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
Gender: □ M □ F **Sex:** □ M □ F □ NB **Email:** _____
Cell Phone: _____ **Home Phone:** _____
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

O F C

Muscle / Joint
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

Genitourinary
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Lack of kidney control
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

O F C

Eye, Ear, Nose and Throat
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nose bleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

Gastrointestinal
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gallbladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

O F C

Skin
- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

Pain or numbness in
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

Women only
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have? ____

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ 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? ☐ Yes ☐ No

What seemed to be the initial cause?

Are you under the care of a physician? ☐ Yes ☐ 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)

Do you:	Yes	No	If yes, briefly explain.
- take any prescription or OTC medications?	☐	☐	
- take minerals, herbs or vitamins?	☐	☐	
- think you need minerals, herbs or vitamins?	☐	☐	
- have any drug allergy?	☐	☐	

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- physical examination?	☐	☐	☐	☐

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

_____

_____

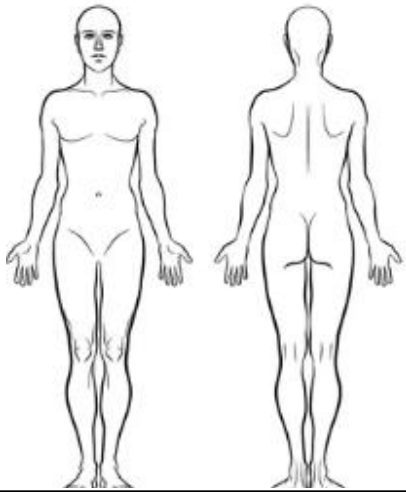
_____

HABITS	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

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

Please mark your areas of pain on the figures below if applicable.



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

1= Occasionally experience mild symptoms

2 = Occasionally experience severe symptoms

3 = Frequently experience mild symptoms

4 = Frequently experience severe symptoms

Digestive Tract	AM	N	PM
Belching			
Bloated Feeling			
Constipation			
Diarrhea			
Nausea			
Gas			
Smelly Stools/ Mucous in Stools			
Stomach Pains			
Total			

Skin	AM	N	PM
Acne			
Dermatitis			
Dry Skin			
Eczema			
Hair Loss			
Itching			
Excessive Sweating/ Flushing/Hot Flashes			
Hives/Rashes			
Total			

Mouth & Throat	AM	N	PM
Canker Sores			
Chronic Coughing			
Gagging			
Receeding Gums			
Sore Throat			
Swollen Tonsils			
Swollen Tongue/ Lips/Gums			
Total			

Nose	AM	N	PM
Excessive Mucous			
Hay Fever			
Post-Nasal Drip			
Sinus Problems			
Sneezing Attacks			
Stuffy Nose			
Total			

Mind	AM	N	PM
Brain Fog			
Focus			
Poor Concentration			
Poor Memory			
Stuttering/ Stammering			
Total			

Mood	AM	N	PM
Aggressiveness			
Anxiety/Fear			
Depression			
Mood Swings			
Nervousness			
Irritability/ Anger			
Total			

Joints & Muscles	AM	N	PM
Achy Muscles			
Arthritis			
Joint Pain			
Stiffness			
Weakness			
Limited Joint Movement			
Total			

Eyes	AM	N	PM
Blurred Vision			
Dark Circles			
Itchy Eyes			
Swollen Eyes			
Watery Eyes			
Sticky/Crusty Eyelids			
Total			

Energy & Activity	AM	N	PM
Apathy			
Fatigue			
Hyperactivity			
Insomnia			
Restlessness			
Total			

Ears	AM	N	PM
Drainage			
Ear Aches			
Ear Infections			
Itchy Ears			
Ringing in Ears			
Total			

Head	AM	N	PM
Dandruff			
Dizziness			
Headaches			
Lightheadedness			
Migraines			
Total			

Lungs	AM	N	PM
Asthma/Bronchitis			
Congestion			
Difficulty Breathing			
Shortness of Breath			
Wheezing			
Total			

Weight	AM	N	PM
Binge Eating			
Compulsive Eating			
Food Cravings			
Underweight			
Weight Gain			
Total			

Other	AM	N	PM
Chest Pains			
Frequent Illness			
Rapid Heartbeat			
Urgent Urination			
Total			

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 associatedtwith 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: _____

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24-Hour Appointment Cancellation/Rescheduling Fee Policy

Sylvan Chiropractic Clinic and Wellness Center, LLC, has a 24-hour appointment cancellation/rescheduling policy.

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

We reserve the right to charge this fee to your credit card in the event that you fail to notify the clinic according to this policy.

By signing this form, you are agreeing to this 24-hour appointment cancellation/rescheduling policy and authorizing Sylvan Chiropractic Clinic and Wellness Center, LLC, to charge your card if this occurrence happens.

Credit Card #: _____

Expiration Date: _____ / _____ / _____ **Security Code: _____**

Patient Name (printed): _____

Patient Signature: _____ Date: _____ / _____ / _____

This fee is your responsibility and cannot be charged to your insurance company.

This policy is in place out of respect for you and your fellow patient. By giving last-minute notice or no notice at all, you prevent another patient from being able to schedule at that time. Notifying our office of your scheduling change in advance gives us the ability to allow other patients needing care to be seen that day—including potentially you if you need immediate care.

We strive to accommodate patients' schedules and offer treatment as soon as possible, but this requires participation from our patients to keep our schedule accurate and available for all patients.

Thank you for your understanding and cooperation.

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Self-Pay Patient Agreement

For patients choosing to NOT bill private insurance

We are contractually obligated to bill your insurance carrier for your treatment if our practitioners are in-network with your carrier. If you choose to NOT bill your insurance carrier for any reason—such as a high deductible plan or limited annual visits—you must indicate this decision by completing this document PRIOR to receiving care to allow us to waive this contractual obligation to your insurance carrier.

If at any time in the future you wish to terminate this agreement and choose to provide us with accurate and appropriate insurance information, your treatment costs will be submitted to your insurance company for payment. We do require that our practitioners be in-network with your carrier for this billing to occur. You must provide your insurance information to our clinic PRIOR to the date of service for which you want us to bill your insurance company on your behalf.

By signing below, I am indicating that either:

1) I do not have health insurance that can be billed for my treatment at the Sylvan Chiropractic Clinic and Wellness Center, LLC; or,
2) I am choosing to NOT have my insurance billed for the services I am receiving.

I hereby agree to pay for my treatment in full at the time of service at the Sylvan Chiropractic Clinic and Wellness Center, LLC.

Patient's name:

_____

Signature:

_____

Date:

_____ / _____ / _____

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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

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

SYLVAN CHIROPRACTIC CLINIC AND WELLNESS CENTER, LLC

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

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).

SYLVAN CHIROPRACTIC CLINIC AND WELLNESS CENTER, LLC

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

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:

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