



New Patient Registration

Name _____ Today's Date _____
LAST FIRST MI

Address _____
STREET APT# CITY STATE ZIP CODE

Date of Birth _____ Age _____ Home Phone (____)____-_____

Work Phone (____)____-_____ Cell Phone (____)____-_____

E-mail Address _____

Emergency Contact _____ Relationship _____ Phone(____)____-_____

Employer _____ Occupation _____

Is this visit routine/accident/illness/other? _____

If accident; Date and brief description _____

Responsible Party Information

Name (Guarantor) _____
LAST FIRST MI

Date of Birth _____ Relationship to Patient _____

Address _____
STREET APT# CITY STATE ZIP CODE

Employer _____ Phone (____)____-_____

Address _____
STREET APT# CITY STATE ZIP CODE

Name of Insurance _____ ID # _____ Grp# _____

Contact Preference

How would you like to be contacted by Dr. Ebling? Please indicated in order of preference (# 1-4); E-mail____ Home Phone____ Cell Phone____ Work Phone____

If I do not reach you, can I leave a message with the office name at your work? Yes/No
If I do not reach you, can I leave a message with the office name at your home? Yes/No
Is it OK to leave a detailed message? Yes / No (If No, I will simply ask for a return phone call to discuss the details of my call.

Do I have your permission to send an email regarding news in the field or information related to the practice? Yes / No (you can opt out at any time).

Please notify me if there are any changes to your contact information or to your insurance at your earliest convenience. Thanks!

In the event that you need to cancel or re-schedule an appointment, kindly give 24 hours notice. A \$50 fee will be assessed with less than 24 hours notice.



2915 SE Belmont St., Suite 1
Portland, OR 97214
503.505.9677
elementalmedicinepdx.com

Acknowledgement and Understanding of Financial Policy

Please initial each item below. If you have questions, do not hesitate to ask.

- _____ I understand that full payment is due at time services are rendered unless prior arrangements have been made.
- _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by Dr. Carrie Ebling at Elemental Medicine.
- _____ After verification of insurance benefits, Elemental Medicine will accept payment directly from your carrier. **Your insurance is an agreement between you and your insurance company. Elemental Medicine does not promise that your insurance company will pay all charges relative to your care even after verification has been made. Therefore, all charges disputed by your carrier will be your personal responsibility, to be paid in full by you no more than 60 days from date of notification from your carrier, via a Square Invoice sent by Elemental Medicine.**
- _____ I agree to pay all Uncovered Services at the time of the visit (i.e. deductible, co-payment etc.)
- _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.
- _____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, Private insurance, and all other health plans to Elemental Medicine, 2915 SE Belmont St, Suite 1, Portland, OR 97214.
- _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.
- _____ I understand and agree that **I will be charged \$50** in the event that I neglect to provide **24 hours notice of cancellation** if I am unable to make my scheduled appointment time. I also understand this fee will *not* be covered by my insurance, if any is available.

_____ Patient Name / Patient Signature

_____ Date

_____ Guarantor Signature

_____ Relationship to Patient

Authorization to Treat a Minor

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ Patient's Full Name

____/____/____ Date of Birth

_____ Age

This authorization will be effective as of _____ and expires on _____

Signature _____

Witnessed by _____

Parent or Guardian



Confidential Patient Health Questionnaire

Name _____ Date of Birth _____ Today's Date _____
LAST FIRST MI

How did you find our office? Friend Flyer Web Other _____

Have you been treated by a Chiropractor before? _____

Please list practitioner names and specialties of your other health care providers: _____

Do I have your permission to contact them to coordinate your care? Yes No

List any medications/vitamins/supplements (prescribed, or over-the-counter) with the dosage, and the duration you have been on them: _____

Name / Dose / Duration _____ Name / Dose / Duration _____ Name / Dose / Duration _____
 Do you have any diagnosed health conditions? _____

Please describe your reason for seeking care today. _____

Date problem began: _____ Is this Work related Auto related Other _____

Does it seem to be getting Worse Better or Staying the same?

It interferes with: Sitting Work Sleep Walking Hobbies Leisure
 Other

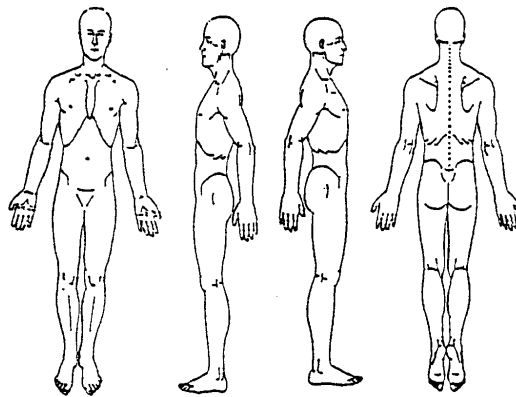
Mark current problems on these pictures:

Check all that apply:
 Sharp Pain Stabbing Pain Ache
 Weak Numb Throbbing Shooting
 Burning Tingling Decreased motion

What is the frequency of your problem?
 Constant (75%-100%) Frequent (50%-75%)
 Occasional (25%-50%) Intermittent (<25%)

