Patient Registration Form

Patient:_____
Last First Middle Initial

Guardian:_____

Address:_____
Street City ZIP

Phone #: _____(Home) _____(Work)

Date of Birth_____ ❑ F ❑ M ❑ Married ❑ Single ❑ Divorced ❑ Separated

❑Widow(er) ❑ Partnered ❑ # of Children _____ **Drivers License # and State**:_____

Occupation:_____ Employer:_____

Student?: ❑ Yes ❑No If Yes, ❑ Full-Time ❑ Part-Time? Where?_____

How Did You Hear About Us?

❑ Newspaper _____ ❑ T.V. ❑ Yellow Pages ❑ Web Page/Internet ❑ Friend ❑ Passing by ❑ Promotional Massage Card

REFERRED BY:_____

EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT: Name:_____

Relationship:_____Home Phone:_____

Work Phone:_____ Ext._____

I certify that the above information is correct to the best of my knowledge. I will provide any changed information as it becomes available. Failure to do so may result in denied charges from my insurance company, if applicable and increase my out-of-pocket expense for treatment.

Signed:_____Date:_____

PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑Unknown

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy

❑ Chiropractic Care ❑ Massage ❑ None ❑ Other_____

Name & address of other doctor(s) who have treated you for your condition_____

_____

Assignment of Benefits / Release of Records / Payment Agreement
Cascade Health Center

ASSIGNMENT OF BENEFITS Patient Initial Here:_____

To Insurance Company: _____ I hereby direct and instruct you to make payment directly to the undersigned provider(s) for medical claims submitted by them on my behalf for medically necessary treatment.

❑ Acupuncture (Terry Chen, L. Ac) ❑ Massage (Cascade Health Center)

❑ Chiropractic (Dr. Garreth D. MacDonald, D.C. or Dr. Hamed Madani, D.C.)

Your denial or delay to do so in a timely manner will be considered just cause for provider or myself to file a complaint with the Insurance Commissioner. I hereby give my permission to the undersigned provider(s) to file this complaint on my behalf if deemed necessary.

OFFICE POLICY Patient Initial Here:_____

Payment: Cash, local checks, and Visa/Mastercard/Discover Cards. **Payment is due at time of service** unless other arrangements have been made in advance.

In the event that you fail to make payment when due, this account (and any accounts you are responsible for) will be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principle and interest due. You be additionally liable for the attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Appointments: Your appointment time is reserved for you. If you find it necessary to reschedule an appointment, *a minimum of 24 hours notice is required* that we might make that time available to someone else that is in need. For appointments cancelled or missed with less than the minimum notice, ***it will be necessary to charge $10 FOR EACH SERVICE APPOINTMENT,*** if you have multiple services scheduled (e.g. chiropractic, rehabilitation, medical massage). Sudden illness or injuries are exceptions. You will receive 1 warning before we are forced to charge for the missed appointment(s). If you are late for your appointment(s), we will attempt to find time to treat you, but there may be a wait and your massage, if scheduled, may need to be shortened or cancelled in order to accommodate you. You will not be scheduled for any further appointments until any missed appointment fees have been paid.

MASSAGE POLICY Patient Initial Here:_____

I understand that massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand the use of Alcohol and Drugs prior to a massage session is incompatible to the healing process of massage/bodywork and are grounds for refusal/ termination of a session.

I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or actions towards the therapist or advances made by me will result in immediate termination of the session, and I will be liable for payments for the ”full” scheduled appointment. ***Any actions deemed “inappropriate” by the therapist would result in permanent expulsion*** from the facility. There will be no sexual involvement of any kinds by the practitioner or the clients.

The practitioners of massage at Cascade Health and Massage Center are not doctors. They do not diagnose, prescribe or practice medicine of any kind.

Patient’s Name (Print):_____

Patient’s Signature:_____ Date:_____

5/27/03

PATIENT PRIVACY NOTICE
Health Insurance Portability and Accountability Act (HIPAA)

Cascade Health Center 1165 Pearl Street Eugene, OR 97401

The staff at Cascade Health Center is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

As required by law, we must have your written consent before we use or disclose information for purposes of arranging for your health care, the payment for or reimbursement of the care that we provide to you and the related administrative activities supporting your treatment.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

By law you have the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting or disclosure of your medical information, requesting that we communicate with you confidentially, requesting that we restrict uses and disclosures of your health information, and registering a complaint if you feel your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations by law. We may revise our Notice from time to time. The Effective Date at the top right corner of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not received a copy of our current Notice, please ask your health care provider and you will be provided a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact us at (541) 343-0269.

