MISSISSIPPI CHIROPRACTIC
3737 N. Mississippi Ave.
Portland, OR 97227
(503) 467-4511 – Fax: (503) 467-4513

CONFIDENTIAL CASE HISTORY FILE

Date:_____

Full Legal Name:_____ Name you prefer:_____

Address:_____ City/State/Zip_____

Phone (Home): _____ Cell: _____ Work: _____

Birth date:_____ Age: _____ Sex: _____

Marital Status: S M W D Separated Partner Partner/Spouse's Name: _____ # of children: _____

Emergency Contact:_____ Phone: _____

Your Employer:_____ Phone:_____

Employer's Address:_____ City/State/Zip:_____

Job title:_____

Email address:_____ Referred by:_____

MEDICAL HISTORY (Please be complete) Height: _____ Weight: _____

List any surgeries (include dates & reason): _____

List any hospitalizations (include date & reason): _____

List any auto accident injuries (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

_____

List all current over-the-counter and prescription medications used (include reason used):

_____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

_____

Have you been in an auto accident or injured on the job in the last 12 months? NO / YES - Date of Injury: _____

Have you been under a physician's care in the past year? NO / YES (reason): _____

_____

When was your last physical examination? _____

Have you ever been under chiropractic care? NO / YES (describe): _____

If female, is there a possibility that you are pregnant? NO / YES

Do you smoke/use tobacco? NO / YES Exercise habits? ____Never ____Occasional ____Frequent

Check any of the following symptoms you have noticed: (▭= Previously, ☐= Now)

▭ ☐ Headaches	▭ ☐ Low back pain	▭ ☐ Sensitive to light or sound
▭ ☐ Dizziness or light-headed	▭ ☐ Leg/foot numbness/tingling	▭ ☐ Visual or hearing disturbance
▭ ☐ Jaw pain, clicking, or locking	▭ ☐ Leg/foot fatigue/weakness	▭ ☐ Memory loss/problems
▭ ☐ Pain or difficulty swallowing	▭ ☐ Leg pain with walking	▭ ☐ Irritability or depression
▭ ☐ Neck pain or stiffness	▭ ☐ Abdominal pain	▭ ☐ Fatigue or loss of energy
▭ ☐ Shoulder pain	▭ ☐ Nausea or vomiting	▭ ☐ Fainting or convulsions
▭ ☐ Mid back pain	▭ ☐ Diarrhea or constipation	▭ ☐ Trouble with balance or coordination
▭ ☐ Chest pain or cough	▭ ☐ Blood in urine or stool	▭ ☐ Sleep disturbances/problems
▭ ☐ Pain/trouble breathing	▭ ☐ Difficulty or pain w/urination	▭ ☐ Rashes (face, body, limbs)
▭ ☐ Arm/hand numbness/tingling	▭ ☐ Difficulty with sexual function	▭ ☐ Joint pain or swelling
▭ ☐ Arm/hand fatigue/weakness	▭ ☐ Abnormal menstrual periods	▭ ☐ Pain with exertion (activity, climbing stairs, etc.)

HAVE YOU HAD ANY OF THE FOLLOWING:

- ☐ Pain worse at night
- ☐ Constant pain
- ☐ Unexplained weight loss
- ☐ Recent bacterial infection (30days)

NOW:

- ☐ Loss of bowel or bladder control
- ☐ Urinary discharge
- ☐ Recent surgery (30 days)

EVER:

- ☐ History of cancer
- ☐ History IV drug use
- ☐ History of blood transfusion

Information about your current condition/complaints

What is your primary complaint/problem?_____

Is condition due to an accident? YES / NO Date of accident:_____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other:_____

List other symptoms:_____

When did your symptoms first begin (give date if possible)?_____

How did your symptoms first begin?_____

Pain is ___Constant ___Intermittent Is your condition getting worse?_____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem and treatment given (use back of page if necessary):

1._____

2._____

3._____

Have you had: ___Xray ___MRI or CAT Scan ___EMG ___Bone Scan ___Blood Work

List all home remedies tried for this problem: _____

Is your condition worse at certain times of the day or night?_____

Does your condition interfere with : YES/NO work___ sleep___ normal daily routine___

Have you had symptoms like this before? NO / YES (describe)_____

Regarding your main complaint:

How bad is your pain?

(make a slash on all 3 scales)

1. RIGHT NOW:
2. AVERAGE:
3. AT WORST:

0 10

0 = no pain 10 = worst pain imaginable

Draw the area of your symptoms using these symbols:

(mark on the figures)

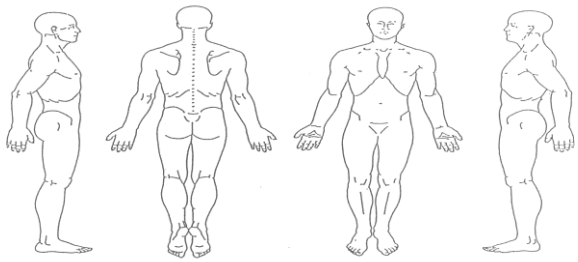
XXX = ache

☆ = sharp

OOO = numb/tingle

⟹ = shooting

//// = stiff/tight



NOTICE TO NEW PATIENTS: *Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy.*

Assignment and Release:

I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges of all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with. I understand the benefits and risks of chiropractic and its related modalities and give my consent for these services. I will consult with my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

_____ _____ _____

Signature *Print Name* *Date*

Effective: October 12, 2016

3737 N Mississippi Avenue Portland OR, 97227

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 CAREFULLY.