Are your symptoms worse...
 In the morning In the afternoon At night

Do your symptoms wake you up? Yes No



Please circle the current level of discomfort your problem causes you, when it is at its worst
 none 1 2 3 4 5 6 7 8 9 10 worst ever

What makes your problem better? Nothing Lying Down Walking Standing Sitting Exercise Rest
 What makes your problem worse? Nothing Lying Down Walking Standing Sitting Exercise Rest

Have you experienced a similar problem in the past? Yes No

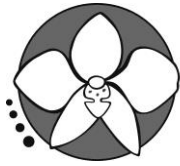
Did you seek care in the past? Yes No. From whom? _____

Physical activity at work: Sitting 50%+ of day Light labor Heavy labor Repeated motion

Occupation: _____ FT PT Has your work changed due to this condition? Yes No

What is your current work status?

FT, no restrictions PT, no restrictions Off work due to injury Unemployed
 FT, with restrictions PT, with restrictions Homemaker FT student Retired



LIFESTYLE

	<u>YES</u>	<u>Notes, if YES</u>
Do/did you smoke/use any tobacco? _____	<input type="checkbox"/>	
Do/did you drink alcohol? _____	<input type="checkbox"/>	
Do/did you use drugs? _____	<input type="checkbox"/>	
Do you consume caffeine? _____	<input type="checkbox"/>	
Do you consume sugar / sugary drinks? _____	<input type="checkbox"/>	
Do you eat a lot of vegetables? _____	<input type="checkbox"/>	
Do you eat fast/processed foods? _____	<input type="checkbox"/>	
Do you drink a lot of water? _____	<input type="checkbox"/>	

What is your current level of stress? Little to none Minimal Moderate Severe
 General Physical Activity: No regular exercise Light exercise Moderate Strenuous

HEALTH HISTORY

Please check all symptoms you have ever had, even if they do not seem related to your current problem

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Urinary retention |
| <input type="checkbox"/> Migraine headache | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prolapse |
| <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Kidney infections |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Abnormal weight gain | <input type="checkbox"/> Meniere's | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Abnormal weight loss | <input type="checkbox"/> Rash or hives | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Slow healing | <input type="checkbox"/> Arm/elbow/wrist pain |
| <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Food intolerances | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Cold/flu often | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Sinus infection | <input type="checkbox"/> Impotency | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyper/hypo thyroid | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ankle pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Corticosteroid use | <input type="checkbox"/> Foot pain |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Suspicious mole(s) | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Surgery/Hospitalization | <input type="checkbox"/> Serious injuries or trauma |
| <input type="checkbox"/> High blood pressure | | <input type="checkbox"/> Metal/surgical implants |

FAMILY HEALTH HISTORY If a family member has or had any of the following, please check the box(s).

Cancer High Blood Pressure Heart Problems Stroke Diabetes Other _____

Patient's Signature _____ Date _____



elemental
medicine

Chiropractic, Acupuncture & Massage

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Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patient's privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that information.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations

We may use and disclose your information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials needed to serve you. We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, worker's compensation, and law enforcement. You may revoke this authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

Your Rights

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in anticipation of, or use in, a civil, criminal, or administrative action or proceeding. A copy of your records must be requested in writing. You have the right to request a restriction of your protected health information. The physician is not required to agree to a restriction that you request. You have the right to request that we communicate with you about your medical information by different means or to a different location. This request must be made in writing. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may request a copy of this notice.

Questions or Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

By signing below, I acknowledge that I have read, understand and accept the terms of this document.

Signature of Patient or Guardian _____

Date _____

Print Patient Name _____



Informed Consent to Chiropractic Treatment

The nature of Chiropractic treatment:

The care we provide is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use his/her hands or tools to adjust your joints and align your soft tissues. You may hear a "click or pop", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, massage, traction, electric muscle stimulation, taping and exercise/nutritional instruction may also be employed.

Possible risks and alternative treatments:

There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Though we take every precaution, there are some risks associated with Chiropractic. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities includes muscular strain, ligamentous strain, and fractures. Injury to the intervertebral discs, nerves or spinal cord is possible, though are considered even less likely. The risks involved with treating the neck may include any of these, but also includes the remote possibility of cerebrovascular injury or stroke. Current literature states the chances of this occurring to be one in one million to one in ten million. The ancillary physical therapy procedures could produce skin irritations, burns or bruising. Other treatment options may include over the counter analgesics, which carry with them the risks of irritation to the stomach, liver, kidneys, and various other side effects.

Alternative treatments for most musculoskeletal complaints include care from an acupuncturist, naturopathic doctor, massage therapist, physical therapist, medical doctor, or surgeon, to name a few. Each of these modalities possesses their own list of possible risks and side effects. One or several of these may be recommended to compliment your Chiropractic care.

Concerns or Questions:

We hold your health and your safety as our top priority. We are glad to explain and address any concerns you may have regarding your treatment. We will only recommend treatment for you that we would feel comfortable having performed on ourselves. This consent form is intended to cover the entire course of treatment for your present conditions, and any future conditions for which you seek treatment at this office.

I have read the above explanation of Chiropractic treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

Signature of Patient or Guardian _____ Date _____

Print Patient Name _____