I have read and understand the above Privacy Notice and sign below willingly.

_____ _____

Patient Signature Date Signed

_____

Please Print Name

INFORMED CONSENT TO CHIROPRACTIC CARE

Garreth D. MacDonald, D.C., Hamed Madani, D.C.
Cascade Health Center 1165 Pearl St. Eugene, OR 97401

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 on the patient named below, for whom I am legally responsible) by Dr. Garreth MacDonald or Dr. Hamed Madani.

Chiropractic examination and therapy (adjustments, heat, electrotherapy, etc.) are considered very safe and effective methods of care. Occasionally, however, complications can arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury (bruising), burns, fractures, disc injury, dizziness, temporary worsening of symptoms, strokes, dislocations and sprains. The risk of stroke has been estimated at 1 in 4-million from neck adjustments. This is considered very safe. The risk of death from a lightening strike has similar odds.

Tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained below including rest, home applications of therapy, prescription or over-the-counter medication, exercise and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence and may have to be continued indefinitely. Some medications may involve serious risks. The risk of death from gastrointestinal bleeding from overuse of NSAID's is 1 in 1,200.

Surgery: Surgery maybe necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reactions to anesthia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

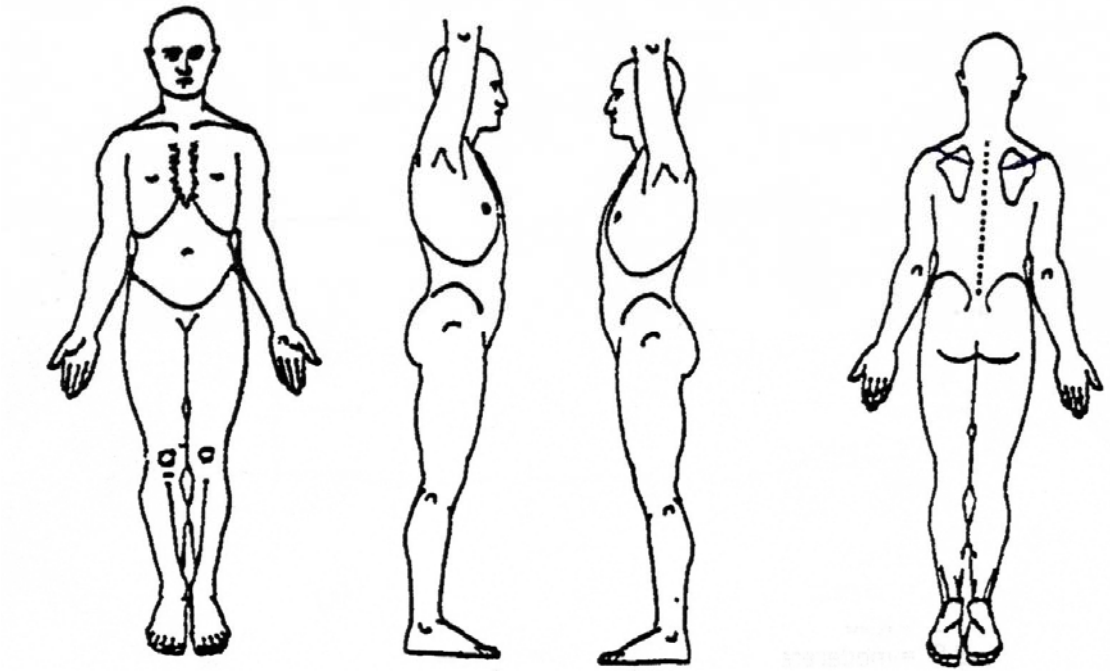
I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely and I hereby affix my signature to authorize for treatment.

Print Patient Name

Patient Signature Date

Symptom Diagram
Cascade Health Center

Please indicate on the diagram below the areas that you are experiencing pain currently.



Please use the following to illustrate your pain.

- Circle areas of pain
- Aching
- Stiffness
- Pins &Needles or Burning
- Numbness or Tingling

Name:

Date:_____

Place a mark ***through*** the line below please indicate how you are feeling ***at this moment***.

