Aspire Chiropractic & Massage
790 E. Powell Blvd.
Gresham OR, 97030
Ph:(503) 618-0147
Fax: (503) 618-0148

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	◯ Male ◯ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Referral Information:

Referring Physician:		Referred Patient:		Referred by	
Advertisement:	◯ Yes ◯ No	Advertisement:			
Referred Directory:	◯ Yes ◯ No	Referred Directory:			

Complaint Information:

Complaint Began ◯ Work ◯ Automobile ◯ Activity ◯ Other When did this begin: _____

Describe how it began _____

Describe Discomfort: _____

Interfere w/ Activities: ◯ Yes ◯ No Affected Sleep: ◯ Yes ◯ No Frequency of issue? _____

Effecting your life: ◯ Yes ◯ No What has it effected? _____ Current Functional % _____

Affected Appetite: ◯ Yes ◯ No _____

Reduced Work: ◯ Yes ◯ No Explain: _____

Does it Worsen: ◯ Yes ◯ No Explain: _____

Weather Affects it: ◯ Yes ◯ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯ Yes ◯ No Explain: _____

X-rays Taken For This: ◯ Yes ◯ No Explain: _____

Pain level Rating - Scale 1 to 10: At its best: ____ At its Worst: ____ Current Level: ____

Same Condition Before: ◯ Yes ◯ No Date: _____ Practitioner: _____

Patient Name: _____ Date:_____

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Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ○ Yes ○ No Date: _____ Condition(s) treated: _____

Chance Pregnant: ○ Yes ○ No Planning: ○ Yes ○ No Interested in improving health? ☐ Yes ☐ No Weight loss? Yes ☐ No ☐

Medications/Vitamins _____

Recent X-ray/MRI/CT _____

Personal Incident History:

Broken Bones: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Sprains/Strains: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Hospitalized: ○ Yes ○ No Explain: _____

Surgery: ○ Yes ○ No Explain: _____

Auto Accident: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Struck Unconscious: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Eating Disorder: ○ Yes ○ No Explain: _____

Stroke: ○ Yes ○ No Explain: _____

Health Checklist: Use the letter "C" for Current Problem and "P" for past problem.

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ Venereal Disease	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Irregular Menstrual	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Nosebleeds
☐ Pacemaker	☐ Polio	☐ Poor Posture
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ High Blood Pressure	☐ Sinus Infection	☐ Insomnia
☐ Spinal Curvatures	☐ Stroke	☐ Swelling of Ankles
☐ Swollen Joints	☐ Thyroid Condition	☐ Tuberculosis
☐ Ulcers	☐ Varicose Veins	

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Family Health History:

Family Health History

HIPPA/Privacy Statement

HIPPA Privacy Statement Health Insurance Portability & Accountability Act Statement (HIPPA) I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors and massage therapist see medically necessary based on my condition. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. Additonally I am signing below and understand Aspire Chiropractic's Privacy Practices, also known as the Health Insurance Portability and Accountability Act (HIPPAA). The notice below describes how related information about you may be used and disclosed and how you can get access to the information. You can request a copy of this at anytime in our office. I consent to the use or disclosure of my protected health information by Aspire Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for Aspire Chiropractic. I understand that diagnosis or treatment of me by Aspire Chiropractic may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Aspire Chiropractic is not required to agree to the restrictions that I may request. However, if Aspire Chiropractic agrees to a restriction that I request, the restriction is binding on Aspire Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Aspire Chiropractic has taken action in the reliance on this content. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Aspire Chiropractic's Notice of Privacy Practices prior to signing this consent document. The Aspire Chiropractic Notice of Privacy Practices has been offered and/or provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment or my bills or in the performance of health care operations of the Aspire Chiropractic. This Notice of Privacy Practices also describes my rights and the duties of Aspire Chiropractic with respect to my protected health information. Aspire Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices; I may obtain a revised notice of privacy practices by calling the Aspire Chiropractic's office and requesting a revised copy be sent in the mail or asking the one at the time of my next appointment. Insurance informationI understand and agree that health and accident insurance policies are an agreement between an insurancecarrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reportsand forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearlyunderstand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees forprofessional services rendered to me will be immediately due and payable. Consent to Use or Disclose Health Information By signing below I authorize Aspire Chiropractic to use and disclose the health and medical information, via fax, mail or electronically for the purposes of Treatment, Payment and Health Care.

