

# SYLVAN CHIROPRACTIC CLINIC AND WELLNESS CENTER, LLC

5440 SW WESTGATE DR., SUITE 100 ♦ PORTLAND, OR. 97221 ♦ 503.297.4447 ♦ FAX: 503.296.8414

## FOOD INTOLERANCE TESTING INTAKE—CONFIDENTIAL

**All sections in RED must be completed.** All information provided is strictly confidential.  
If you do not understand a question or are unsure of the information, please ask for assistance.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Marital Status:**  M  S  W  D  
**Primary Phone:** \_\_\_\_\_ **Secondary/Cell Phone:** \_\_\_\_\_  
**Cell Phone Carrier:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**Confidential communication preference (lab/x-ray reports, appt. confirmations):**  Cell#  Home#  Work#  Email  
How did you learn about our clinic?  Google  Yelp  Insurance Co.  Internet: \_\_\_\_\_  
 Physician/Friend Referral: \_\_\_\_\_  Other: \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ **Relation:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### EMPLOYMENT INFORMATION

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
**Work Address:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_  
Spouse Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### MEDICAL INFORMATION

**Date of last physical exam:** \_\_\_\_\_ **Are you pregnant?**  Yes  No  
**Current primary care physician:** \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
What operations have you had? \_\_\_\_\_  
Serious illnesses: \_\_\_\_\_  
Have you ever been under chiropractic care?  Yes  No Dr.'s Name: \_\_\_\_\_

### PAYMENT IS EXPECTED AT TIME OF VISIT

*I understand and agree that the health and accident insurance policies are an arrangement between me and an insurance carrier. I give this office power of attorney to endorse checks made out to me, to be credited to my account. I authorize the physician to release any information that is required or necessary for my claim. I clearly understand and agree that all services rendered to me are charged directly to me and will be immediately due and payable. I understand that I am directly and fully responsible to Sylvan Chiropractic Clinic, LLC for services rendered and that this agreement is solely made for the protection of Sylvan Chiropractic Clinic, LLC. Should collection procedures become necessary to collect the amount due Sylvan Chiropractic Clinic, LLC for my treatment, additional charges for attorneys' fees and interest will be added to the balance owed for treatment. I further understand that such payment is not contingent on any settlement, insurance payment, including the balance remaining after payment of possible insurance benefits, judgment, or verdict by which I may eventually recover said chiropractic services.*

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## **ACKNOWLEDGEMENT AND UNDERSTANDING**

**Please initial each item below:**

1. \_\_\_\_\_ I hereby authorize Sylvan Chiropractic Clinic and Wellness Center, LLC to provide chiropractic services for me. I have also received a Notice of Privacy Practices and the Insurance Coverage and Patient Liability Policy.
  
2. \_\_\_\_\_ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Sylvan Chiropractic Clinic and Wellness Center, LLC.
  
3. \_\_\_\_\_ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys' fees and cost of collections.
  
4. \_\_\_\_\_ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Sylvan Chiropractic Clinic and Wellness Center, LLC (5440 SW Westgate Drive, Suite 100, Portland, OR 97221).
  
5. \_\_\_\_\_ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

**By signing this application I affirm under penalty that I have given true complete information.**

**Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Guarantor's Signature**

\_\_\_\_\_  
**Guarantor's Relationship to Patient**

## **AUTHORIZATION TO TREAT A MINOR**

By signing below, I acknowledge and represent that I am the parent or legal guardian of:

\_\_\_\_\_  
**Patient's Full Name**

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Date of Birth**

I hereby authorize any chiropractic, physiotherapy, or massage therapy treatments deemed advisable at this time as well as at the time of any future visits deemed necessary for this patient if a parent or legal guardian is not available when the child is brought in for treatment.

I agree to hold Sylvan Chiropractic Clinic and Wellness Center and its staff free and harmless from any claims, suits for damages or complications which may result from such treatment.

This authorization will be effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_.

