…3..…4..…5…..6..…7..…8..…9…..10**
3.____**0….1..…2..…3..…4..…5…..6..…7..…8..…9…..10**
4.____**0….1..…2..…3..…4..…5…..6..…7..…8..…9…..10**

Your general stress level: ☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed
Physical activity at work: ☐ Sitting more than 50% of day ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor
General physical activity: ☐ No regular exercise program ☐ Light exercise program ☐ Strenuous exercise program
Please describe any other physical/emotional/hormonal medical concerns that you are considering seeking care for,
currently receiving care for, or in the past have sought care for:

____
____

Patient signature Date ➔➔➔➔**(please see other side)** ______________________________ _____/_____/_____

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Patient Name:________________________________Initial:______ Condition Continued…

Patient Initials:______ Dr Initial: _____

_______← For Re-exams/Updates Only—please initial if there has been no change since your last visit. ____________

For ALL new patients and patients who have had a new injury please answering the following.

If you have ever been treated for a listed condition in the past, please check it in the Past column.
If you are currently under the care of a medical professional for a listed condition, check it in the Present column.

Past Present
- Neck Pain (723.1)
- Aortic Aneurysm (441.5)
- Shoulder Pain (719.41)
- High Blood Pressure (401.9)
- Pain in Upper Arm or Elbow (719.42)
- Angina (413.9)
- Hand Pain (719.44)
- Heart Attack (410.9)
- Wrist Pain (719.43)
- Stroke (436)
- Upper Back Pain (724.1)
- Asthma (493.9)
- Low Back Pain (724.2)
- Cancer (199.1)
- Pain in Upper Leg or Hip (719.45)
- Tumor (229.9)
- Pain in Lower Leg or Knee (729.5)
- Prostate Problems (601.9)
- Pain in Ankle or Foot (719.47)
- Blood Disorder (790.6)
- Jaw Pain (526.9)
- Emphysema (chronic lung disorders) (492.8)
- Swelling/Stiffness of Joint(s)
- Arthritis (716.9)
- Fainting (780.2)
- Rheumatoid Arthritis (714.0)
- Visual Disturbances (368.9)
- Diabetes (250.0)
- Convulsions (780.3)
- Epilepsy (349.5)
- Dizziness (780.4)
- Ulcer (556.9)
- Headache (784.0)

Past Present
- Pregnancy (V22.2)
- Birth Control Pills
- Hormonal/Estrogen Replacement
- Medications (please list)_________________________
- Vitamins/Herbs________________________________
- Hospitalization/Surgical Procedures (please list)

____

Past Present
- Liver (573.9) / Gallbladder (575.9) problems
- Muscular Incoordination (781.3)
- Kidney Stones (592.0)
- Tinnitus (Ear Noises) (388.30)
- Hepatitis (573.3)
- Rapid Heart Beat (785.0)
- Bladder Infection (595.9)
- Chest Pains (786.50)
- Kidney Disorders (by condition)
- Loss of Appetite (783.0)

Past Present
- Colitis (558.9)
- Anorexia (307.1)
- Irritable Colon (564.1)
- Abnormal Weight Gain (783.1) Loss (783.2)
- HIV/AIDS (042)
- Excessive Thirst (783.5)
- Systemic Lupus
- Chronic Cough (786.2)
- Other
- Chronic Sinusitis (473.9)
- General Fatigue (780.7)
- Irregular Menstrual Flow (626.4)
- Profuse Menstrual Flow (626.7)
- Breast Soreness/Lumps (611.72)
- Endometriosis (617.9)
- PMS (625.4)
- Loss of Bladder Control (788.30)
- Painful Urination (788.1)
- Frequent Urination (788.41)
- Abdominal Pain (789.0)
- Constipation/Irregular Bowel Habits (564.0)
- Heartburn/Indigestion (787.1)
- Dermatitis/Eczema/Rash (692.9)
- Depression (311)

If you or a family member has had any of the following, please mark the appropriate box:

Cancer	Epilepsy
Rheumatoid Arthritis	Chronic Back Problems
Diabetes	Chronic Headaches
Heart Problems	Lupus
Lung Problems	Other Conditions
High Blood Pressure	

Yes No
- Do you have a permanent disability rating?
- Difficulty in Swallowing (787.2)
- Location ________________________
- Date rating received ____/____/____
- Rating Percentage ______%

Please check any of the following that apply to you.

Past Present
- Tobacco (305.1)
- Alcohol (305.0)
- Drug or Alcohol Dependence (303.9)
- Coffee/Tea/Caffeinated Soft Drinks: Cups/Cans per day (please list) Present

Weight: _____ pounds Height: ____ feet ____ inches

Doctor's additional comments/general health concerns:
____
____
____

Patient's signature: ____Date ____/____/____

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protection health information by **Performance and Spine Chiropractic Center, LLC (PSCC)** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for **PSCC, LLC**.

