Plasker Chiropractic & Functional Neurology

Patient Intake Form

Name _____
Date _____
Address _____
City _____ State ____ Zip _____
Phone: (H) _____ (W) _____
E-mail _____
Date of Birth _____ (Age _____)

Referred By _____
Occupation _____
Employer _____
Marital Status S M D W
Spouse's Name _____
Spouse's Occupation _____

Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?
Major _____
Pain or Problem started on _____
Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Is this condition getting progressively worse? _____
Other Doctors seen for this condition _____
Any home remedies? _____

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Stomach Upset
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Constipation
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in Ear
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Fatigue	❒ Loss of Taste	
❒ Dizziness	❒ Depression	❒ Diarrhea	

Please describe any previous care you have received for this condition?

_____

_____

_____

Please list your current medications:

_____

Please list your full surgical history: _____
How Long? _____ Have you had surgery? _____ What? _____ When? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

▯ Plasker Chiropractic & Functional Neurology ▯ 2500 NE Twin Knolls Dr Suite 270 Bend, OR 97701 ▯
▯ www.plaskerchiro.com ▯ (458) 206-3461 ▯ frontdesk@plaskerchiro.com ▯

Financial and Cancellation Policy

Service	Fees
Functional Neurology Exam	$375
Initial Chiropractic Exam	$250
Functional Neurology Re-examination	$150
Treatment	$75/15 min

We are a cash-based practice other than personal injury protection in relation to a motor vehicle accident. We do not bill any other types of insurance for any reason. We are happy to provide you with a superbill that you can submit to your insurance company, and they will make a determination on direct reimbursement based upon your out-of-network chiropractic benefits. The financial responsibility for all care provided is ultimately yours and we reserve the right to submit any unpaid bills to collections if absolutely necessary.

Before beginning care, you will be asked to provide us with valid credit card information, which will be stored securely in our billing system. **24 business hours prior to your appointment you will be billed and your card will be charged for the full cost of your appointment.** Once your card is charged there are no refunds as you are within the 24-hour cancellation period. Please be courteous and notify us promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of care. In the event of an actual emergency when prior notice cannot be given, consideration will be held, and an exception may be granted.

To cancel or reschedule appointments call our office at (458) 206-3461. If we are unable to answer the phone, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

I, (name) _____ have read and agree to the above policies.

_____ _____

Patient signature Date

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

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Patient Name:_____ Date of Birth:_____

I acknowledge that I received and/or reviewed a copy of Plasker Chiropractic and Functional Neurology's Notice of Privacy Practices.

I give permission to communicate messages in the following manner:

_____ You may leave a message on my answering machine located at this number _____

_____ You may leave a message on my cell phone_____

_____ You may leave a message with my spouse, _____at this number _____

_____ You may leave a message with another person, _____ at this number _____

_____ You may email me regarding my health care at _____

I give permission to communicate messages about the following via phone or email:

_____X-rays, and other test results
_____ Billing or insurance matters

_____ _____

Patient Signature Date