If you have any questions about the above notice, please contact our Privacy Officer, Rachel Roy (503) 467-4511

Our Obligations: We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information: Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practices privacy officer.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. It is our policy that we may provide a substitute health care provider, authorized by Mississippi Chiropractic, P.C. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation." It is possible that you will be treated in an open treatment room. In the case that another patient is present during your treatment, personal health information may be discussed between you and the provider. Should you wish to address issues that you may wish to remain confidential, a private room will be made available to you upon your request.

Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the Chiropractic care, soft tissue work and rehabilitation care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services: We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations as required by law: We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans: If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation: We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities: We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints: If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

This notice was published and becomes effective on/or before October 12, 2016

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with the respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person, Rachel Roy or by phone at (503) 467-4511. Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

_____	_____	_____
Signature	*Print Name*	*Date*

MISSISSIPPI CHIROPRACTIC

Office Policies

The following is a list of our **office policies**. The purpose of these policies is to enable our office to serve you to the best our abilities. It is also our experience that patients who adhere to these policies benefit the most from the wonderful results of chiropractic care.

- **Making Appointments:** For healing to be most effective, the doctors usually suggest a series of visits. We advise that you schedule in advance to ensure continuity of appointments.
- **Cancellation Policy:** Missed appointments without prior notification may be subject to a $25 charge. Please give prior notice of at least 24 hours so the Doctor can help other patients in that time slot. Please, note that if your bill is currently paid by insurance of any type, they will not pay for this fee. You will be personally responsible for it.
- **Payment Policy**: We charge for services provided. Payment is due at the time of service for insurance co-payments, deductibles, supplements, and cash payments. We offer a discount to clients who pay in full at the time of service. Due to rising bank charges, we must charge a $10 fee for all returned checks. Cash, check or credit cards (Visa/MC/Discover/Amex) are accepted. Administrative costs, such as insurance processing, are one of the components used in an equation developed by the Health Care Financing Administration to arrive at reasonable fees physicians may charge for the services they provide. The elimination of this component results in monetary remuneration shared throughout the health care industry, and is realized in the form of a courtesy discount to patients or third-party payers who make prompt payment AT THE TIME SERVICES ARE RENDERED.
- **Motor Vehicle Accidents & Work Place Injuries:** Please notify us if you are in an accident. We will be happy to bill under your PIP/WC coverage.
- **Collection Policy:** If an account is over six month in arrears, it may be subject to legal collection. The key to avoid this situation is communication. **WE WILL WORK WITH YOU!** Just talk to us.
- **Childcare Policy:** We do not offer childcare in this clinic. Please do not leave children unattended.
- **Cell Phones:** Please turn off all cell phones before entering the treatment rooms. We ask that you be courteous to those in the waiting area by monitoring your volume.
- **Address Change:** Please notify us when your address and/or your phone number changes as soon as possible.

"PAYMENT AT TIME OF SERVICE OPTION" AGREEMENT: PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED. A written copy of the fees for specific services provided in this office is available to each patient by mail on request and all fees are subject to change without notice.

❑ I elect to use this prompt payment option. I will pay in full at the time services are rendered.

❑ I do not choose to use this payment option as I elect to have Mississippi Chiropractic, P.C. bill my insurance carrier/ third party payor for their portion of the services covered by them. I understand that any discounts do not apply. I agree to pay my scheduled co-payment and/or the percentage not covered by my insurance policy.

OUR POLICY ON INSURANCE

Most insurance companies do cover chiropractic care however each insurance company processes and pays claims according to the patient's benefits and their individual administrative policies. It is important to understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, and their insured. We do accept insurance in this clinic. Most insurance companies require a yearly deductible, and a co-payment. The co-payment is determined by the percentage of the visit that the insurance will cover.

We will continue to bill insurance for our patients and verify insurance benefits as a courtesy to our patients. Due to the complexity of the insurance processing procedures, we are informing you that this is not a guarantee of benefits. You must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment. Any amount authorized to be paid directly to Mississippi Chiropractic, P.C. will be credited to your account upon receipt.

_____	_____	_____
Signature	*Print Name*	*Date*

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other procedures by the doctors of Mississippi Chiropractic Clinic. I have had an opportunity to discuss with Dr. Pitcairn the nature and purpose of chiropractic adjustments and other procedures.

The following points have been explained to my satisfaction, and I have had the opportunity to discuss them with Dr. Pitcairn and/or other clinic personnel:

- Chiropractic care is the science, philosophy and art of locating and correcting spinal subluxations (misalignments), and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurologic aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.
- I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint which may cause an audible “pop” or “click”.
- As with the practice of medicine, the practice of chiropractic is not an exact science. It relies upon information related by the patient, information gathered during examination, the doctor’s interpretation of this information, as well as the doctor’s judgment and expertise in working with like cases.
- It is not reasonable to expect my chiropractor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit. I wish to rely on the doctor to exercise professional judgment during the course of any procedures which he feels at the time to be in my best interest.
- An undesirable result or side effect does not necessarily indicate an error in judgment or an improper treatment.
- As with any health care procedure there are certain complications which may arise during a chiropractic adjustment. Those complications include sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. These complications are extremely rare occurrences.

I have read the above consent or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis.

_____	_____	_____
Signature	*Print Name*	*Date*