

SYLVAN CHIROPRACTIC CLINIC AND WELLNESS CENTER, LLC

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

CHIROPRACTIC AND FOOD INTOLERANCE TESTING PATIENT REGISTRATION PACKET

PLEASE COMPLETE ALL SECTIONS. 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: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Age: _____ SS#: _____ - _____ - _____

Address: _____ Apartment/Unit #: _____

City: _____ State: _____ Zip: _____

Sex: M F Gender: M F NB Prefer not to say Marital Status: M S W D

Preferred Email: _____

Cell Phone: _____ Home Phone: _____

Confidential communication preference: Cell Phone Home Phone Work Phone Email

How did you learn about our clinic? Google Yelp Insurance Co. Internet/social media

Physician/Friend Referral: _____ Other: _____

Emergency Contact Name: _____

Relationship to patient: _____ Phone: _____

EMPLOYMENT INFORMATION

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

INSURANCE INFORMATION

Name of Insurance Co.: _____ Phone: _____

Policy ID #: _____ Group #: _____

Are you the main policy holder? Yes No

If you answered NO, what is the name and the date of birth of the policy holder?

Name: _____ Date of Birth: ____ / ____ / ____

Is your condition due to an injury/illness that occurred at your place of employment? Yes No

Is your condition due to an injury/illness that occurred due to an auto accident? Yes No

If you answer YES to either of the above questions, you MUST complete additional forms for your case.

Please download these forms from our website or alert the front office staff at the time of your visit.

Date symptoms occurred or accident happened: _____

Have you lost days from work? Yes No How many? _____ Date last worked? ____ / ____ / ____

MEDICAL INFORMATION

Date of last physical exam: _____ Are you pregnant? Yes No

Current primary care physician: _____

Phone: _____ Fax: _____

Have you ever been under chiropractic care? Yes No Dr.'s Name: _____

PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT

I understand and agree that my 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, or any other health plan) 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 registration, 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 Name (printed): _____

Parent/Guardian Signature: _____

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PERSONAL HEALTH HISTORY

Name: _____ DOB _____ / _____ / _____ Date _____ / _____ / _____

Please check all of the conditions or symptoms you currently have or have had previously. All information will be kept strictly confidential.

General

- Allergy
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Weight loss, unexplained
- Nervousness, depression
- Neuralgia
- Numbness
- Sweats
- Tremors

Muscle / Joint

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

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain
- Poor circulation
- Rapid heartbeat
- Slow heartbeat
- Swelling of ankles

Genitourinary

- Blood in urine
- Frequent urination
- Kidney infection
- Painful urination
- Prostate issues

Eye, Ear, Nose and Throat

- Asthma
- Colds
- Deafness
- Earache
- Enlarged thyroid
- Eye pain
- Failing vision
- Far/Near sightedness
- Gum trouble
- Nasal obstruction
- Nose bleeds
- Sinus infection
- Sore throat
- Tonsillitis

Gastrointestinal

- Belching or gas
- Colitis
- Constipation
- Diarrhea
- Difficult digestion
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hemorrhoids
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Rash
- Varicose veins

Pain or numbness in

- Shoulders
- Arms
- Elbows
- Hand
- Hips
- Legs
- Knees
- Feet
- Tailbone
- Sciatica
- Spinal curvature

Respiratory

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

WOMEN ONLY

- 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:

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

What brings you to the clinic today? _____

How long have you had this condition? _____ Is it getting worse? Yes No

Does it bother your (check appropriate box): Work Sleep Sports Other (please specify): _____

What seemed to be the initial cause? _____

Have you seen a chiropractor before? Yes No If yes, how long ago? _____

For what reason? _____ Was treatment effective? Yes No

Are you under the care of a physician? Yes No If yes, for what reason? _____

PHYSICIAN Signature _____ Seth Alley, DC, CCSP Date _____ / _____ / _____

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

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Name: _____ DOB _____ / _____ / _____ Date _____ / _____ / _____