**Today's Date**

**Parent/Guardian Signature:** \_\_\_\_\_ **Witnessed by:** \_\_\_\_\_

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## PERSONAL HEALTH HISTORY

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

All information will be kept strictly confidential. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

**O = Occasional                      F = Frequent                      C = Constant**

<p><b>O F C</b>  <b>Muscle / Joint</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain, stiffness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p><b>General</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of weight  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness, depression  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p><b>Cardiovascular</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heartbeat  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heartbeat  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p><b>Genitourinary</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of kidney control  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p>	<p><b>O F C</b>  <b>Eye, Ear, Nose and Throat</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental decay  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noise  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p> <p><b>Gastrointestinal</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating abdomen  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood</p>	<p><b>O F C</b>  <b>Skin</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash)  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p><b>Pain or numbness in</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful tailbone  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor posture  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p><b>Respiratory</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><b>Women only</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excess menstrual flow  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, how many months? _____          How many children do you have? _____</p>
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*Check any of the following conditions you currently have or have had:*

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Cancer
- Chicken pox
- Cholera
- Cold sores
- Diabetes
- Diphtheria
- Eczema
- Edema
- Emphysema
- Epilepsy
- Fever blisters
- Goiter
- Gout
- Heart disease
- Herpes
- Influenza
- Lumbago
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Pacemaker
- Pleurisy
- Pneumonia
- Polio
- Rheumatic fever
- Scarlet fever
- Scoliosis
- Stroke
- Tuberculosis
- Typhoid fever
- Ulcers
- Venereal disease
- Whooping cough

**Describe purpose of appointment:** \_\_\_\_\_

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
What seemed to be the initial cause?	
Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, for what reason?	

Physician Signature \_\_\_\_\_ **Seth Alley, DC** Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*\*\* PLEASE CONTINUE TO OTHER SIDE OF FORM \*\*\*

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Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Have you been hospitalized in the last 5 years?  Yes  No If yes, for major surgery?  Yes  No for serious injury?  Yes  No

Indicate the drugs do you now take?  Birth control pills  Tranquilizers  Pain Killers  Other (specify)

<b>Do you:</b>	Yes	No	If yes, briefly explain.	
- take any prescription or OTC medications?	<input type="checkbox"/>	<input type="checkbox"/>		
- take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>		
- think you need minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>		
- have any drug allergy?	<input type="checkbox"/>	<input type="checkbox"/>		

<b>When did you last have:</b>	Never	0-6 mos.	6 -18 mos.	longer
- physical examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

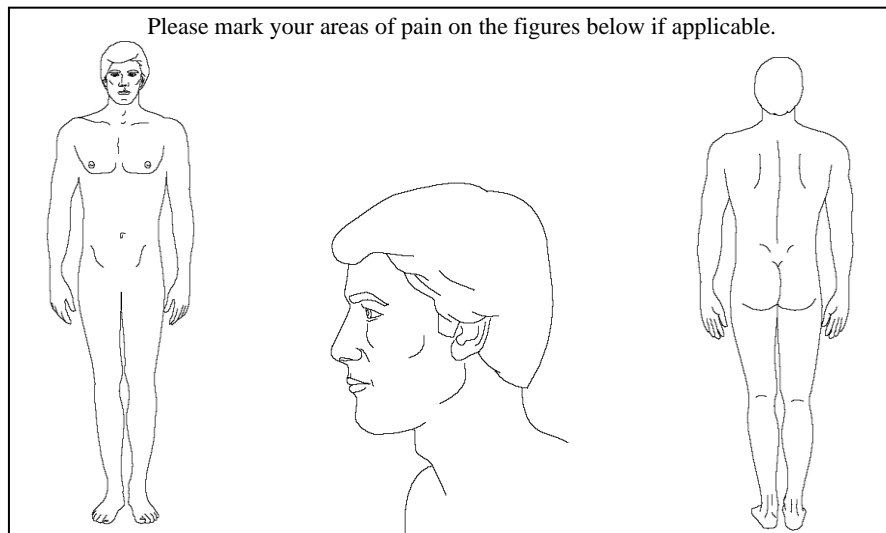
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HEALTH HISTORY:** Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS



Physician Signature \_\_\_\_\_ Seth Alley, DC Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## Digestion Questionnaire

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

### Symptoms Checklist

Enter your scores into the appropriate categories in the chart.

