TOTAL HEALTH WELLNESS CENTER
10224 SW Park Way, Suite A Portland, OR 97225 ph: 503.297.1174 fax: 503.297.2623
Kelly L. Hubbard, D.C.

PATIENT INFORMATION

_____
Last Name First Name MI Gender M/F How did you hear about us?

_____
Street Address City State & Zip Code Marital Status?

(____)_____(____)_____(____)_____/_____/_____
Home Phone # Cell Phone # Work Phone # Email Address DOB

_____(____)_____
Employer's Name Occupation Emergency Contact Emergency Contact Ph #

PRIVATE HEALTH INSURANCE

_____/_____/_____
Name of Insured & Employer Insured DOB Relationship to Insured

_____(_____)_____
Insured Address & Phone # (if different from patient) Insurance Co Name

AUTO INSURANCE (complete if you were in an auto accident. WE MUST bill Auto Insurance of the car you were in)

_____
Name of Insured Insurance Co. Name Insurance Claims Address

_____/_____/_____
Claim # Policy # Date of Accident

WORKMEN'S COMPENSATION INSURANCE (Complete if you had a work-related accident. This information can be obtained from your employer.)

_____
What kind of accident? Driver's License #

_____(_____)_____
Employer's Name Employer's Address Employer's Phone #

_____(_____)_____
Employer's Insur. Carrier Name & Address Claims Phone #

_____
Claim # Date of Accident Social Security Number

RECORDS RELEASE (Please read and sign)

I hereby authorize the release of any medical or other information necessary to process my claim for medical benefits. I authorize my Insurance Company to issue payment directly to this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

_____ _____
Patient or Parent/Legal Guardian for patient under 18 years of age Date

_____ _____
Witness's Signature Date

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Authorization & Consent to Examine & Treat

To Whom It May Concern:

I hereby authorize the Providers of Total Health Wellness Center to administer all Medical examination procedures as deemed necessary. I have reported all health conditions that I am aware of and will inform my Practitioner of any changes in my health.

_____ _____
Patient signature Date

_____ _____
Signature of Parent or Legal Guardian (under 18) Date

Our Cancellation Policy

Since your appointment time is important and reserved especially for you, we ask that you please call AS SOON AS POSSIBLE, preferably 24 hours in advance, to make any changes to it. This allows us to offer that time to another patient who needs care.

We reserve the right to charge a Missed Appointment Fee of $55.00 to those patients who miss their appointment without notifying us, or who repeatedly cancel with less than 24 hours notice.

We value your business and strive to ensure that we are always available to you, as well as the rest of our patients, when you need us.

Thank you.
I understand and agree to the above:

Patient/ Legal Guardian Signature: _____ **Date:** _____

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Acknowledgement of receipt of Notice of Patient Privacy Practices

I have received the NOTICE OF PATIENT PRIVACY PRACTICES, which describes how The Providers and Representatives of **Total Health Wellness Center** may use and disclose my protected health care information to carry out treatment, payment of services, health care operations and other purposes that are allowed by law. This notice also describes my patient rights and the requirements of **Total Health Wellness Center** to protect my health information.

Total Health Wellness Center reserves the right to change the privacy practices that are described in the NOTICE OF PATIENT PRIVACY PRACTICES. All changes will be posted in the clinic. I understand that I may request a copy of this notice at any time and discuss its content with the Privacy Officer.

Signature of Patient or Personal Representative **Date**

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**

TOTAL HEALTH WELLNESS CENTER
FINANCIAL RESPONSIBILITY AGREEMENT
KELLY L. HUBBARD, D.C.

Policy:

1. All patients not covered by insurance must pay at time of service.

2. All co-pays, deductibles, and balances will be collected at the time of service.

3. In those cases where your insurance company denies payment, you are responsible for costs incurred. Payment is expected before the end of the billing month.

4. Any balances due to Total Health Wellness Center Providers after your Insurance carrier has notified the Clinic of payment or non-payment will be billed to you.
After thirty (30) days of the first bill, a finance charge of $2.50 per month will begin to apply to your account. Any bill over ninety (90) days past due will be subject to collection procedures.

If you need to make payment arrangements, you can do so by contacting our Billing office. Once you agree to a payment plan, you will sign on your agreement. All payment agreements must be followed through within the allotted timeline.

We reserve the right to agree, or not, to payment plans, as they are not a guaranteed service of our clinic.

I, _____ (patient's name or name of parent/legal guardian or responsible/legal party) as a patient of Total Health Wellness Center, acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

_____
Signature of Patient or Parent/Legal Guardian/Responsible Party

_____
Patient's Printed Name

Date _____

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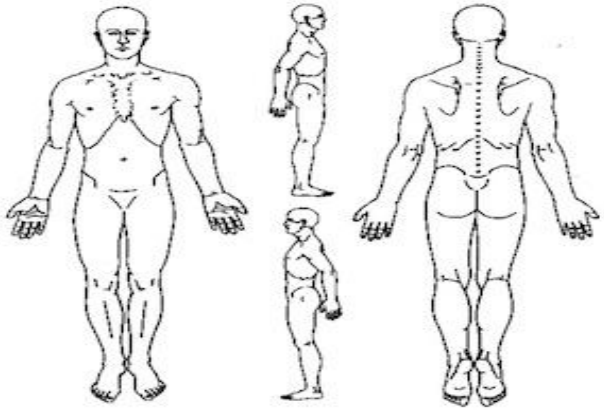
Confidential Patient Health Record

File #:

Patient Name: **DOB:** **Exam Date:**

Occupation: Previous Chiropractic Care?

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began: _____

Current complaint (how you feel today):

No Pain 1 2 3 4 5 6 7 8 9 Unbearable

How often are your symptoms present?

(Occasional) ☐ 0 - 25% ☐ 26 - 50% ☐ 51 - 75% ☐ 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (work, socializing, household activities)

No interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

Briefly describe any other info regarding your condition: _____

Does bed rest make your symptoms?

☐Better ☐Worse ☐No Effect

How long do your symptoms last?

_____

What symptoms did you notice first?

_____

Have you seen other Doctors for this condition?

☐ No ☐ Yes

If yes, who & when _____

Spinal X-Ray, MRI, CT Scan? ☐ No ☐ Yes

If yes, when & where _____

Any past auto accidents? ☐ No ☐ Yes (Describe) _____

Any hospitalizations/surgeries? ☐ No ☐ Yes (Describe) _____

Any prior injuries we should be aware of? ☐ No ☐ Yes (Describe) _____

Please check all of the following that apply to you:

☐ Cancer
☐ Diabetes
☐ High Blood Pressure
☐ Heart Problems
☐ Stroke
☐ Rheumatoid Arthritis
☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Abnormal weight Gain/Loss
☐ Marked Morning Pain/Stiffness
☐ Unrelieved Pain by Position/Rest
☐ Pain at night
☐ Visual Disturbances
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Tobacco Use
☐ Shoe Lifts
☐ Currently Pregnant
If Yes, # of weeks _____

Please check any medications you are taking currently:

☐ Blood Pressure Medication
☐ Aspirin
☐ Birth Control Pills
☐ Insulin
☐ Nerve Pills
☐ Corticosteroid Use (Cortisone, Prednisone, etc)
☐ Antidepressants
☐ Vitamins/Supplements
☐ Pain Killers/Muscle Relaxants
☐ Other: _____

Any Allergies? ☐ No ☐ Yes (Describe) _____

Doctor's name & date of last physical exam: _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems ☐ Stroke ☐ Rheumatoid Arthritis