Have you been hospitalized in the last 5 years? Yes No If yes, why? _____
 Are you currently taking any of the following: Birth control pills Sedatives Sleep aids Pain killers
 Do you wear: heel lifts orthotics negative heels platform shoes orthopedic braces (knee, ankle, etc.)?
 How old is your mattress? 1-5 years 6-10 years > 10 years
 Is it comfortable uncomfortable? Type: latex/foam coil/padding other: _____
 How is most of your day spent? Standing Sitting Walking

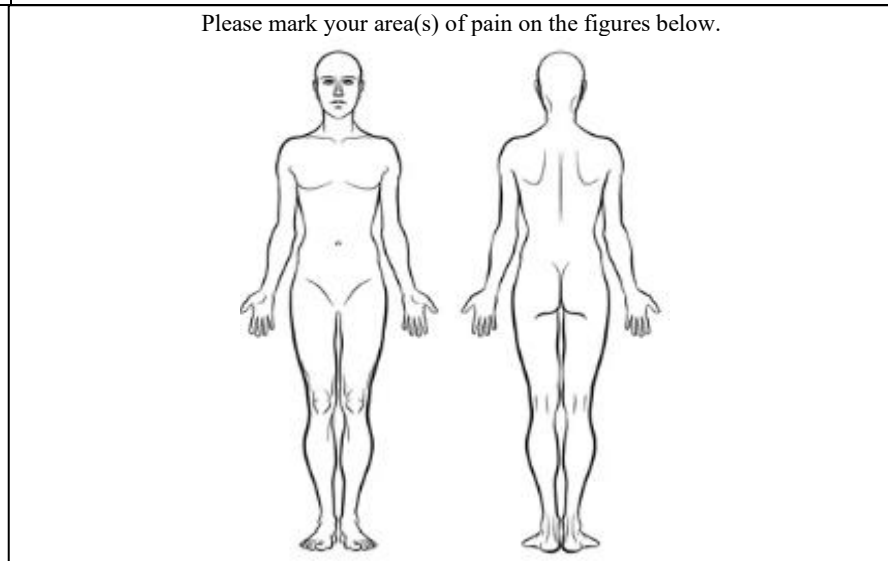
Have you ever:	Yes	No	If yes, briefly explain:	
- had a broken bone?	<input type="checkbox"/>	<input type="checkbox"/>		
- been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>		
- had strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>		
- been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>		
- been in a motor vehicle accident/collision?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you:				
- 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 allergies?	<input type="checkbox"/>	<input type="checkbox"/>		
When did you last have:				
- spinal x-ray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- spinal examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- 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 10 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, CCSP Date _____ / _____ / _____

Digestion Questionnaire

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

Mind	AM	N	PM	Mood	AM	N	PM	Joints & Muscles	AM	N	PM	Eyes	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			
Total				Irritability/ Anger				Limited Joint Movement				Sticky/Crusty Eyelids			
				Total				Total				Total			

Digestive Tract	AM	N	PM	Skin	AM	N	PM	Mouth & Throat	AM	N	PM	Nose	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											
Total				Total				Total				Total			

Energy & Activity	AM	N	PM	Ears	AM	N	PM	Head	AM	N	PM	Lungs	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				Ringling in Ears				Migraines				Wheezing			
Total				Total				Total				Total			

Weight	AM	N	PM	Other	AM	N	PM
Binge Eating				Chest Pains			
Compulsive Eating				Frequent Illness			
Food Cravings				Rapid Heartbeat			
Underweight				Urgent Urination			
Weight Gain							
Total				Total			

For FEMALE patients:

Are you currently taking any oral contraceptive pills? YES NO

If yes: Which contraceptive are you using? _____

How long have you been using this contraceptive? _____

Consent to Treatment

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 a patient 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. 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.

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 including attending scheduled appointments.

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.

Parent/Guardian Signature: _____

Parent/Guardian Name (Printed): _____

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 \$50 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. **Due to privacy limitations imposed by insurance carriers regarding coverage disclosures, the clinic WILL NOT assume responsibility to determine your benefits in advance of treatment. 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:** _____

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 \$50 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.

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:

_____ / _____ / _____

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. The clinic WILL NOT assume responsibility 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

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).

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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