Rate the frequency and severity of your symptoms:

0 = Never have the symptom

3 = Frequently experience mild symptoms

1 = Occasionally experience mild symptoms

4 = Frequently experience severe symptoms

2 = Occasionally experience severe symptoms

Digestive Tract				Skin				Mouth & Throat				Nose			
AM	N	PM		AM	N	PM		AM	N	PM		AM	N	PM	
Belching				Acne				Canker Sores				Excessive Mucous			
Bloated Feeling				Dermatitis				Chronic Coughing				Hay Fever			
Constipation				Dry Skin				Gagging				Post-Nasal Drip			
Diarrhea				Eczema				Receding Gums				Sinus Problems			
Nausea				Hair Loss				Sore Throat				Sneezing Attacks			
Gas				Itching				Swollen Tonsils				Stuffy Nose			
Smelly Stools/ Mucous in Stools				Excessive Sweating/ Flushing/Hot Flashes				Swollen Tongue/ Lips/Gums							
Stomach Pains				Hives/Rashes											
<b>Total</b>				<b>Total</b>				<b>Total</b>				<b>Total</b>			
Mind				Mood				Joints & Muscles				Eyes			
AM	N	PM		AM	N	PM		AM	N	PM		AM	N	PM	
Brain Fog				Aggressiveness				Achy Muscles				Blurred Vision			
Focus				Anxiety/Fear				Arthritis				Dark Circles			
Poor Concentration				Depression				Joint Pain				Itchy Eyes			
Poor Memory				Mood Swings				Stiffness				Swollen Eyes			
Stuttering/ Stammering				Nervousness				Weakness				Watery Eyes			
<b>Total</b>				Irritability/ Anger				Limited Joint Movement				Sticky/Crusty Eyelids			
				<b>Total</b>				<b>Total</b>				<b>Total</b>			
Energy & Activity				Ears				Head				Lungs			
AM	N	PM		AM	N	PM		AM	N	PM		AM	N	PM	
Apathy				Drainage				Dandruff				Asthma/Bronchitis			
Fatigue				Ear Aches				Dizziness				Congestion			
Hyperactivity				Ear Infections				Headaches				Difficulty Breathing			
Insomnia				Itchy Ears				Lightheadedness				Shortness of Breath			
Restlessness				Ringing in Ears				Migraines				Wheezing			
<b>Total</b>				<b>Total</b>				<b>Total</b>				<b>Total</b>			
Weight				Other											
AM	N	PM		AM	N	PM									
Binge Eating				Chest Pains											
Compulsive Eating				Frequent Illness											
Food Cravings				Rapid Heartbeat											
Underweight				Urgent Urination											
Weight Gain															
<b>Total</b>				<b>Total</b>											

**For FEMALE patients:**

Are you currently taking any oral contraceptive pills?  YES  NO

If yes: Which prescription are you using, and for how long? \_\_\_\_\_

Physician Signature \_\_\_\_\_ Seth Alley, DC Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **Consent to Treatment**

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) 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. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurological impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of 0.5 to 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

*I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.*

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Please read the following carefully and initial each statement:**

\_\_\_\_\_ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the supervising physician because it may affect care.

\_\_\_\_\_ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Sylvan Chiropractic Clinic and Wellness Center, LLC reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

## **CONSENT FOR TREATMENT OF A MINOR**

By signing below, I acknowledge and represent that I am the parent or legal guardian of:

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Patient's Full Name** **Date of Birth**

I hereby authorize any chiropractic, physiotherapy, or massage therapy treatments deemed advisable at this time as well as at the time of any future visits deemed necessary for this patient if a parent or legal guardian is not available when the child is brought in for treatment.

I agree to hold Sylvan Chiropractic Clinic and Wellness Center and its staff free and harmless from any claims, suits for damages or complications which may result from such treatment. This authorization will be effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_.

**Today's Date**

**Parent/Guardian Signature:** \_\_\_\_\_

**Witnessed by:** \_\_\_\_\_

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## **Clinic Financial Policy**

**Thank you for choosing Sylvan Chiropractic Clinic and Wellness Center to help you maximize your body's potential for performance and longevity. Please familiarize yourself with our clinic's financial policy by reading the following information about how your medical charges will be handled.**

