

Name: _____



Date of Birth: _____

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with Pure Life Clinic and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

3 PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

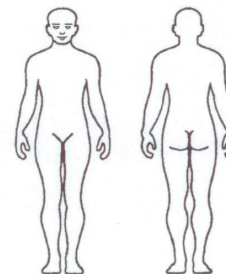
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

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

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



Name: _____



Date of Birth: _____

Pure Life Clinic Consent Form

Chiropractic examination and therapeutic procedures (including chiropractic manipulation, hot and cold applications, frequency specific microcurrent, electrotherapy, taping and bracing, and manual muscle therapy, etc.) are considered safe and effective methods of care. Occasionally, however, complications may 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 may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare, such as disc herniations and strokes. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read, understand, and have no further questions regarding the above statements concerning treatment side effects and risks, and I also understand that there is no guarantee for a specific cure or result. I understand both my rights and responsibilities in this doctor/patient relationship.

Patient Signature or Guardian if patient is under 18 years of age

Date _____

Print Name

Name: _____



Date of Birth: _____

Patient History and Condition

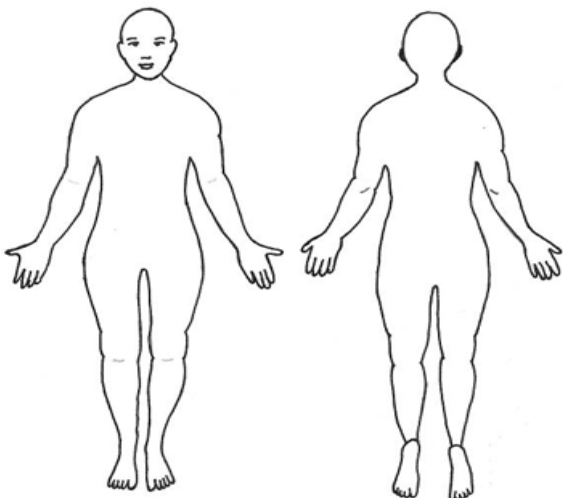
Reasons for Visit

Describe the conditions/symptoms you are currently experiencing:

- Concern #1: _____
- Concern #2: _____
- Concern #3: _____

	Condition #1	Condition #2	Condition #3
When did these symptoms begin?	_____	_____	_____
Is the condition getting progressively worse?	_____	_____	_____
Rate the severity of your pain from 1 to 10	_____	_____	_____
How often do you experience these symptoms?	_____	_____	_____
Is the pain constant or varied in duration?	_____	_____	_____
Describe the pain using words below (Sharp/Dull, Throbbing, Aching, Shooting, Burning, Cramps, Stiffness, Swelling)	_____	_____	_____
Does the pain interfere with your....			
Work?	_____	_____	_____
Sleep?	_____	_____	_____
Daily Routine?	_____	_____	_____
Recreation?	_____	_____	_____
Does it cause numbness, tingling, or weakness?	_____	_____	_____
What treatment/therapy have you tried?	_____	_____	_____
Have you experienced this condition previously?	_____	_____	_____
If yes, when did you previously experience it?	_____	_____	_____
Has the issue resolved previously?	_____	_____	_____

Mark an X on the picture where you continue to experience symptoms.



List activities that are painful, such as sitting, standing, etc:

For Women Only -

Are you pregnant: _____ if yes, Due date: _____

Do you have children: _____ if yes, list ages: _____

Name: _____



Date of Birth: _____

Health History

What treatment you have already received for your condition? (circle all that apply)

Chiropractic Massage Acupuncture Medications Physical Therapy Surgery None

Date of Last: Physical Exam: _____ Spinal X-ray: _____ Blood Test: _____
Spinal Exam: _____ Chest X-ray: _____ Urine Test: _____
Dental X-ray: _____ MRI, CT-Scan, Bone Scan: _____

Please circle to indicate if you have had any of the following:

- | | | | |
|---------------------|------------------|----------------------|--------------------|
| AIDS/HIV | Diabetes | Measles | Rheumatic fever |
| Alcoholism | Emphysema | Migraine Headaches | Scarlet fever |
| Allergy Shots | Epilepsy | Miscarriage | Stroke |
| Anemia | Fractures | Mononucleosis | Suicide attempt |
| Anorexia | Glaucoma | Multiple Sclerosis | Thyroid Problems |
| Appendicitis | Goiter | Mumps | Tonsilitis |
| Arthritis | Gonorrhea | Osteoporosis | Tuberculosis |
| Asthma | Gout | Pacemaker | Tumors, growths |
| Bleeding Disorders | Heart Disease | Parkinson's disease | Typhoid Fever |
| Breast Lump | Hepatitis | Pinched Nerve | Ulcers |
| Bronchitis | Hernia | Pneumonia | Vaginal Infections |
| Bulimia | Herniated Disk | Polio | Venereal Disease |
| Cancer | Herpes | Prostate problem | Whooping Cough |
| Cataracts | High Cholesterol | Prosthesis | Other: _____ |
| Chemical Dependency | Kidney Disease | Psychiatric care | |
| Chicken Pox | Liver Disease | Rheumatoid arthritis | |

