

PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ - _____ - _____ E-mail: _____

Date of Birth: _____ Sex: M F Prefer Not to Answer

Marital Status: _____ Occupation & Employer: _____

Work #: _____ - _____ - _____

Name of Family Doctor: _____ Preferred Language: _____

What are you most concerned about? _____

Who can we thank for referring you? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone #: _____ - _____ - _____

Name: _____ Relationship: _____ Phone #: _____ - _____ - _____

INSURANCE CLAIM INFORMATION

Date of Accident: ____ / ____ / ____ Driver's Name: _____

Insured Name: _____ Relationship to Insured: _____

Insurance Company: _____ Insured Policy #: _____

Claim #: _____ Adjuster: _____

Other Driver's Name: _____

Other Vehicle's Insurance: _____ Claim #: _____

ATTORNEY INFORMATION

Is there an attorney involved? Yes No Law Firm: _____

Attorney's Name: _____ Phone #: _____ - _____ - _____

If you were a pedestrian or on a bicycle:

- Do you or anyone in your household own a car? Yes No Auto Insurance: _____

PLEASE PROVIDE YOUR PHOTO ID AND CAR INSURANCE

The above information is accurate to the best of my knowledge.

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

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and, if necessary, diagnostic x-rays, on me by one of the clinic's physicians.

I have had the opportunity to discuss with the Chiropractic Physician the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am aware that, as in all healthcare, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, fractures and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor/associates/personnel to exercise judgment during the course of the procedure which they feel is at the time, based upon the known facts, is in my best interest.

I have read the above and consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the chiropractic procedures mentioned above. I intend for this consent form to cover the entire course of all treatments.

Patient/ Guardian Signature

Date

Print Name

Signature of Chiropractic Physician



11138 NE Halsey St.
Portland, OR 97220
Phone 503.575-9934

HIPAA Patient Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing the consent.

The terms of the notice may change. You can contact our office for an updated copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree with these restrictions.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

Patient/ Guardian Signature: _____ Date: ____ / ____ / ____

Print Name (Patient/ Guardian): _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FORM

I authorize: _____
(Name of Person / Entity disclosing information)

To disclose a copy of all medical and health records regarding;

(Patient Name) DOB: ____ / ____ / ____
MM DD YYYY

To Cura Chiropractic (Recipient),

At the request of the individual, for the purpose of providing healthcare.

If the information to be disclosed contains any type of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

- ___ HIV/AIDS Information
- ___ Mental health information
- ___ Genetic testing information
- ___ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You may revoke this authorization in writing at any time. If you revoke your authorization described above, it may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, send a written statement declaring you are revoking authorization to:
Cura Chiropractic
11138 NE Halsey St.
Portland, OR 97220

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires in seven years.

By: _____ Date: ____ / ____ / ____
(Individual or Representative)

Description of representative's authority: _____

IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the clinic and doctors on whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of certain accident or injury-producing event which occurred on or about the date of injury(DOI) indicated below, to the full extent of the cost and treatment provided me by the Clinic.

I hereby authorized and direct my attorney(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing to the Clinic for the treatment and other professional services. Rendered me both by reason of this accident and by any other bills that are due the Clinic and to withhold such sums from the settlements, judgments, or verdicts which may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by the clinic.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the clinic's additional protection and in consideration for the Clinic's waiting for payment. I further understand that payment for services rendered by the Clinic is not contingent on any settlement, judgment, or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand that if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against attorney(s) for failing to honor this binding and irrevocable agreement between me and the Clinic.

I further understand and agree that the Clinic is not responsible for paying any of my attorney's fees and the Clinic does not agree to pay my attorney fees for honoring this agreement between me and the Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM SIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT ANY PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, AND LIEN."

Patient/Guardian Signature: _____ Date: ____/____/____

Patient/Guardian Printed Name: _____



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Authorization for Release of Information to Family Members

Patient Name: _____

Date of Birth: _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical and/or billing information. Under the requirements of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to family members you must sign this form. Signing this form will only give information to the family members indicated below.

I authorize **PDX Chiropractor (True Wellness LLC.)** to release my medical and/or billing information to the following individual(s):

Name: _____	Relationship to Patient: _____
Name: _____	Relationship to Patient: _____
Name: _____	Relationship to Patient: _____

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Signature: _____	Date: _____
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