### **OFFICE POLICY AND PAYMENT RESPONSIBILITY**

The responsible party is obligated for payment in full of this account. In the event your private insurance company does not compensate us within sixty (60) days after billing, we must require you to pay us directly and work out your difficulties with your insurance carrier. **You are responsible for timely payment of your account. Patient balances are due 30 days after receipt of your statement. Balances over 60 days are subject to a \$20 statement re-billing fee. Balances 90 days past due may be reviewed for collections and if sent to collections, a fee of 30% of the overdue amount may be assessed.** Any worker's compensation and/ or motor vehicle claims that are denied by the insurance carrier will become due in full once our office receives an official denial of the claim. If you suspend or terminate your care and treatment, fees for professional services rendered will be charged directly to you and are immediately due and payable. In the event of non-payment, the responsible party shall bear the cost of collection and/or court costs and reasonable legal fees should this be required. All supplements/vitamins, lab work, supports and other supplies must be paid for at the time they are received. **There will be the additional charge of \$30.00 for all returned checks due to insufficient funds.**

**There will be a \$35 fee charged for missed appointments not cancelled or rescheduled at least 24 hours in advance.**

### **BILLING YOUR INSURANCE CARRIER**

We will gladly submit your medical bills to your primary insurance. All estimated co-pays, co-insurance, deductibles and supply charges are due on the day of treatment, unless special arrangements have been agreed upon prior to visit. We accept cash, check, and credit card (Visa, MasterCard) payments at this time. You will be balance billed any remaining charges after your insurance processes your claim. Insurance policies are a contractual arrangement between an insurance carrier and the insured. Possession of a medical insurance member ID card is NOT a guarantee of coverage. **As a courtesy, the clinic will make the best effort in determining your benefits in advance of treatment. However, you are ultimately responsible as the policy holder to contact your insurance company to determine your own benefits and coverage.**

**If you do not have chiropractic coverage or elect to not use your insurance coverage, you must complete a Self-Pay Discount form if you elect to not have us bill your insurance or you have no coverage.**

### **INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS**

I authorize my insurance benefits to be paid directly to Sylvan Chiropractic Clinic and Wellness Center, LLC. I authorize the release of any medical information necessary to process this claim. By signing below, acknowledge that any quote of benefits that has been given to me by the clinic staff, is only a quote, and does not guarantee payment from my insurance company. In the event that my insurance fails to pay partially, or in full, I am held financially responsible for any and all charges. I understand it is my responsibility to verify my insurance coverage and must direct any questions I may have to my employer and/or insurance. I attest that I have provided Sylvan Chiropractic Clinic and Wellness Center, LLC with any and all insurance coverage information. I have read this form and understand and agree to all of the above applicable responsibilities and policies. **I acknowledge I have received and reviewed the Insurance Coverage and Patient Liability Policy hand out that outlines further policy details.**

I have read, understand and agree with the above financial policy.

**Patient or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# **SYLVAN CHIROPRACTIC CLINIC AND WELLNESS CENTER, LLC**

5440 SW WESTGATE DR., SUITE 100 ♦ PORTLAND, OR. 97221 ♦ 503.297.4447 ♦ FAX: 503.296.8414

## **Insurance Coverage and Patient Liability Policy**

**♦♦♦ PLEASE KEEP THIS DOCUMENT FOR YOUR RECORDS ♦♦♦**

We accept assignment on most medical insurance plans, auto injury cases and worker's compensation claims. The contract of medical health insurance is between the patient and the insurance company. The patient is responsible for knowing their individual insurance plan coverage. The patient is also responsible for knowing any changes made to their insurance plan by the insurance company or the subscriber's employer, and notifying the clinic of such changes. Possession of a medical insurance member ID card is NOT a guarantee of coverage. As a courtesy, the clinic will make the best effort in determining your benefits in advance of treatment. We cannot guarantee the accuracy of the information they provide because a quote is NOT a guarantee of payment from your insurance company. Payment is subject to the terms and conditions of your policy. You are ultimately responsible as the policy holder to contact your insurance company to determine your own benefits and coverage.

### **Co-Pays, Co-insurances and Deductibles**

We will collect all co-pays, co-insurance and deductibles at the time of service based on the insurance quote we have been given. Final patient responsibility will be determined once your insurance company processes your claim.