No Discomfort — Extreme Discomfort

Type of pain ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Comments: _____

Activities or movements that are painful to perform: ❑Sitting ❑Standing ❑Walking ❑Bending ❑Driving ❑Lying Down ❑Reading ❑Extended Forward Reach ❑Overhead Reach

INITIAL

HEALTH HISTORY

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

INJURIES/SURGERIES YOU HAVE HAD	DESCRIPTION	DATE

Falls/Accidents _____

Head Injuries _____

Broken Bones/ Dislocations _____

Surgeries/Hospitalizations _____

NECK, BACK, EXTREMITIES : Check (✓) symptoms you CURRENTLY have & (x) those you HAD in the past

NECK
- ❑ pain in neck
- ❑ neck stiffness
- ❑ neck weakness
- ❑ muscle spasm in neck

SHOULDERS
- ❑ can't raise arms
  - ❑over head ❑above shoulders
- ❑ pain across shoulders
- ❑ tension in shoulders
- ❑ pain in shoulder joint

ARMS & HANDS	Right	Left
❑ weakness of arm	❑	❑
❑ numbness in arm	❑	❑
❑ pins & needles in fingers	❑	❑
❑ pain in upper arm	❑	❑
❑ pain in elbow	❑	❑
❑ pain in forearm	❑	❑
❑ pain in hand	❑	❑
❑ pain in fingers	❑	❑
❑ pins & needles in arm	❑	❑

LOW BACK
- ❑ muscle spasms in low back
- ❑ low back weakness
- ❑ low back stiffness

HIPS, LEGS & FEET	Right	Left
❑ weakness of knee	❑	❑
❑ weakness of leg	❑	❑
❑ leg cramps	❑	❑
❑ pain in buttocks	❑	❑
❑ pain in hip joint	❑	❑
❑ pain down leg	❑	❑
❑ pain in knee	❑	❑
❑ pain in ankle	❑	❑
❑ pain in foot	❑	❑

MID-BACK
- ❑ muscle spasms in mid-back
- ❑ pain between shoulder blades
- ❑ mid-back stiffness

Please mark either "**C**" – currently or "**Y**" – yes but resolved – **(Leave the remaining conditions BLANK)**

GENERAL
- ___Diabetes
- ___Cancer
- ___Loss of Sleep
- ___Fatigue
- ___Dental Problems
- ___Jaw Pain/TMJ
- ___Hepatitis____
- ___Sinus Trouble
- ___PMS
- ___Infectious Disease
  - Name_____
- ___Depression
- ___PMS
- ___Weight Loss/Gain
- ___Eating Disorders

CARDIOVASCULAR
- ___Lymphedema
- ___Blood Clots
- ___Varicose Veins
- ___High/Low BP
- ___Heart Condition

HABITS
- ___Chew Tobacco
- ___Caffeine
- ___Recreational Drug Use
- ___Smoking ___ packs/day
- ___Drinking

RESPIRATORY
- ___Wheezing/Asthma

GENITOURINARY
- ___Kidney Disease

FEMALES: Are you Pregnant? ❑ Yes ❑ No Weeks?___

FAMILY HISTORY
- ___Diabetes ___Lung Disease
- ___Cancer ___High Blood Pressure/Stroke

MUSCULOSKELETAL
- ___Bone and Joint Disease
- ___Tendinitis/Bursitis
- ___Low Back Pain
- ___Swollen Joints
- ___Painful Joints
- ___Muscle Aches/Soreness
- ___Spinal Curvature
- ___Arthritis
- ___Headache

SKIN
- ___Scars Location
- ___Itching
- ___Bruising Easily
- ___Athlete's Foot/Rashes
- ___Skin Cancer

DIGESTIVE
- ___Constipation
- ___Gas/Bloating
- ___Diverticulitis
- ___Irritable Bowel Syndrome (IBS)

NEUROLOGIC
- ___Vertigo
- ___Fainting
- ___Dizziness
- ___Epilepsy/Seizures
- ___Falls/Loss of Balance
- ___Sleep Disorder
- ___Numbness/Tingling
- ___Chronic Pain
- ___Herpes/Shingles
- ___Headache

EXERCISE
- ___None
- ___1-2 times/week
- ___3-5 times/week
- ___6-7 times/week

Types:_____
_____

Name:_____ **Date:**_____