Consent For Care:

When a patient seeks chiropractic health care it is essential for both patient and doctor to be working toward the same objective. A chiropractic adjustment is the primary treatment used by doctors of chiropractic and will most likely be part of your care. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy, electrical stimulation, stretching, mechanical traction, and massage on me (or on the patient named below, for whom I am legally responsible) by the above named Doctor of Chiropractic or Licensed Massage Therapist.Chiropractic Adjustment and Possible Risks: Dr. Betsill will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process. Though chiropractic treatments are usually beneficial and rarely cause any problem, I understand that, like many other forms of healthcare, there are some risks and potential complications. These risks and complications can include but are not limited to worsening of your condition, fractures, rib strains or separations, disc injuries, strokes, dislocations, sprains and strains, diaphragmatic paralysis, and cervical or lumbar myelopathy. Some types of manipulations to the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Dr. Betsill is aware of these complications and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. Massage: Audrey Roberts will use her hands and elbows to massage, knead, percuss, stretch and mobilize the tissues of the body. Though massage treatments are usually beneficial and rarely cause any problem, I understand that, like many other forms of healthcare, there are some risks. These can include but not limited to worsening of your condition, soreness, bruising, stiffness, fatigue, dizziness, or lightheadedness. Alternatives to chiropractic and massage therapy for common musculoskeletal conditions may include but not limited to allopathic medicine, surgery, physical therapy, acupuncture, and medications; such has muscle relaxers and pain killers, anti-inflammatory drugs.PARQ: I have had the opportunity to discuss and ask Questions with the doctor and massage therapist in regards to the Purpose, benefits, and Risks of the recommended chiropractic and massage treatment, and Alternatives to chiropractic and massage treatment have been reviewed.I further understand that health care providers cannot guarantee the results of treatment. I acknowledge that no guarantee or cure through chiropractic and massage has been made. I have had ample opportunity to ask questions, and my questions have been answered to my satisfaction. Having been informed of the risks, I hereby give my consent for treatment.To be signed by patient, patient's legal guardian, or legally responsible adult for a Minor.

I HAVE BEEN GIVEN AN OPPORTUNITY TO REVIEW A COPY OF THE ABOVE HIPPA AND CONSENT FOR CARE STATEMENT THAT IS LARGER IN TEXT.

Aspire Chiropractic & Massage Financial Agreement

Dear Patient:
Aspire Chiropractic will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Aspire Chiropractic. We wish to make it very clear that your health is your sole responsibility. These policies apply only to the services actually performed, and in no way obligates the patient to continue the course of care recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I choose the following method of payment for my care at Aspire Chiropractic:
_____ CASH, Check Debit, Credit Card (Co-insurance and Co-pays), COUPON OR VOUCHER - Payment is due at the time of services. All patients who wish to file their own insurance may receive the same cash price by paying for the service at the time of the service and waiting for reimbursement from their insurance company.

_____ WORKERS COMPENSATION INSURANCE - My employer's work compensation insurance company has agreed to pay for the services rendered by Aspire Chiropractic & Massage. I understand that I am responsible for any portion of this bill that my employer or their insurance carriers may refuse to pay.

_____PERSONAL INJURY – We will file your claim with the appropriate insurance carrier (your health insurance and/or auto med-pay), and the third party carrier (other person's insurance) as you are treated and file a Physician's Lien to assure payment. The third party carrier will not pay until settlement is reached. To prevent your premium from being affected due to a claim being made, even if you were not at fault, you may need to inform the third party insurance carrier to subrogate upon settlement of your claim; any balance will be forwarded to you. You agree not to allow your attorney to reduce our fees for their/your profit. When released, a 90 day time period is allowed for settlement. If you have not settled with the third party carrier within this time, or if you have suspended/terminated care without your doctor's approval, the balance of your account is due immediately.

_____INSURANCE POLICY COVERAGE – Group insurance is an agreement between you and your insurance company, not between your insurance company and your doctor. We will call your insurance company and investigate your benefits. As a reminder, investigation of benefits is a quote and is no guarantee of payment. You are ultimately responsible for any balance due. As a courtesy to our patients, our office will complete and file your claims on standard forms at no charge. We are credentialed by most insurance plans. The amount they pay varies from one policy to another. Because of the difference between policies, we request that each patient pay the deductible, percentage, and/or co-pay as stated in your policy at the time of service.

_____ MEDICARE –We have chosen to accept assignment with Medicare. This means that we will bill Medicare for adjustments only. Medicare covers only spinal manipulation and excludes exams, x-rays, and any therapies performed. It is your responsibility to pay your co-insurance or co-pay that is specific to your Medicare coverage. It is also your responsibility to pay the allowed amount per adjustment until your deductible has been met. Payment for co-pays and deductibles is due at the time of service.

By signing below: I hereby direct my insurance carrier(s) or attorney to pay by check made and mailed directly to: Aspire Chiropractic, 790 E. Powell Blvd. Gresham OR, 97030.
I also understand that I am personally responsible and agree to pay, in a current manner, any balance due after payment or non-payment by my insurance carrier(s) or attorney.
By signing below: I understand the Health Privacy Statement above have had time to discuss my condition with the doctor or massage therapist and consent to care.

Patient/Guardian Signature: _____ Date: _____

Dr. Mark Betsill's Signature: _____ Date: _____