

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 prepared 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
19365 SW 65th Ave. Suite 104 Tualatin, OR 97062

Heather Kinney, D.C. Member
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:** ___/___/___

Workers' Compensation ELIGIBILITY CHECK-LIST AND FINANCIAL POLICY

Performance and Spine Chiropractic Center, LLC
19365 SW 65th AVE Ste. 104 Tualatin, OR 97062

PHONE (503) 486 – 5199
FAX (503) 486 – 5190

Date of injury: _____ Time of injury: _____
STATE OF OR Claim#: _____ **OR** SELF-INSURED Claim#: _____
Name of Self-insured Company: _____
Name of claims adjustor: _____ Adjustor's Phone Number: _____
Location/Address of Accident: _____ City _____ State _____
Name of Employer: _____ Name of your Supervisor: _____ Phone _____
Address of Employer: _____ City _____ Zip _____
Name of Dr who opened your claim: _____ Phone _____
Address of Dr. who opened your claim: _____ City _____ Zip _____
Did your Dr. write a referral to get Chiropractic care? _____ Please give it to the office staff!

FINANCIAL POLICY

As a patient of this office, you are directly responsible for all charges incurred. If your worker's compensation claim is denied you are fully responsible for prompt payment. If your claim cannot be verified as open and payable, you will be required to pay cash for your visit(s). If Worker's Compensation denies any services or deems them to be not medically necessary, you will be responsible for prompt payment. All supplies/supplements must be paid for before leaving the office and are not billed to Worker's Compensation. If you refuse to sign below, you acknowledge that you will be required to pay at the time of your visit(s).

HIPAA Notification & Authorization to Release Information: I hereby authorize the office of Performance and Spine Chiropractic Center, LLC to release necessary information to file a medical lien to secure payment for care received from PSCC should the need arise. The information on the medical lien is made public record. It identifies the patient, their address, 3RD Party, insurance parties involved, date of accident, location of accident and gives a general medical description of conditions being treated: "Soft tissue injuries to the spine, paravertebral structures and extremities."

Print Patient/Guardian Name Signature of Patient/Guardian Date

TO BE COMPLETED BY OFFICE STAFF

VERIFICATION OF WORKERS' COMPENSATION CLAIM

Receive Phone Number of Claim Adjustor

Date: _____ Spoke with: _____ Phone: _____
Claim Adjustors Name: _____ Phone: _____ Ext: _____
Has the claim been "allowed" yet? Yes / No Is the claim "pending"? Yes / No
*Diagnostic codes allowed: _____
Attending Physician: _____ Phone: _____
Is there a referral for chiropractic from the attending? Yes or No
Mail Claims To: _____

_____ Claim # _____

Additional Information: _____

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WORKERS COMPENSATION HISTORY FORM

Name: _____ Date of Accident: _____

1. Name of employer at the time of accident: _____

2. Length of time worked there prior to accident: _____

3. Type of work being done at time injury: _____

4. In your own words, please describe accident: _____

5. Have you been treated by another doctor for this accident? _____ Yes _____ No

If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

6. Are you: improved unchanged getting worse

7. What types of medicines are you taking? _____

Do these medicines help? Yes No Don't know

8. Have you had physical therapy? Yes No If yes, how often? _____

Daily Every other day Several times a week Weekly

Every other week Monthly Other

9. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

Yes No Don't know

If yes, describe: _____

Were these similar complaints the results of previous accident(s)?

Yes No Not Applicable

Please provide details of accident(s): _____

10. Have you had any other serious accidents which required medical care?

Yes No

Describe: _____

11. Have you had any serious illnesses that required hospitalization?

Yes No

Describe: _____

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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": _____

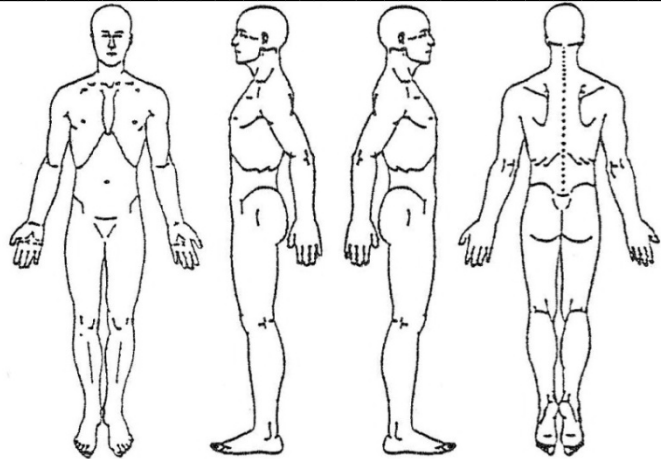
Pain Diagram: Use symbols below to mark the figures.

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 | 4 Moderate, bothers during work/activities | 8 Intense, preoccupied, seeks relief instead of activity |
| 1 Maybe | 6 Limiting, prevents full activity | 10 Severe—on bed rest, stops all activity |
| 2 Mild, forgotten w/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) _____ / ____/____

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		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain (723.1)	<input type="checkbox"/>	<input type="checkbox"/>	Colitis (558.9)	
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm (441.5)	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia (307.1)	
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (719.41)	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon (564.1)	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure (401.9)	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain (783.1) <input type="checkbox"/> Loss (783.2)	
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (719.42)	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS (042)	
<input type="checkbox"/>	<input type="checkbox"/>	Angina (413.9)	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst (783.5)	
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (719.44)	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (410.9)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough (786.2)	
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (719.43)	<input type="checkbox"/>	<input type="checkbox"/>	Other	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (436)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis (473.9)	
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain (724.1)	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue (780.7)	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (493.9)	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow (626.4)	
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain (724.2)	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow (626.7)	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (199.1)	<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps (611.72)	
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (719.45)	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis (617.9)	
<input type="checkbox"/>	<input type="checkbox"/>	Tumor (229.9)	<input type="checkbox"/>	<input type="checkbox"/>	PMS (625.4)	
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (729.5)	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control (788.30)	
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems (601.9)	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination (788.1)	
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (719.47)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination (788.41)	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder (790.6)	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain (789.0)	
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain (526.9)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular Bowel Habits (564.0)	
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders) (492.8)	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion (787.1)	
<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Stiffness of Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash (692.9)	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (716.9)	<input type="checkbox"/>	<input type="checkbox"/>	Depression (311)	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting (780.2)	If you or a family member has had any of the following, please mark the appropriate box:			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis (714.0)	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances (368.9)	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Chronic Back Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (250.0)	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Chronic Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions (780.3)	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (349.5)	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	Other Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness (780.4)	<input type="checkbox"/>	High Blood Pressure		
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer (556.9)				
<input type="checkbox"/>	<input type="checkbox"/>	Headache (784.0)				

Past Present

Pregnancy (V22.2)

Birth Control Pills

Hormonal/Estrogen Replacement

Medications (please list) _____

Vitamins/Herbs _____

Hospitalization/Surgical Procedures (please list) _____

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 ____/____/____

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:

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

PRINT Patient's Name

PRINT Patient's Name

Signature of Patient

PRINT Name of Patient's Guardian

Date

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