### **Payment**

We are happy to provide the service of billing your insurance company on your behalf and will accept payment from them directly, but any monies owed on your account are ultimately your responsibility per our financial agreement. The clinic cannot be responsible for disputing or appealing the way your insurance has processed payment on a claim. It is very important that you provide legible and accurate patient information to the clinic at the time of your first appointment and update us of any changes. Incomplete or inaccurate information can cause claim processing delay and/or denials. If once your insurance has addressed your claim and we are not paid in full by your insurance company (less any contractual write-offs resulting from network participation) you will be balanced billed any remaining charges and be required to pay us directly. Please be aware that when dealing with insurance companies, misquotes can be given, maximums can be met, policies and coverage can change, certain services involved in your treatment plan may not be covered under your policy, amounts billed may be above your insurance allowable, and deductibles may not be met in full—all of which can alter the amount of your bill after the claim has been submitted and processed. We encourage you to verify your own insurance coverage every year to review any changes in your policy. We also ask that before your first visit of the year, you notify us of any changes in your insurance and upon your visit give us a copy of any new insurance cards you might have received. We do our best to help you with your insurance benefits. If you are ever balanced billed an amount that you may find difficult to pay, please contact us for possible payment arrangements.

You are responsible for timely payment of your account. Patient balances are due 30 days after receipt of your statement. Balances over 60 days are subject to a \$20 statement re-billing fee. Balances 90 days past due may be reviewed for collections and if sent to collections, a fee of 35% of the overdue amount may be assessed. Any worker's compensation and/or motor vehicle claims that are denied by the insurance carrier will be considered due in full once our office receives an official denial of the claim. We will mail you a statement to the address you provide us if any additional balances are due which will be due upon receipt.

### **Auto Injury Cases**

If you are hurt in an accident and it is deemed the other driver's fault, the other driver's auto insurance company is responsible. However, in some cases this third party will not pay out on a claim until the case is settled. If you choose not to file a PIP claim and want to wait on the third-party settlement then it is required that you are a self-pay patient and pay at the time of service and submit the bill yourself to the third party so you can be reimbursed when you claim settles.

All auto liability policies in Oregon are required to provide Personal Injury Protection (PIP [no-fault]) coverage for prompt payment of reasonable and necessary medical expenses resulting from an accident. There is no penalty to you for making a PIP claim under your own policy. However, your insurance company is entitled to be reimbursed by the responsible person's insurance company. First general rule: "PIP follows the car." If the car is insured, PIP covers all occupants no matter who was at fault. By law, PIP must cover at least \$15,000 worth of medical expenses occurring within 365 days of the accident as long as it is deemed reasonable and necessary. Any amounts over your PIP should be



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covered by your healthcare insurance. If you do not have healthcare insurance or your healthcare insurance policy does not cover the services provided in our clinic, you will be personally liable for any amounts in excess of your PIP insurance. Even though you file a PIP claim there may come a time during the course of your treatment where your PIP stops making payments on your medical expenses. For this reason, we have all motor vehicle accident patients sign an "Assignment and Understanding" document with our clinic, which you will be given at the time of your first appointment. If your PIP exhausts, denies and/or expires and we are unable to secure payment from your healthcare insurance, the lien gives the clinic added protection so that we can be assured reimbursement for services rendered from any settlement awarded to you resulting from the injury case. Your insurance company will not advise us on how much money is available in your PIP or warn us when it is about to exhaust. Only you are authorized to obtain that information.

## **Medicare Non-Covered Services**

According to existing Medicare law, many of the services in our office are NON-COVERED and are the responsibility of the patient.

### **Examples of Non-Covered Services:**

**All Services Other than Chiropractic Adjustments:** office visits to evaluate and manage, re-evaluate, advise, or give counsel regarding your health; physiotherapy such as massage, traction, electrical stimulation, neuromuscular re-education, etc.; x-rays, laboratory, supplies, and vitamins

**Various Chiropractic Adjustments or Treatments:** non-spinal manipulation to the shoulder, arm, leg, etc.; maintenance care of a condition which is stable and not making any more improvement; wellness care to promote health

## **Time of Service (Self-Pay) Payments**

Our clinic strives to provide exceptional care that is reasonable and necessary for our patients at a price that is affordable. For those patients that do not have insurance coverage or do not wish to utilize existing coverage, you must sign the Self-Pay Patient Agreement form to acknowledge that you do not have health insurance or you are choosing not to have your insurance billed for the services you are receiving. If at any time you present insurance to our clinic to bill on your behalf within your insurance company's timely filing and policy guidelines, we will commence submitting claims to your insurance company. You may choose to submit a statement to any insurance company to seek reimbursement yourself provided that our clinic is not contracted with that insurance. Under some circumstances payment plans may be available for Self-Pay patients.