Lifestyle Habits – please circle the choices that apply

Exercise	Work Activity	Habits	
None	Sitting	Smoking	Packs/Day: _____
Moderate	Standing	Alcohol	Drinks/Week: _____
Daily	Light Labor	Coffee/Caffeine	Cups/Day: _____
Heavy	Heavy Labor	High Stress Level Reason:	_____

List the following	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____



Date of Birth: _____

Pure Life Clinic Financial Policy

118 N. Killingsworth St. Portland, OR 97217 503.288.4454

Cost of Services

All health insurance and personal injury protection PIP rates are billed according to the Oregon Workers' Compensation Fee Schedule. The state of Oregon determines these fees every second April. Visit the Oregon.gov website to better understand how health insurance works in Oregon.

Pure Life Clinic is pleased to offer a time of service discount. A Time of Service Discount is a discount off of our standard fee schedule. This discount is available to any and all patients making full payment at time of service. Payment can be made via check, cash, or credit card. By eliminating the many administrative costs and tasks that must be completed when processing insurance claims, we are able to pass the savings onto our patients that have no coverage.

Insurance

We strongly advise you to contact your insurance company to discuss your benefit coverage for chiropractic, massage and other therapeutic services as coverage for these can vary greatly. As a courtesy we can verify the benefits on your plan. However, this is not a guarantee of coverage for the services provided. Your insurance company may require that you pre-certify or register your treatment with us prior to your visit. It is your responsibility to monitor insurance benefits, deductibles, pre-certifications, re-certifications, annual benefit maximums, primary care physician notification, effective date and termination dates of coverage. If your insurer denies payment for services, payment will be your responsibility.

We are participating providers for most health insurances; however, it is your responsibility to make sure the provider that you are scheduled with is participating in the network.

This office requires that you pay your co-pays and any deductibles required at each appointment.

Patient Responsibility

As mentioned above, it is the patient's responsibility for any co-payments, coinsurance, deductible and non-covered services. This office reserves the right to refer out to collections, any account we deem delinquent with one prior notice to the patient. Payment arrangements should be made prior to the account being referred to our collections department.

Confidentiality

Your records or information about your case cannot be shared without your prior written permission, and your records will not be released without written approval of the patient or the responsible party of a minor.

Missed Appointments

We require at least 24 hours notice if you need to change or cancel your appointment. If you fail to keep your appointment or do not provide us with 24 hours notice, you will be charged a \$40 "broken appointment fee". This fee is the same for all patients regardless of insurance coverage. Broken appointment fees must be paid prior to rescheduling your appointment. Broken appointment fees also cannot be billed to your insurance carrier and are solely the responsibility of the patient.

I have read, understand, and agree with the preceding described financial policies. By signing I agree that I also understand that as the patient or legal guardian of the patient, I am ultimately personally responsible for any and all costs associated with the course of my treatment and care at Pure Life Clinic.

Signature _____

Date _____

Name: _____



Date of Birth: _____

Pure Life Clinic visit our website @ www.purelifeclinic.com 503.288.4454

Pure Life Clinic visit our website @ www.purelifeclinic.com 503.288.4454

Pure Life Clinic 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 IT CAREFULLY.

This notice takes effect on February 1st, 2007 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Follow the terms of the notice that is now in effect.
3. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information we keep, including information previously created or received before the changes.

Notice of change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or

Name: _____



Date of Birth: _____

services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTHCARE OPTIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality of care, evaluation of the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to better serve you.

4. ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and healthcare operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location and contact information; your condition described in general terms. We may use these listings when sending out information to our patients.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get you permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court of administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances such as a court order, warrant, or grand jury subpoena, a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official of correctional institution under certain circumstances.

Name: _____



Date of Birth: _____

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with prevention or controlling disease, injury or disability including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk if contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement official capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises and crimes in emergencies.

5. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information, you may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you \$2 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and healthcare operations and other specified exceptions.
3. Request that we place additional restriction on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to one of the contacts listed at the end of this notice.
5. Request that we change you medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request we will provide you a

Name: _____



Date of Birth: _____

written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed, If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing the Privacy Officer at our office.

Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

I have read and understand the contents of this document.

Print name: _____

Signature: _____ **Date:** _____

Signature of Legal Guardian (if patient under 18): _____

Print name: _____