I understand that diagnosis or treatment of me by **PSCC, LLC Licensed D.C. or Massage Therapist** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **PSCC, LLC** is not required to agree to the restrictions that I may request. However, if **PSCC, LLC** agrees to a restriction that I request, the restriction is binding on **PSCC, LLC** and **PSCC, LLC Licensed D.C. or Massage Therapist** or **PSCC, LLC.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **PSCC, LLC Licensed D.C. or Massage Therapist** or **PSCC, LLC** has taken action in the reliance on this content.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **PSCC, LLC's** Notice of Privacy Practices prior to signing this consent document.

The **PSCC, LLC's** Notice of Privacy Practices has been offered and/or provided to me. The Notice of Privacy Practices for **PSCC, LLC** is also provided in each treatment room.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment or my bills or in the performance of health care operations of the **PSCC, LLC.**

This Notice of Privacy Practices also describes my rights and the duties of **PSCC, LLC** with respect to my protected health information.

PSCC, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices, I may obtain a revised notice of privacy practices by calling the **PSCC, LLC**'s office and requesting a revised copy be sent in the mail or asking the one at the time of my next appointment.

Consent to Use or Disclose Health Information

I authorize *PSCC, LLC Licensed D.C. or Massage Therapist* to use and disclose the health and medical information, via fax, mail or electronically for the purposes of Treatment, Payment and Health Care Operations of:

→**(PRINT NAME OF PATIENT)** ____

*__Treatment__ (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations/communications with the between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician)

*__Payment__ (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification, pre-authorization, and dealing with a third-party entity).

*__Health Care Operations__ (includes the necessary administrative and business functions of our office).

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon request.
as more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

By signing below I fully understand and accept the terms of this fully page consent. I understand and have been offered and/or provided a copy of the Notice of Privacy Practices from PSCC, LLC that describes a more complete description of information uses and disclosures. My signature serves as a receipt of Notice of Privacy Practices. If I decline the terms of this consent I understand I will not receive care at PSCC, LLC.

→____ ____________________________
Signature of Patient or Personal Representative (Parent/Guardian/Interperter) DATE

→____ ____________________________
Print Name of Patient or Personal Representative (Parent/Guardian/Interperter) For office Use: Consent received by

□ Consent Refused by patient, and treatment refused as permitted

PERFORMANCE AND SPINE CHIROPRACTIC CENTER, LLC
INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND MASSAGE CARE

Chiropractic treatment consists of manipulations of joints and soft tissues, using the hand and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment. These are normal and not a cause for concern. There are different techniques used in Chiropractic spinal manipulations. There are also alternatives to Chiropractic care, including but not limited to: Physical Therapy, Massage therapy, Osteopathic manipulations, and Medical care. There are also material risks inherent in the above listed alternatives, which should be discussed between you and the specialty care provider. You also have the option of not seeking any care. The risk of remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks which may arise during the exam and treatment. Those complications include: strokes or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equina. 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 upon the facts then known, is in my best interest. The risks of massage are bruising, local tenderness, and the release of toxins in the body. There are also risks in taking nutritional supplements, please contact your Primary Care Physician/ health care practitioner before using any nutritional products, including those dispensed in this office.

I have read or have had read to me the above explanation of the nature and purpose of chiropractic adjustments, other alternatives/ procedures for care, massage, and possible risk. I have also had the opportunity to ask questions about its content and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended, and listed below. Having been informed of the risk, **I hereby request and consent to the performance of** chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays-if warranted, massage, and the use of natural substances, such as vitamins, minerals, or other natural substances on me or on the patient name below, for whom I am legally responsible, by the doctor of chiropractic named below and/or license doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below and by the Licensed Massage Therapist listed below, including those working at the clinic or office listed below or any other office or clinic. I intent 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.

The anticipated results of the proposed treatment as described by Dr./LMT ________________________________ is: (to be completed by the Doctor / LMT)____

____

____

****

To be completed by patient:

____
PRINT Patient's Name

____
Signature of Patient

____
Date

If patient is a ***MINOR****, this section to be completed by patient's legal guardian, legally responsible adult.*

____
PRINT Patient's Name

____
PRINT Name of Patient's Guardian

____
Signature of Patient's Guardian

____
Date

To be completed by Doctor/ LMT

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Name of Doctor(s)/LMT treating this patient:
Jonathan Kinney, D.C.
Heather Kinney, D.C.
Licensed Massage Therapist

____
Witness to Patient's Signature

____
Date

____
Translated by:

____
Date