## **Billing Questions**

The financial realm of health care can be confusing and frustrating for patients as well as practitioners and support staff. We want to be your partner in the process to help you receive the most of your insurance benefits. An Explanation of Benefits (EOB) from your insurance company is a statement detailing your medical benefits account activity. It is important to carefully read your EOB once you receive it as the information on the EOB helps you understand how your benefits were applied to that particular claim. It will show the amount we billed for the service, the amount the insurance allows for the service, any co-pays, co-insurance and or deductible that was applied, and amounts not covered because it is either a provider contractual write-off or patient responsibility. It should provide an explanation of any denial, reduction, or any other reason for not providing full reimbursement for the amount billed. If you don't feel the claim was processed correctly we encourage you to contact your insurance so that their customer service can explain why your policy did not allow for reimbursement. As a member you are entitled to appeal denials and to receive a copy of the criterion relied upon in making the determination to deny your claim. The more proactive you are with your healthcare, the better chance you have of getting your claims paid accurately with the least amount of out-of-pocket expense to you.

If you have any questions regarding your medical bills or account status, please contact our offices at (503) 297-4447.

Thank you,  
Sylvan Chiropractic Clinic and Wellness Center

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## **Notice of Privacy Practices**

**♦ ♦ ♦ PLEASE KEEP THIS DOCUMENT FOR YOUR RECORDS ♦ ♦ ♦**

This notice illustrates how your personal health information may be used and disclosed, and how you can gain access to this information. Please review this notice carefully. Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this notice of our privacy practices, and to inform you of your rights and our obligations concerning your health information. We are required to follow the privacy practices described below while this notice is in effect. This notice is effective as of April 14, 2003, and will remain in effect until it is replaced.

### ***CHANGES TO NOTICE***

We reserve the right to change this notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this notice to reflect the changes, and make the revised notice available to you upon request. Any changes we make to our privacy practices and/or this notice may be applicable to health information created or received by us prior to the date of the changes. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

### ***PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION***

**A. TREATMENT, PAYMENT, and HEALTHCARE OPERATIONS:** You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

*Treatment:* We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

*Payment:* We may use and disclose your health information to obtain payment for services we provide to you.

*Healthcare Operations:* We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

**B. AUTHORIZATIONS:** You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

**C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES:** We must disclose your health information to you as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

**D. MARKETING:** We will *not* use your health information for marketing communications without your written authorization.

**E. USES OR DISCLOSURES REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health 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.

**F. PATIENT AND THIRD PARTY PROTECTION:** Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**G. LAW ENFORCEMENT/NATIONAL SECURITY:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law, and to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

**H. APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## ***PATIENT RIGHTS***

A. **ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. **We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you \$10.00 for the first page and .50 for each additional page, and postage if you want the copies mailed to you.** If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. **ACCOUNTING OF CERTAIN DISCLOSURES.** Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. **RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS:** You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. **AMENDMENTS TO RECORDS:** You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. **ELECTRONIC NOTICES.** If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## ***QUESTIONS AND COMPLAINTS***

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Please direct any of your questions or complaints to:

Dr. Seth Alley, DC, CKTP  
Sylvan Chiropractic Clinic and Wellness Center, LLC  
5440 SW Westgate Dr., Suite 100  
Portland, OR 97221  
Phone: 503.297.4447  
Fax: 503.296.8414  
Email: drseth@sylvanchiropractic.com

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**Self-Pay Patient Agreement  
(For Patients Choosing NOT to Use Their Insurance Benefits)**

Treatment: Chiropractic and/or Massage Therapy

I understand that I am agreeing to pay for my care in full at the time of service for my treatment at the Sylvan Chiropractic Clinic and Wellness Center, LLC. By signing below, I am indicating that I have no health insurance that the Sylvan Chiropractic Clinic and Wellness Center, LLC can bill, or I am choosing not to have my insurance billed for the services I am receiving.

If at any time after this date, I present insurance for the Sylvan Chiropractic Clinic and Wellness Center, LLC to bill on my behalf within my insurance company's timely filing and policy guidelines, my treatment costs will be submitted to my insurance company for payment.

Patient's name:

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Signature:

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Date:

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Witnessed by:

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